

## **Submission to Senate Enquiry into Veteran and Ex-serviceman Suicide**

### **Term of Reference (a) – Why?**

Thomas Joiner, author of *Why People Die By Suicide*, postulates that three conditions must be met for suicidal ideation to become an actual suicide attempt. They are (and I paraphrase) the following:

1. Thwarted belonging. (ie: I feel alone.)
2. Perceived burdensomeness. (ie: I feel like a burden.) and
3. The acquired ability to enact lethal self-injury. (ie: I am not afraid to die, because I am used to pain and death.)

Applying these conditions to veterans, it can be seen why veterans in particular are at risk of suicide.

### ***Alone***

When an infantry soldier is medically retired, whether for physical or mental ailments, he loses the intense sense of belonging he had in the regiment. When he reaches out to civilian organisations, whether that be a sporting club or a local hobby group he is likely to be let down. The esprit de corps he previously enjoyed is not found in civilian street. The bond with his “brothers in arms” simply cannot be replicated. His friends and family do not understand. They have not seen what he has seen.

His former brothers no longer associate with him. This is understandable. It is bad for morale on both sides. Once he has been “left out of battle” he is a reminder to those continuing to serve of the dangers. And looking on from the sidelines re-enforces to him that he is no longer part of the team.

### ***Burden***

After serving his country for so long, the retired soldier is at a loose end. To imperfectly quote Beccy Cole’s song *Broken Soldiers* “they took his uniform away – he’s no good to them like this”. His experience as a highly competent, respected, contributing member of a team now only serves to remind him of what he is no longer. His skills are not easily translatable to civilian roles. His communication style is likely to cause offence. He feels useless. Having lived to serve, having risked death to serve, he can no longer be of service.

Even worse, his physical or mental condition may mean that he requires assistance from others. He now sees himself as a drain on resources. This can be re-enforced by unthinking civilians “teasing” him about his pension or making comments about how “lucky” he is to have free health care.

### ***Fearless***

Lastly, the retired soldier is used to physical pain and has been trained to ignore it and press on with his mission. If a veteran, he has become inured to blood and gore. He may have seen many others die. Death is unlikely to hold any fear for him. In fact, he has been immersed in a culture where death must be viewed without fear. “Death is the ultimate bludge”

### ***Action To Be Taken***

In my view, war veterans fit Joiner’s criteria to a frightening degree. It is my belief that to have a meaningful effect on veteran suicide rates we must strive to provide those discharged from the military with a sense of belonging and a sense of purpose. This is particularly the case for those who

are medically discharged (ie: discharged not because they want to leave, but because they can no longer perform a role within the armed forces.)

While many worthy charities exist, their programs are largely metropolitan based. Rural and regional veterans are left with almost no resources. Local “pie and beer nights” at the RSL Hall are unable to provide that sense of brotherhood or purpose.

Others better placed than I could probably suggest ways to engage with veterans, to provide that sense of purpose and to make them understand that they are not a burden, but valued for their contribution to our society.

### **Term of Reference (e) – Effective Rehabilitation and Compensation**

#### ***Issue***

For the veteran or ex-serviceman civilian street can be bewildering. Having been institutionalised in the true sense, having been told what to eat, when to eat, what to wear, when to sleep the veteran is often unable to adjust easily to the “freedom” of civilian life.

Nowhere is this “freedom” more damaging than in health care. The veteran must now negotiate the civilian health care system, which is difficult enough for anyone, but when your experience is of the military medical system (ie: one stop shop, continuity of care and a holistic approach) it is impossible.

To navigate the complex system of referrals, appointments, DVA forms, rehabilitation aids etc is beyond anyone who has been assessed as Totally and Permanently Incapacitated regardless of the reason they have been assessed as TPI. This is particularly the case if the veteran’s conditions include PTSD or depression. Too many veterans are not getting help to which they are entitled because they are simply unable to access it.

#### ***Action To Be Taken***

TPI veterans need to have designated Care Co-ordinators within DVA. Those Care Co-ordinators should act as the primary point of contact for all claims, including acting as the liaison for the veteran with civilian health care providers. Far too many health care providers are unable to navigate the DVA system and persist in trying to fit the veteran into the Medicare or private health framework. The veteran should not have to deal with the stress of being the liaison between his health care provider and DVA.

Further the Care Co-ordinators ought to facilitate multidisciplinary care plans for veterans. Most veterans have a complex set of physical and mental issues which are not often seen by civilian health care providers in this country, whether that be tropical diseases or musculo-skeletal injuries due to bearing heavy loads. Care Co-ordinators could facilitate treatment by general practitioners, physiotherapists, psychologists and orthopaedic surgeons, for example.

