Royal Commission Update – Hobart Day 45 – 8 August 2022

RSL References

Positive:

Negative:

9:00am – 12:00pm – Mr Allan Woodward – Commissioner - National Mental Health Commission

National Suicide Prevention Taskforce

- Decision made by the Commonwealth Government – looking at what more could be done for suicide prevention – but has received bipartisan support
- Included Special Adviser's role to provide professional advice in terms of National Strategy and leadership and how the Commonwealth could work more effectively with States and Territories to prevent suicide – lived experience was used at all times to inform the work of the Special Adviser
    - Research was deliberately targeted towards lived experience informing policy and strategy
- All portfolio areas can make a contribution to prevent suicide – by engaging Government widely, there will be more touchpoints between Government and people
- Identified four shifts for whole-of-government approach to suicide prevention:
    - Early engagement and intervention
        - Earlier trauma can be triggered by future distress – adverse childhood experiences for example
        - Should look at social determinants of suicide, in addition to health
        - For ADF during recruitment and screening – need to be flexible enough to provide support to people with that context to help them to live well – need an understanding of that person and they need to understand what service in Defence means – this understanding will help the Service person perform at the very highest they can
    - Compassionate care directed towards addressing suicidal thoughts and attempts
        - Inputs to suicide prevention sometimes dominated by seeing suicide behaviour as illness or evil, without input of lived experience – profoundly misunderstands suicide
        - Suicide is driven by profound pain, with suicide driven by trying to stop that pain
        - Suicide prevention is first and foremost about reaching out to people experience distress and pain, and offering alternatives to that pain
        - Need to focus on people, and what they need at the time of distress – this is very personal and require a nuanced approach
        - Need to understand importance of the person, and not apply tickbox administration

        - Need to developmental culture that is open to people being stressed and focus on how to support them
    - Deliberate reaching out to those more at-risk of making suicide attempts
        - Cannot expect person feeling distress to make clear how they're feeling – shame, stigma, fear, lack of knowledge, concern about help-seeking as barriers
        - Need to create an environment where we are open to people in distress coming forward
        - Use all available outlets of Government and community service provision – act as a connector to open pathways to find what was needed, especially where suicidality is multi-factorial
        - This is about tailoring response to the person's needs
    - Systematically address policy or systematic issues contributing to suicide
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Crisis points and transition

- Often at times of transition, change or incidents – disproportionate number of deaths by suicide by those who has exited Service
- Raises need for attention around transition, particularly for those exiting on an involuntary basis – need to wraparound support to provide for that person's needs
- Risks of person leaving feeling defeated, hopeless or trapped when leaving
- Any system does not allow a level of continuity around transition, does not support access to services because of funding etc., doesn't make certain supports available, then fundamentally the system needs to be reformed

Connecting people to compassionate support

- Looking at ways we respond to the person by offering pathways for support – goes beyond the notion of a service response, to include social supports that a person may be encouraged to use (families, peer-based services)
- Need to understand a person's situation and what is happening for them, in a fundamentally empathetic way – a sort of friendship
- Might also consider collaborative care, with inputs from those outside the individual – need to reduce concerns re. privacy, timeliness, professional judgement should not be barriers
    - Need to listen to the needs of the person at the centre – ask the person who would be helpful
- Need to shift default position to find ways to allow more connections to occur

Impact of suicide and suicidality on families

- Distress an individual is feeling is likely to be felt by others around them – need wider supports available for families etc.
- Not enough support to enable and engage with protective factors i.e. family
- Can also be a risk factor for suicide and suicidality if family relationships are toxic or tough

Safety planning

- Putting in place systems and plans to support a person postvention, where they may be struggling
- Identifying safe people in a network who can assist if there is additional distress

Problems with risk assessment

- Often these are stratified – this is often related to the provision of service or service response – create a

determination if a person is likely to end their own life – point in time based and not sensitive to changes in the person's circumstances
- Have no predictive reliability – even where data is being used as part of analysis, as there is always in-built biases in the data – need to know limitations of data
- Not effective in understanding the actual risk – should not be used to determine the resources available to address suicide prevention

Changes for improvement

- Suicide prevention will be aided by a whole-of-population approach that promotes mental health and wellbeing – need to equip everyone to deal with life struggles and stresses to aid causes of suicide prevention
- For Defence and veterans populations, want to offer living well, health and wellbeing-promoting programs – actively dismiss the myth of weakness of a person who is struggling – need to turn that around and say all of us will struggle at some point
- Need to speak out against counter-productive practices – things like sleep need to be promoted
- Transition process needs to uphold the notion of supporting veterans to live well
- By problematising suicide and suicidality this can engender shame – our culture has a narrow range of what is acceptable – this is what we don't do i.e. talk, seek help
- Important to have reliable data – allows us to plan and strategise, track changes in what's happening
- Need workforce and community capability – people equipped at all levels to contribute to suicide prevention – one-to-one intervention, strategy

Normalising distress

- All of face stressful situations where we feel overwhelmed

Leadership

- Pointing to suicide and suicide prevention as a priority for Australia as a whole
- Governments in Australia have by and large accepted this – governments at different level have different roles – haven't worked out how to connections between many of these sectors just yet

