Royal Commission Update – Canberra Day 27 – April 2022

RSL References

Positive:
NA

Negative:
NA

General Summary

- Full day of professional witness testimony
- Family support networks and involvement in Defence and care for members/veterans
- Intergenerational and child trauma
- Review of the Defence Abuse Review Taskforce
- Evidence re. suicide, especially amongst men and boys

9:00am – 10:30am Professor Sharon Lawn (Professor, College of Medicine and Public Health, Flinders University) and Dr Elaine Waddell (Researcher, College of Medicine and Public Health, Flinders University)

- No set definition of family – define themselves – differs amongst cultures – families are relational
- Those performing caring role may not define themselves as 'a carer' – but often feel they are more than just that – term is limiting – not necessarily family member
- Impacts of mental health issues on families – burden of the caring role
- 'Lived experience' – person with direct experience of mental ill health and/or in intimate personal space of living with someone who has experienced consequences of interaction with the person – important because it is best way to have an understanding what someone goes through
- Not everyone has formal PTSD diagnosis – can take a long time to seek support
- Critical role of families for Defence members and veterans – provide so much support – often through family member encouragement that veterans will seek help – first to recognise something is wrong – ongoing encouragement and support – help to manage the person's environment –
- Partner v. parent is very different form of caring - partners often don't join support groups – see it is as a relationship – commitment to person
- Families can help alleviate PTSD – practical aspects re. treatment and care – working it out with the person – empathising – provide resources for help seeking – place importance on recovery – make the treatment happen
- When help seeking works, it relieves pressure on entire family – but can be long-term process – family in the room can help – families provide connection to services

- When family breaks down, veterans can withdraw – no help seeking – tipping point can be a crisis when behaviour is bad (may also lead to help seeking) – something has to change, is a coping issue
- Veterans can find it difficult to seek help – culture of not coming forward
- High levels of family support led to better wellbeing, health and mental health outcomes for veterans
- Job is different – higher levels of emotional support required for families who lives with veterans or ESFR – families need support before, during and after joining – need education from ADF – want to know how to help – 'the family serves' – families may blame themselves
- Families need support finding health professionals – want to be included as partners in care – partnes can be seen as annoyance or ignored – where families are involved there are better outcomes, for veteran and family, as health providers can get better understanding of how the person is going
- Barriers to seeking help – finding providers veterans can trust (not understanding service), within person themselves, stoicism, seeing oneself as weak, threaten career
- Life course approach – family-focused approach to care – veteran isn't an isolated being
- Defence and DVA doing better for families – making of a soldier may strip them of community/family identity – once they've left service, drops them back in – crisis of identity – limits to how family-friendly service can be – need for acknowledgement and recognition for families – may need time out, time to themselves – need for specific peer support with hose who don't judge – could treat families as part of Defence members or veterans' support team

[Livestream offline final 10 minutes – will review transcript for any outstanding matters]

10:45am – 12:15 pm Robert Cornall AO –

<u>Defence Abuse Taskforce</u>

- Taskforce setup following inquiry into abuse in Defence for abuse prior to 11 April 2011 – cut off date because otherwise there would be no chance to investigate – essential purpose was delivery of outcomes to help redress complainants who had been abused in Defence – abuse meaning physical assault, sexual assault, sexual harassment, general harassment or bullying
- Counselled reparation payment, referral to civilian police, referral to CDF, and restorative engagement and free counselling – path to be determined by what complainant wanted – referrals depended on consent of complainant – often long time to come to restorative engagement program
- Sole case managers for each complainants – developed relationship and trust – trained in trauma-informed care, experience in women's help centres, rape crisis centres etc.
- Defence didn't have access to info received by DART – info received from DART in strict confidence by small secretariat – minimum info provided to Defence
- Time limits on time to make complaints 31 May 2013, with exception for women wishing to allege abuse at ADF Academy between 1991 and 1998
- Specific concerns of abuse at ADFA and HMAS Leeuwin, but no location limits
- Establishment phase of the taskforce to May 2014 – 150 FTE personnel engaged
- Allowed to determined own scope of outcomes from taskforce – pioneering restorative process
- 2439 complaints, 1751 assessed as plausible, 113 referred to police, 130+ referred to CDF – plausibility chosen to deal with volume of cases and to avoid some more bureaucratic processes of higher levels of proof
- Key issues of concern –
    - Abuse of young people in early stages of careers – pattern at HMAS Leeuwin and training institutions, particularly ADFA
    - Abuse of women in Defence – disproportionate response – often when women first served in Defence
    - 2001-2011 was a focus of taskforce – initial recruitment employment were lower, but levels remained high, almost equal numbers of males and females
    - Sexual harassment and management of those complaints – vast majority experienced by women –