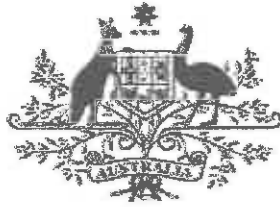
Sadly, DVA currently offers something like this. However, only certain veterans are eligible. And veterans who are assessed as TPI due to PTSD are not currently being offered this program. Please

see attached DVA Fact Sheets HSV101 – Coordinated Veterans' Care Program and HCS10 – Coordinated Veteran's Care Social Assistance.

This program urgently needs to be expanded to include veterans suffering from PTSD, especially those assessed as TPI.

**Sarah Perkins**

Partner of a TPI veteran due to PTSD following tours of East Timor, Iraq and Afghanistan



## **Australian Government**

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### **Department of Veterans' Affairs**

# **Factsheet HSV101 - Coordinated Veterans' Care Program**

## **Purpose**

This Factsheet explains what the Coordinated Veterans' Care Program is and how you can participate.

## **What is the Coordinated Veterans' Care (CVC) Program?**

CVC is a team-based program designed to increase support for Gold Card holders with one or more targeted chronic conditions, complex care needs and who are at risk of unplanned hospitalisation. The Program uses a proactive coordinated model of care to improve the management of chronic conditions and quality of life for eligible Gold Card holders. The care team generally comprises a General Practitioner (GP), a nurse coordinator and you - the Gold Card holder.

CVC aims to assist you to better understand your health and provide support in self-managing your conditions using a Comprehensive Care Plan. This plan is developed in consultation with you and you will receive a patient-friendly version.

## **Who is the CVC Program for?**

CVC is for Gold Card holders who meet all of the following criteria:

- are living in the community (not in a Residential Aged Care Facility)
- have been diagnosed with one or more of the following chronic conditions:
  - congestive heart failure
  - coronary artery disease
  - pneumonia
  - chronic obstructive pulmonary disease, or
  - diabetes.
- have complex care needs, and
- are at risk of unplanned hospitalisation.

## **How can I participate in the CVC Program?**

Participation in CVC is voluntary. If you think you are eligible, the program can be accessed in a number of ways:

- Your GP may assess your eligibility and enrol you after you consent, or
- Another health professional or your carer may suggest you ask your GP about CVC.

## How does the CVC Program work?

After enrolling you in CVC, your GP and nurse coordinator will develop a personalised Comprehensive Care Plan for coordinating and monitoring your ongoing health care.

Your Care Plan will include:

- detailed information about your medical history
- goals and strategies for managing your illness
- details of your medications, dosage and how often to take them
- which symptoms you should watch out for, and
- appointments to specialists and other allied health providers and medication reviews.

You (or your carer) will be given a patient-friendly version of your Care Plan.

The nurse coordinator will explain the Care Plan to you, coordinate ongoing health care and contact you regularly to:

- help you make appointments with other health professionals involved in your care
- remind you of appointments
- monitor your conditions and address any concerns
- coach and assist you in achieving your health goals, and
- provide any feedback to the GP.

Your GP and nurse coordinator will regularly review your Care Plan, monitor your progress and, where necessary, take appropriate action.

The CVC Program also recognises the benefits of social inclusion in supporting good health. Your GP may identify a need for short-term assistance to encourage you to become involved in community or other social activities. If appropriate for you, your GP will refer you to a Veterans' Home Care Assessment Agency for an assessment.

## Are there any restrictions for entry into the CVC Program?

Yes, you cannot:

- live in a Residential Aged Care Facility
- have been diagnosed with a condition which is likely to be terminal within 12 months, or
- be a participant in a similar Government coordinated care program.

## How will I benefit from CVC?

CVC aims to improve your general health and well being by:

- helping you to better understand and manage your health
- helping your carers and family to understand your condition and how they can best help you, and
- improving communication between you, your GP and your other health care professionals.

## Can I still go to hospital if I need to?

Yes. CVC aims to improve your health and reduce the need to go to hospital in the first place, but you should always go to hospital if you need to.

## Will there be any cost to me?

There is no cost to enrol in or remain a participant in CVC. You will still be required to meet co-payments that exist for other DVA services that form part of your Care Plan.

## **Will the CVC Program affect my other DVA entitlements?**

No, participation in CVC will not affect your other DVA entitlements.