Defence and DVA – implementing change and compassionate support

- Suicide ideation is more likely to emerge if you feel defeated, humiliated and trapped – administrative systems should not be designed in such a way that they add to people's distress, without offering them any way out – don't box someone in, because that will cause feelings of entrapment
- Care and service provision must be built into the health entitlements offered to Defence members and veterans – need to create a 'care pathway'
- Need to build into care planning and the outcomes sought is the intersection with the non-health care, social supports as part of the recovery process
    - Shouldn't be seen as separate or less important approaches

Priority Groups

- Some population groups may demonstrate a greater vulnerability to suicidality
- Population or sub-population approaches are required here
- This can advance a selected approach in a public health approach to suicide prevention
- Need to use data to identify and assess these characteristics/factors of suicides or attempted suicides
- Lived experience perspective can then bring qualitative insight to the analysis

Whole of Government approach to suicide prevention

- Shared understanding of what suicide is
- Comprehensive approach
    - Policy responses addressing social and economic drivers
    - Cross agency programs and linkages
- Need to identify intersections of different departments – not siloed between different portfolio agencies
- Need to cut across range of events and circumstances
- Need to promote the work of those in the workforce who are promoting suicide prevention among others

1:15pm – 3:00pm – Madonna Paul – Lived Experience Witness

- Husband Michael Paul died by Suicide after being discharged from the Australian Army
- Transferred to the Air Force – was in ordinance, and then became a plane outfitter
- Became distressed when the Army didn't apply the same safety standards, in his experience, as the Air Force
- Declined following an incident where workmates died – moods changed, became more aggressive, started sitting in the dark – had to move away from home
- Referred to social worker – believed there were marriage problems
- Michael didn't know how to deal with what was going on – Michael didn't seek help, Ms Paul did
- Discharged in 1994 – worked as a contractor on a RAAF base – happy to be out of the Army, and relaxed for a while, and then did some FIFO work
- Had a breakdown after being in an incident in a light aircraft – erratic, hypervigilant, paranoid, sitting in the dark, isolated himself, violent
- Was homeless in Cairns – found a VVCS in Townsville to get help – referred to Psychiatrist at Townsville Hospital where he was heavily medicated
- No formal diagnosis of PTSD, but diagnosed with depression
- First attempt in front of their son
- Came back to Cooktown with Ms Paul, stayed at hospital – but was transitioning back to Townsville
- No financial support from DVA around this time in 2002 – started living in a halfway house with other veterans where they could get treatment – started working with an advocate – this was the first time they'd ever heard of DVA
    - The advocate helped to get Michael a White Card – Ms Paul was working 2 jobs to support the family
    - Started application for a pension for Michael – that was rejected – arranged for VRB hearing, which also rejected the application – had lawyers look at the case, but Michael suffered because of this
- Couldn't earn an income – affected his personality
- Started affecting their sons – elder son attempted suicide twice – decided Michael could no longer live in the family home – still Michael's primary carer, with no other support in place
- Michael couldn't work out what to do – completed a PTSD course in Townsville
- Michael eventually died by suicide – was suicidal, and withdrew action with lawyers after DVA
- No support from the Australian Army or DVA following Michael's death
- DVA dealt poorly with the matter after Michael's death – refused to deal with because Michael withdrew – after the *7.30 Report* covered it, DVA took up the case – eventually got a widower's pension

  - No compensation provided for sons –
  - Has to pay a perpetual offset against her own pension, for the rest of her life
  - Retraumatised by having to retell her story
  - Has more than repaid the amount received in compensation – having a major financial cost
  - Deprived of the chance to have a proper life
  - 'Cruel and inhumane treatment'
- Had bad experiences with counselling from Open Arms or VVCS
- Talked about the TAPS program in the US, where there is access to free counselling following a suicide

2:45pm – 4:45pm – Dr Stewart Muir Executive Manager, Child & Family Evidence and Evaluation, Australian Institute of Family Studies - Dr Jody Hughes Senior Manager, Defence & Veteran Family Research, Australian Institute of Family Studies

Role of family in ADF rehabilitation

- Facilitators/barriers of recovery – flows on to family:
  - Degree of damage from injury
  - Length of rehabilitation
  - Members experience of rehabilitation
  - Financially secure
  - Adequate support from Defence
  - Other forms of support
- If family, member and rehabilitation professionals were on the same page, it facilitated the rehabilitation of the member
- Little contact between rehabilitation professionals and families
- Circumstances of members in rehabilitation vary a lot, but things can be done to improve outcomes with families:
  - Families be involved in implementation planning
  - Better communication with families – timely and at time of need
  - Make it clear that families are involved in the rehabilitation process
  - Dedicated liaison personnel for members undergoing complex rehabilitation – this is not universal – could be single point of contact for families

Trends and issues

- Frequency and lack of control of relocations
- Family separation and lack of autonomy – lose informal support networks
- Secure and guaranteed childcare – Defence childcare centres only on some bases
- To identify trends, might need to do longitudinal research

Future research

- Most of the work currently being done is directly commissioned – there is not much room to go beyond that