incident exacerbated and complainant victimised after complainant becoming aware – often carried out by abuser of higher rank
    - Poor and inadequate management and response to reports – 2001-2011 cases – more reporting, but no action taken, ignored, complainant being punished, inadequate support to complainant – caused trauma and distress to complainant – element of being disbelieved
- DART was found to be effective to applicants in most cases where there was feedback
- Levels of reparation payment based on type of abuse – all done by Emeritus Professor Robin Creyke
    - Vast majority included payments for Defence mismanagement ($5000) – 97% - improvements since that time – this was the focus for most complainants – where mismanagement was not found, majority of complainants felt the reparations process had failed them – acknowledgement of Defence mismanagement was important to most complainants – can't estimate effect on suicidality
- There were clashing cultures – support mates under any circumstances and teamwork v. culture of 'not dobbing' on mates, even if they have assaulted you – the second came out on top as the stronger throughout the process
- Factor in belief that complainants didn't believe that any action would occur or that they would be punished and ostracised
- Meeting needs of complainants – processes including case managers, transparent procedures, trained employees – not having to go to higher level proof allowed to achieve outcomes for complainants
- Beneficial impacts of free counselling and reparations easier to assess – reactions were basically positive – but most beneficial was knowing they were contributing to see Defence abuse was stopped in future
- Positive outcome impact of restorative program – huge relief, level of reconciliation with Defence
- Did Defence take the lessons on – don't know, but would think so
- Recommendations relating to mismanagement
    - Need follow-up when complaints are made – need for proper HR processes
    - This should be even where no complaint has been made, but Defence has constructive knowledge
- Need for ongoing ability to come forward and report abuse in Defence
- Importance of process that offers healing at individual level
- Clear, limited, simple and straightforward as possible recommendations should be made by the Royal Commission

12:45pm – 2:15pm Professor Jane Pirkis (Director, Centre for Mental Health, Melbourne School of Population and Global Health)

- Suicide is very complex – very rarely influenced by a single factor
- Terminology
    - Suicide – Death by suicide
    - Suicide attempt – Actions taken to end one's life
    - Suicidal Behaviour – Speaks only to the behaviour around suicide
    - Suicidal ideation – thinking seriously about suicide, longer-term general thoughts about suicide
    - Self-harm – self-injurious, but not with intent at suicide
    - Non-suicidal self-injury – explicitly no intent to die
- Classification of risk factors – about probabilities – not certainty
    - Socio-demographic i.e. males more at risk
    - Clinical i.e. mental illness, previous attempt
    - Personality-based i.e. impulsivity, self-reliance
    - Situation/environmental i.e. stressful life events
    - Genetic i.e. family history of suicide
    - Neurobiological i.e. low levels of serotonin

