DEFENCE FORCE WELFARE ASSOCIATION
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21 May 2021

SUBMISSION

TERMS OF REFERENCE
ROYAL COMMISSION INTO DEFENCE AND VETERAN SUICIDE

The Defence Force Welfare Association (DFWA) welcomes the opportunity to make a Submission relating to the establishment of the Terms of Reference for a Royal Commission into Defence and Veteran Suicide. The Royal Commission is a follow on from the Government's recognition of the depth of feeling within the veteran community regarding such tragedies and also that all sides of politics within both Houses of the Parliament supported the initiative.

This Submission wishes to acknowledge the outstanding work and research undertaken by Associate Professor Ben Wadham, within the Orama Institute for Mental Health and Wellbeing at Flinders University, South Australia.

DFWA strongly supports his observations that it was important to:

- explore claims of systemic failures of institutions, including maladministration, and their incapacity to prevent suicide and suicide behaviors; and
- identify best practice to protect against the occurrence of veteran suicide and to respond appropriately when veteran suicide/suicide behaviors (suicidal thoughts, plans and or attempt) occurs.

DFWA supports also Professor Wadham's contention that the Royal Commission's Terms of Reference should be broad enough to explore, among various issues, the following:

1. the findings of inquiries and reports about the deaths of individual veterans and ADF personnel from at least 2001 until 2021 to determine system failures and identify steps to be taken to minimise the risk of these failings being repeated in the future. Make recommendations about how to correct these failings.

2. what research has been conducted into the suicide and suicide behaviours of ADF personnel and veterans. What is the relationship between their health and the treatment services and policies?

3. the way suicide and suicide behaviour data is collected across jurisdictions and how it is collated to represent the national picture.

4. how institutions and governments achieve best practice in encouraging the reporting of and responding to reports or information about incidents or risks of suicide or suicide behaviours and related matters in institutional contexts.

5. what should be done to eliminate or reduce impediments that currently exist for responding appropriately to suicide or suicide behaviours and related matters in institutional contexts, including addressing failures in, and impediments to, reporting, investigating and responding to incidents that may heighten the risk of suicide and suicide behaviours.

6. what institutions and governments should do to address, or alleviate the impact of, past and future veteran suicide and suicide behaviours and related matters in institutional contexts, including ensuring processes for referral for investigation and prosecution and support services including postvention.

7. the experience of people directly or indirectly affected by veteran suicide and suicide behaviours and related matters in institutional contexts, and the provision of opportunities for them to share their experiences in appropriate ways (while recognising that many of them will have special support needs).

8. reviewing/analysing the adequacy and appropriateness of the responses by institutions, and their officials, to reports and information about incidents or risks of veteran suicide and suicide behaviours and related matters in institutional contexts.

9. examine steps that could be taken to rigorously review the mental health of individuals prior to deployment to ensure fitness for the operational service in question, including a rigorous post deployment health assessment to ensure any mental (and physical) health issues are diagnosed/identified and treated. The policy on the length and number of deployments should also be reviewed, together with the adequacy of post ADF separation mental health support.

10. changes to laws, policies, practices and systems that have improved over time the ability of institutions and governments to better protect against and respond to veteran suicide and suicide behaviours.

Reviewing Mental Health Evidence

The Royal Commission's Terms of Reference should ensure that there is a proper review of evidence-based literature about suicide prevention. The Commission should examine how and the extent to which DVA uses this literature in its policy development and service delivery to veterans and ex-services personnel, and the adequacy of the clinical governance arrangements to identify gaps in service delivery.

Based on this examination, the Commission should recommend how to address any barriers to the regular review of this evidence and the implementation the existing body of knowledge in the provision of services and programs in suicide prevention for ADF personnel, veterans, and ex-service personnel. This review should consider the ability to provide evidence-based programs relating to the identified inadequacy of mental health services addressed in the recent Productivity Commission report into Mental Health and Victorian Royal Commission into Mental Health.

Optimal outcomes from Veterans' Suicide Commission

1. To identify strategies that can decrease the probability of the preventable loss of life.
2. Identify failings of the system to implement optimal mental care that is central to minimizing the risk of suicide.
3. Recommend steps to implement changes needed to correct the identified failings.
4. Recommend a system to ensure ongoing accountability and responsiveness to identified failings.

