Royal Commission Update – Hobart Day 46 – 9 August 2022

RSL References

- RSLs are everywhere in Tasmania – being able to have a physical location for face-to-face is phenomenal
  - Some resistance with younger veterans to the RSL – the RSL are trying, but there is a bit of a divide – some cultural work to do there
  - See it as a waste of resources if an ESO can't get together to be one family

10am – 11:15am – William McCann, Lived experience witness

Career overview and introduction

- Counsel Assisting asked Mr McCann about his early life and when he joined the army
  - Joined the army on 24th January 2006 at 18-years old as a signals officer
  - Pre army life, he lived in Wagga Wagga – his parents were both in the army force
  - Graduated from ADFA in 2008 with a Bachelor of Science
  - Met his wife Rachel in her first year of ADFA – she was enlisted in the Navy
  - Medically discharged after 13 years on 24th January 2019
- Counsel Assisting asked why Mr McCann wanted to provide evidence to the Royal Commission
  - He wanted to provide a submission as he considers himself lucky and fairly treated by DVA with a great support and medical network – however, despite this, throughout his time dealing with a mental condition post-deployment he has suffered with persistent suicide ideation and wants to bring awareness to this

Private motor vehicle accident in 2010

- Counsel Assisting asked Mr McCann about his private motor vehicle accident while travelling to work and the support provided from the DVA
  - Mid 2010 he was involved in a single motor incident when travelling to base – injured arm and back, still hindered by this injury today
  - At this stage, McCann decided not to submit a claim the DVA – did not believe he was entitled to anything from a car accident and did not pursue it

The impact of Mr McCann's wife's delayed post from 2013

- Counsel Assisting asked Mr McCann about the impact of his wife's delayed post to Darwin while he was in Sydney had on him
  - McCann's wife posted to Sydney in 2013 while McCann was posted in Darwin
  - He felt that to keep the personal things he had to sacrifice opportunities on the professional / career side
  - This was the most significant stressor during his time in the army – prior to McCann's deployment, he put

in a request to be posted to Canberra as his wife's unit was moving to Canberra and she was pregnant – this was a long process and didn't get approved until the imminent birth of his impending child

The impact of the 2015 deployment on McCann's mental health

- Counsel assisting asked why 2015 was the year that changed McCann's life forever
  - Deployed to Egypt on Operation Reserve in the MFO North Camp in Sinai in May 2015
  - The pre-deployment was a 2-week course in Sydney which did not prepare them for what they experienced – it focused on how much fun seeing the sights of Egypt would be
  - Once deployed, they realised they were staying in an increased security risk – as a peace observing course, they were caught in the crossfire of Egyptian defence hostility
  - The equipment provided was not suitable for the vehicles they were using as the MCBAS is a larger and cumbersome body armour system (compared to the TBAS) that was difficult to wear
  - There were not enough weapons for everyone during the transition period of rotation of personnel which saw the number of deployed Australians increased by half
  - The issue of poor body amour was highlighted within the first two days of deployment. Due to McCann's heigh and size of the lightly armoured vehicles they drove, he was unable to wear his MCBAS helmet in the vehicle. Fellow soldiers who were also over 6-feet tall had the same issues
  - McCann and others addressed some of the pre-deployment issues and helped plan to move majority of the soldiers in the north camp to the south to combat security issues
- Counsel Assisting asked McCann to elaborate on the impact of this deployment on his mental health
  - McCann felt shame, guilt, and embarrassment
  - He became overcome with constant noise of ammunitions in the air and loud sirens
  - Despite these feelings, he continued with the deployment as normal
  - There was no process of debriefing during these incidents on camp – psychological assessments were only available post-deployment
- Counsel Assisting asked McCann to talk about the mental health effects post-deployment
  - Undertook a second medical in 2016 – shared he was lacking motivation and was having issues connecting with his newborn child. The GP recommended he takes his post-deployment psychological assessment
  - McCann felt utterly broken after he left that appointment and was physically shaken. The next day, the psychologist sent him an email and asked to take him to the GP to assign him a psychiatrist
  - During the first appointment with the psychiatrist, McCann answered no to having PTSD as he did not believe he could have this condition as the type of combat operation he experienced – he did not want to show weakness
  - At this time, he was eventually diagnosed with major depressive disorder and anxiety
  - In 2018, McCann started a new position and struggled with his mental health again – he saw a psychiatrist who confirmed he had PTSD
  - Due to his medical classification and treatment, this again had issues with his career management. During the posting cycle, McCann's Career Manager informed him that he was looking to place him in to a 24-hour Watchkeeper role at Headquarters Joint Operations Command
  - His medication, which he used to allow him to sleep and combat nightmares, meant this posting would not work for him. He sought medical evidence to demonstrate why this posting would not work and would not benefit himself or the army

