Royal Commission Update – Brisbane Day 8 – 8 December 2021

RSL References

Positive:
NA
Negative:
NA

General Summary

- Importance of lived experience being integrated into approaches to suicide prevention
- The need for integrated models of care for veterans, and particularly during transition
- Improved support for clinicians working in veterans mental health

10:00am – Ms Bronwen Edwards – CEO, Roses in the Ocean – Importance of lived experience

Lived Experience:

- Complexity of suicide means the response needs to be tailored and multi-level
- Lived experience can include experiencing suicidal ideation, survived attempt at suicide, being the family or loved one of someone who has died by suicide, and the experience of ATSI communities
- Suicidal ideation can happen to anyone at any time – is not (50%) linked to mental illness – often suicide is about ending pain
- People with lived experience emphasise the power of imagery and language – can be traumatising if used incorrectly i.e., 'successful suicide'
- WHO says people with lived experience are central to suicide prevention and must be integrated within organisations
- Defence Lived Experience Framework and peer worker model – emphasises therapeutic relationship between someone needing support and someone with lived experience – to be integrated with existing supports – with peers staffing safe spaces and providing referrals
- Lived experience integration can help to change culture, encourage help-seeking
- Defence culture provides purpose and mateship – when a member is removed due to suicide/mental health, these protective factors are removed also – need support to stay in role, including after a suicide attempt

11:15am – Mr Simon Marshall – Lived Experience

- Systemic abuse during training – reported to Chain of Command – Defence whistle-blower line was ineffective
- Yoyoing in medical status – trying to come off medication to return to duty – limited options if you don't want to be discharged
- Help-seeking not encouraged – wife sought help – no support provided – Crisis lines calls monitored and placed on medical record
- Self-committed to repatriation hospital – received Chain of Command support – Chain of Command changed – support was withdrawn and mental health issues weaponised
- Transition support was poor – confused as to entitlements – no claims settled before discharge – handed in ID and backpack and that was it – no housing until 6 months after when TPI was settled
- More sensitivity, flexibility and confidentiality needed during crisis

12:00pm – Dr Kieran McCarthy & Mr Rod Martin – GO2 Health

<u>DVA and system:</u>

- Well-meaning, dysfunctional, government-owned insurance agency – bureaucratic, clunky and adversarial – causes trauma and mental health issues
- Many GPs, psychiatrists, specialists and Allied Health workers do not want to work in the DVA system due to = bureaucracy and paperwork, poor fees that are not sufficient (should be NDIS equivalent), complexity of the clients
- Access to services is the challenge – there is an overload on mental health system and professionals – administration and referrals take a lot of time – risks burnout of clinicians

<u>Transition</u>

- With GO2, this is seamless – catch transitioning veterans early and provide continuous care and access to services
- Need to extend this care for a longer period
- Especially important for medically discharged veterans – must identify and keep track of them
- Records – information sharing should be improved between Defence, DVA and health professionals

<u>Health</u>

- Individualised, multimodal care approach is beneficial, particularly in a hub and spoke model – doctor or psych as the centre, with additional allied health care from there

- Physically, soldiering is hard – has effect on all joints and the body
- Also involves life coaching, education of DVA system and civilian life, referrals and returning Veterans to be civilians
- Advocated a Gold Care for all those who have served

1:30pm – Phoenix Australia

Professor Andrea Phelps - Professor David Forbes - Professor Meaghan O'Donnell - Associate Professor Nicole Sadler AM CSC - Dr Lisa Dell - Dr John Cooper

Integrated system:

- Flexile and adaptable system, responding to individual needs – these needs will change, and available services must also – people will access the level of care that they need, and that will differ over time
- Intake is incredibly important and must direct veteran in the right direction – better understanding of needs will allow ESO to target services more effectively
- Must utilise a broader system (ESOs, community, health, family, financial) as base services – ESOs should be able to direct to these broad services
- Assertive (proactive) services if risk factors are identified
- Navigation of the system is important - all services must work together and help those engaging with the system to meet their needs at that point in time

Illness:

- Suicidality is complex, therefore the responses must be also
- Sizable majority of those who suicide have diagnosable mental health illness – not a simple relationship
- Often occurs in combination with social problems – employments, family, education, finance
- Need for evidence-based treatments
- Early intervention – services made available when sub-threshold mental health issues are identified

Other:

- Influence of anger, sleep and moral injury
- Medical Employment Classification Scheme – lacks flexibility and results in restrictive responses – makes it easy to ID those struggling with mental health – which then leads to stigma, reduces help-seek behaviour and encourages individuals to go outside system
- When mental health issues are identified, this vulnerability cannot be stigmatised – social supports should be engaged (family, friends, colleagues) – need to move beyond vulnerability
- What causes move from ideation to suicide attempt is unknown