What is the evidence that the systems that are in place to apply these principles?
Three key reports are relevant as follows:

Productivity Commission Report into Supporting Veterans 2019

The way treatments and supports are commissioned and provided to veterans and their families also needs to change. The VSC would more proactively engage with veterans and their families (taking a person-centred approach, tailoring treatments and supports) and have greater oversight of providers than under current arrangements. This approach will require more extensive use of data and a greater focus on outcomes.

Joint Standing FADT Committee - The Constant Battle: Suicide by Veterans

1. Develop and implement specific suicide prevention programs targeted at those veterans identified in at-risk groups.
2. The committee recommends that the reference to the Productivity Commission should also include examination of the following areas in the Veterans' Affairs portfolio:
    a. governance arrangements
    b. administrative processes
    c. service delivery.

2017 National Mental Health Commission Inquiry into Suicide Prevention Services

1. Several service gaps were identified by reference to a stepped care framework.
2. For current serving members, a greater diversity of 'step-up' services is needed – particularly in early intervention and lower intensity on-base services.
3. Many of the negative views regarding currently available services appeared to relate to the barriers people have faced in accessing services.

Possible Additions:

The Royal Commission should identify any aspects of bullying or institutional abuse that contributed to the suicide of veterans. In the light of any identified issues, the Commission should recommend what further steps be taken and other matters investigated.

Administrative Influences of Negative Outcomes on Mental Health

CSC manages invalidity superannuation benefits of ADF members compulsorily discharged on medical grounds, whether the incapacity was service-caused or not. It includes veterans discharged with mental health and substance abuse conditions. These veterans are most likely to experience transition difficulties, family breakdowns and financial difficulties and be in a suicide risk category.

The military superannuation schemes, especially related to invalidity benefits are particularly complex and challenging. Justice logan commented on this and was critical of CSC performance in a recent legal case over four years involving three veterans, two of whom were PTSD sufferers. (Douglas and Walker v Commissioner of Taxation (AAT 2015/6964 and 2017/4218)).

The complexity is compounded by offsetting arrangement with DVA administered benefits for those veterans whose invalidity was service caused, and the variable treatment of such income by Service Australia, the Family Court and the ATO. Mistakes are made frequently. Due to inter-systemic failures, there is a review involving DVA, CSC and the ATO of all calculations of payments and tax between 2014 and 2019.

The Royal Commission should inquire into the experiences of ADF members compulsorily discharged from the ADF on medical grounds and their families, in dealing with Commonwealth

and State or territory government entities, corporate and un-incorporated entities during and after transitioning out of the ADF.

Commonwealth and State /Territory government entities and corporate and un-incorporated entities would include but is not limited to the ADF, both regular and Reserve, Defence, DVA, CSC, the Family Court, Services Australia and non-government bodies interacting with veterans and veteran families.

Suicide Only the Tip of a Larger Problem

Indications are that there are thousands of veterans and veteran families suffering mental and physical wounds and moral injury as a direct result of ADF service. The symptoms are one or more financial problems, relationship breakdowns, homelessness, substance abuse, incarceration (mental and criminal). There is a multiplier effect. There are the additional stresses of that transitioned veteran environment. Added to this are the stresses of dealings with unfamiliar bureaucratic agencies of DVA, CSC, Family Courts, various elements of Services Australia, ATO, police and justice systems and Federal/State and non-government organisations.

It is from beneath the tip of the problem that suicide instances and attempts emerge. Beneath the tip, veterans and veteran families have to deal with the problems of the "average" Australian, as well as those induced by the effects of ADF Service.

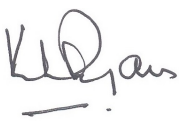
Suicide and suicide attempts should not be the only start point of a line of enquiry by the Royal Commission. It is essential that evidence is sought from this "suicide risk area" beneath the tip, as this is where all suicides have their origins.

It is essential that the contributing factors to suicide, suicide attempts and suicide risks are identified, and evidence sought.

The Royal Commission should work to identify what worked beneath the tip in preventing suicides and suicide attempts and how veterans and families dealt successfully with the suicide risk area and lessons are learned.

The Royal Commission should inquire into veterans' and families' experiences in dealing with suicide risk conditions and the adequacy and appropriateness of responses by government and non-government institutions in dealing with affected veterans and families and the identify factors which increased risk of suicide and those which reduced risk of suicide and prevented suicide.

Yours sincerely,



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