## **Disclaimer**

The information contained in this Factsheet is general in nature and does not take into account individual circumstances. You should not make important decisions, such as those that affect your financial or lifestyle position on the basis of information contained in this Factsheet. Where you are required to lodge a written claim for a benefit, you must take full responsibility for your decisions prior to the written claim being determined. You should seek confirmation in writing of any oral advice you receive from DVA.

## **Related Factsheets**

- [HCS10 Coordinated Veterans' Care Social Assistance](#)
- [HSV59 Eligibility for the DVA Health Card All Conditions \(Gold\) or Totally & Permanently Incapacities \(Gold\)](#)
- [HSV60 Using the DVA Health Card – All Conditions \(Gold\) or DVA Health Card Totally & Permanently Incapacitated \(Gold\)](#)

## **More Information**

### **DVA General Enquiries**

Metro Phone: 133 254 \*

Regional Phone: 1800 555 254 \*

Email: [GeneralEnquiries@dva.gov.au](mailto:GeneralEnquiries@dva.gov.au)

DVA Website: [www.dva.gov.au](http://www.dva.gov.au)

Factsheet Website: [www.dva.gov.au/factsheets](http://www.dva.gov.au/factsheets)

\* Calls from mobile phones and pay phones may incur additional charges.

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## **Australian Government**

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### **Department of Veterans' Affairs**

## **Factsheet HCS10 - Coordinated Veterans' Care (CVC) Social Assistance**

### **Purpose**

This Factsheet provides information about the Coordinated Veterans' Care (CVC) Social Assistance services. It includes who is eligible and how to access these services.

### **What is the CVC Program?**

CVC is a health care program available to eligible Gold Card holders who have one or more chronic conditions, complex care needs and are at risk of unplanned hospitalisation. By encouraging a greater level of planning and coordination of health care services, the CVC Program aims to reduce unplanned hospitalisations and improve participants' quality of life.

For more information about the CVC Program, see Factsheet [HSV101 Coordinated Veterans' Care Program](#).

### **What is CVC Social Assistance?**

CVC Social Assistance is a 12 week service designed to (re)connect socially isolated CVC participants into community life. The services are community-based activities that meet the need for social contact to strengthen well-being and a sense of belonging.

The aim is to give those eligible CVC participants the confidence and independence to be involved in community activities, resulting in better health and a greater support network.

CVC Social Assistance services are provided through the Veterans' Home Care (VHC) program.

### **Am I eligible for CVC Social Assistance?**

To be eligible, you must be:

- Gold Card holder
- enrolled in the CVC Program
- socially isolated or at risk of becoming socially isolated; and
- at risk of unplanned hospitalisation due to social isolation.

### **How do I access CVC Social Assistance?**

To access CVC Social Assistance you will need a referral from your GP or Local Medical Officer. You will also need to be assessed by a VHC Assessment Agency to determine your social assistance needs. Most assessments are done over the phone. To arrange an assessment call a VHC Assessment Agency on 1300 550 450^.

### **How does it work?**

Following your VHC assessment, the services you need will be written in a care plan and sent to you and a VHC Service Provider. The VHC Service Provider will call you to discuss a suitable time to provide their service(s).

You will be visited regularly by your VHC Service Provider over the 12 week period. Towards the end of the program, focus will shift to helping you do these activities independently.

## How much does it cost?

Your VHC care plan will show if a copayment is required. \$5 per week is usually requested, but your VHC Service Provider will discuss this with you. You will have to cover the costs for activities, such as admission fees or equipment.

You are not expected to pay for travel when accompanied by your VHC Service Provider.

## Other Government services

Long term social support services are available through the Commonwealth Home Support Programme (CHSP) or the Home and Community Care (HACC) Program (in Victoria and Western Australia). A VHC Assessment Agency can refer you to these services.

These programs are not funded by DVA and could have additional costs associated with this care.

For more information on social support services and other services, please telephone the My Aged Care national contact centre on 1800 200 422\* or visit the My Aged Care website at [www.myagedcare.gov.au](http://www.myagedcare.gov.au)

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## Related Factsheets

- [HCS01 About Veterans' Home Care](#)
- [HSV59 – Eligibility for the DVA Health Card All Conditions \(Gold\) or Totally & Permanently Incapacities \(Gold\)](#)
- [HSV60 – Using the DVA Health Card – All Conditions \(Gold\) or DVA Health Card Totally & Permanently Incapacitated \(Gold\)](#)
- [HSV101 Coordinated Veterans' Care Program](#)

## More Information

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\* Calls from mobile phones and pay phones may incur additional charges.

^ Calls should be made from a standard landline telephone, as calls from mobile phones are unable to be connected to a VHC Assessment Agency.



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