Discharged by the army due to no longer being medically fit for service

- Counsel Assisting asked Mr McCann about being deemed medically unfit for service and support from the DVA during this time
  - When McCann returned him his Mood and Anxiety course, he was advised by his Rehabilitation Coordinator that he had been taken to a military employment classification review board and assessed as no longer being medically fit for service
  - He signed his paperwork with Defence Civilian supervisor from SATCOMSPO who stated, 'I don't really know what I am doing, but I have been told I have to be here'

- Felt like he was left to fend for himself with this new diagnosis – he was discharged on 24th January 2019 and asked to be discharged in 2019 for more time to find a psychiatrist
- He was trying to find a way to get treatment for PTSD – he was advised that DVA does not fund this
- McCann's psychiatrist was retiring at the end of 2018, and he needed to find a new one to continue his treatment post discharge. He found that the only ones that had availability would not bill DVA and those that did had a 9-to-12-month waitlist
- Stressed by this, he spoke to his treating GP at the Duntroon Medical Centre. He acknowledged this issue and made a priority referral for him to a psychiatrist that billed DVA. He acknowledged that this is not necessarily a veteran specific issue and access to mental health care is a much broader community wide issue
- Found an issue with medical practitioners who are willing to bill to DVA – mental health resources available to veterans are stretched thin

• Counsel Assisting asked about his current mental health and the main source of support that has helped him heal
  - When he was actively planning his suicide, it was his medical team who intervened and prevented this from happening
  - The best support he received during this time was from his wife and psychiatrist

Recommendations

• Counsel Assisting asked McCann to expand on the fear of being deemed a 'linger'
  - McCann was fearful of this term, and it prevented him from getting treatment as he did not want to appear lesser or weak
  - This concept comes from the idea that for a mental health condition you are not going to be believed – this stigma is what needs to change
• Counsel Assisting asked about the experiences that Rachel McCann had in 2020 from her discharge in the navy
  - Prior to his wife's discharge, his wife was Service Category 6 and working three days a week. Under this concept, an ADF member is not to be disadvantaged due to working part time, they are considered normal members of the ADF, they just work different hours and days
  - In 2020, it became evident that his wife's superior officer did not like the fact that she was SERCAT6. At times, she threatened to forcibly remove her SERCAT6 arrangement to force her to work fulltime. She threatened to deploy her despite his wife saying she was undeployable due to her need to care for children – this treatment is what needs to change

Commissioners' questions

• Commissioner Brown asked McCann to clarify in relation to the psychological examination he had prior to returning from his deployment – what was the experience of this and were they not interested in what he was saying or was it to dismiss or dimmish it
  - It was not to dismiss or diminish it – it was a Sunday afternoon and he had 12 people to get through in a short amount of time, so it felt quick
• Commissioner Brown asked if there was any education or awareness around PTSD prior to this time and had any information been given to his wife about things to look out for
  - There was no support to spouses about what to expect post-deployment
  - As for training, he can only recall watching a video as a trainee who had PTSD from car crash
• Commissioner Brown asked if Mr McCann thinks it would have made any difference if he had any awareness around PTSD prior to deployment
  - Yes – these conditions will occur, and it needs to be involved in the planning process that this will be the ongoing cost of doing business
  - He did not believe he was experiencing the known symptoms of PTSD following his deployment – he was suffering from the classical symptoms
• Commissioner Brown noted his support for rehabilitation seemed to evaporate once the discharge date came through. Brown asked if there an actual change once this happened or whether McCann was

anticipating this change

- It was a notable change in how he was treated where help and support was not as forthcoming – he felt they needed to get him out the door

11:30am – 1:30pm – Associate Professor Amanda Neil Select Foundation Principal Research Fellow, Menzies Institute for Medical Research, University of Tasmania – Professor Christine Stirling Head of School of Nursing, University of Tasmania – Professor Steven D'Alessandro Professor of Marketing, University of Tasmania

- RSLs are everywhere in Tasmania – being able to have a physical location for face-to-face is phenomenal
  - Some resistance with younger veterans to the RSL – the RSL are trying, but there is a bit of a divide – some cultural work to do there
  - See it as a waste of resources if an ESO can't get together to be one family
- Risk if lead agency is poorly chosen
  - Waste of resources
- Peers want to connect with veterans who went through the same thing they did – i.e. Afghanistan with Afghanistan
- ESO collaboration
  - Can bring in stronger funding requirements re. partnerships between ESOs – need genuine collaboration to get the funds
- ESOs need to work together to deliver these services

<u>Veterans funding</u>

- Problem is that in some states with large RSLs, the funding is…
- Committee model is important – not just shiny doors, but how best to suit local needs
- Less adversarial approach to veterans' health, including through funding
- Lack of access to funding from DVA is an issue that needs to be addressed
- Need to utilise online, health, wellbeing, and local allied health services, to improve preventative health for veterans, ensure these are online so we don't retraumatise through retelling stories, and save money in the longer-term

<u>Acute Care</u>

- Acute model of care
- Recognition of GPs who provide good referrals for veterans

<u>Challenges</u>

- DVA requested they stopped using the Centre language
- DVA also wanted wording to be changed from veterans' 'needs', to veterans' 'wants', unless the need was identified by an 'expert', rather than the person themselves
- Felt the UTAS study may have been a little out of scope, as it referred to the lack of services in health and mental health services, rather than the wider wellbeing centre model focussed on 'wellbeing' and the Centres specifically
- Not sure how you separate mental health from the wellbeing approach
- This ecosystem model requires Federal, State and ESOs to work together
- DVA needs to work far more strongly to re-able people to have a much more satisfying life – put them on a pension, and you put someone into stasis – blocks people from becoming reintegrated

Report

- Report submitted in April 2021, released in December 2021
- UTAS no longer working with DVA – not sure if they're implementing their model – has not been ongoing contact with DVA

Commissioner's questions

- Used AIHW model as the basis of the UTAS research's understanding of 'wellbeing'
    - But mental health services came out during consultation as the key concern
    - Recognition and respect was the goal identified as second-most important
    - Social support and connection, income and finance, education and employment, and housing came afterwards
- Any role for local government, non-veteran community groups, and primary health networks?
    - Yes, all these need to be involved if they are relevant – can use these services in the wellbeing centres – but need to be catered for veterans
    - All parts of the system need to work together – I should be able to go to an area and find out how I can access services, and make sure I don't have to repeat my story over and over again
- Continue to refer to Canadian models for veterans' hubs – suggested speaking to the Royal Canadian Legion – also spoke about the Scottish system

2:30pm – 4:30pm – Professor David Forbes Director, Centre for Posttraumatic Mental Health, Phoenix Australia

Anger and problematic anger

- A normal emotion experienced on a spectrum, with different manifestations and timeframes
- It is a mobilising response – we want to solve what is creating the emotion/problem
- When it becomes disordered or problematic is when it starts to destroy own lives, rather than solve problems – problems with relationships, aggression towards others, economic problems etc.
- Anger can have an impact on many areas that are considered part of wellbeing – relationships, employment, finance etc.

Relationship between anger, violence and aggression

- Overlap in the middle – reactive aggression or anger-driven aggression – when emotionally aggressive, can be a loss of control or an oversensitivity to violence
- Violence is always a choice – anger is associated with violence
- Intimate partner violence can be a part of this use of anger-driven aggression

Anger and aggression in veterans

- Problematic anger rates rise in veterans following transition – up to double post-transition – difficulties in adaptation following separation
    - May be a honeymoon period that occurs in the 6 months after separation – adaptation difficulties usually only appear after this
- These elements relate to Defence life across the word – we are training people to be sensitive to detection of threat, determine situations as threatening
    - Anger may be a response to allow Defence members to solve these threats
- Repeated deployments and combat exposure can lead to recalibration of levels or arousal/readiness and consolidated awareness to threat detection, and a thinner line in reacting to potential threats

Problematic anger, suicidality and suicide risk

- Suicidality among veterans and serving members, has some crossover with problematic anger – for many of these veterans, there is also a connection with intimate partner violence
- Connection between anger, risk to self and risk to others
- This is an international problem, not just an Australian problem
- Risk factors for problematic anger include:
  - Trauma, sleep difficulty and pain disorders, difficulty finding work etc. are risk factors for problematic anger – perception that service isn't valued
  - Military values aren't observed in the same way in the community, such as value of the collective
  - Injustice or betrayal – moral injury
  - Significant risk of social isolation/alienation

Measures of anger

- Dimensions of Anger Reactions (DAR-5) is a concise measure of anger – can be useful in the Defence context and particularly in combat veterans with PTSD
- Currently used in DVA trauma recovery programs, and by Open Arms – not used more routinely in Defence screening – still quite a new tool engaging with new data
- International recognition that anger is core to the risk to self
- DAR-5 screening should occur whenever normal Defence screening is undertaken – it's never too early
- Rates and expression of anger in female veterans are equivalent to males – but expressions of aggression and violence are less harmful

Management, treatment of problematic anger

- Cognitive Behaviour Therapy – need to recognise that the burner is always on, creating sensitivities to anger
- Adapting evidence-based treatments in the community to veterans and veterans with PTSD is possible and effective – will make other treatments more effective and to reduce risk to those around the veteran
- Can use technology, brief interventions, and interventions outside a clinical setting to allow this to happen
- DVA and Defence are now on this path
- Anger needs to be dealt with frankly and directly – it is not usually an extension of a clinician's existing skillset, but can be difficult for a clinician that feels uncomfortable
  - More about building up the confidence – although once they have the skills, they have the confidence

Commissioner's questions

- Medication can be used as a management tool, rather than a therapeutic tool – won't treat underlying causes
- Impact of anger on families – expect significant mental health effects on a family members – impacts of the anger, trans generationally, and reduced parenting confidence affecting the next generation as well
  - Need to consider what services need to be offered to families
- Medicinal cannabis – doesn't know enough to comment – hasn't been a lot of attention for anger
- Training for members, commanders and providers in identification and management of problematic anger