- Suicidal crisis – point where risk factors all come together into a point where they feel like they can't go on – prevention is about stopping people to get to this point, but also good crisis care
    - Suicidal crisis period is variable – can be short-lived, can be cycling
- Male health – boys and men represent 75% of suicides – high correlation with suicidal thinking and self-reliance
- Self-reliance in itself is not bad – societal norm of self-reliance, particularly among men, need to be challenged in harmful form that blocks help-seeking – it's OK to be vulnerable, say you're not OK, seek professional help, talk to your mates – changing how people view masculine norms
    - Man Up documentary – thought they could use the media for good as a suicide prevention tool
    - Testing a range of interventions in a range of settings
- Need better portrayal in the media
    - Reporting that glorifies or provides info about method of suicide can spike suicide following the report – worked with EveryMind re. responsible reporting
    - Media used as a positive tool – reporting of getting through a suicide crisis can lead to dip in suicide
    - Connection with veterans – need right messaging, so co-design with Defence members, veterans and those with lived experience
- Suicide prevention – suicide is preventable
    - Often survivors say they're glad they survived
    - Risk factors are modifiable – can reduce suicide – can assist people to work through them
    - Suicide prevention includes preventing suicidal behaviours and thinking
    - Early intervention is important
- Interventions – shifting risk factors to make them less common
    - Universal – target whole population, not individuals i.e. restricting access to means
    - Selective – treating individual with risk factors i.e. mental health support, ensuring professionals are equipped to help
        - For Defence and veterans – examples include Mates in Construction program, Mental Health First Aid
        - Are there lessons from overseas?
    - Indicated – getting with those people who have suicidal behaviour i.e. psychological therapy, emergency treatment, crisis lines
- Problematic anger – easier to be angry than demonstrably sad
- Protective factors for suicidality – these should be augmented
    - Resilience
    - Good connectedness with social networks – should take lessons from good programs
- Systems-based approaches
    - Still learning what works and doesn't work, so worth trying different things
    - Putting interventions together so whole is greater than sum of parts
    - Life-Span – good follow-up care, resilience programs in school, gatekeeper training, media reporting of suicide
- Suicide Registers – Official statistics take time to come through (usually due to Coronial processes) – registers are timelier as deaths can be classified as probable suicides – more useful data if timely – can identify patterns quicker – generally accurate
- Psychological autopsy – like case studies - information gained from family and friends about the life of the person leading up to death – good for determining patterns
- Urgent recommendations:
    - Lessons learnt from wider society about best interventions
    - Co-design with Defence members, veterans and those with lived experience and their families

2:30pm – 4:00pm Professor Louise Newman (Professor of Psychiatry, University of Melbourne)

- Quality of emotional care related to early brain development
- Those in positive caring relationships have better brain growth
- Examples when it doesn't occur – children in depravation and lack of care and support – many implications
- Multiple factors and risk factors can impact development – from genetic, neurodevelopmental, mental health issues

Process of reciprocal interaction been child and caregiver fundamental to brain development?

- Yes – even in utero listening to the external environment
- As species – relative state of prematurity – cant fend for selves – we are dependent on others for survival
- Innate primary drive we have to interact with others

Attachment – can you explain what attachment is?

- Attachment – psychologically – enduring emotional connections - infants development from 12 months of age
- Infants have need for social connection – signal own emotional states
- Provide infants with capacity to know who in the world is their available carer
- Know very clearly who there person or people are
- Not just biological mothers or fathers

Does infant need attachment to be a healthy adult?

- Yes early attachment reflects later relationships
- Development a sense of trust
- Capacity to communicate
- If less optimal experience then can be anxious about attachment
- Might be disorganized and cant form trusting relationships

Early attachment impacts later development?

- Individuals who had difficulty with early relationships still struggling in adult lives - have harder time in adult life

Expand on child behaviour when needs not being met – what does it look like?

- Varying patterns we can observe
- Some children will approach people to get emotional needs met
- If been neglected they might approach strangers for emotional connection
- Could become avoidant – no one responds to me so looks after self
- Other children – been in traumatic early relationships – angry and confused
- Difficulties in regulating own feelings
- Can cause major functional difficulties
- Disrupt peer relationships
- Falling into a more clinical area – related to disturbances of early attachment
- Behaviour problems and psychological problems

Disorganising behaviour in families

- Mental health services often see people with these difficulties
- Struggling on how best to help their child – vicious cycle and impact on family
- Can't manage child – if there are existing mental health problems
- Child who might well be difficult because of vulnerable family
- Factors that affect child development
- Trauma and adversity are key factors

Trauma in families and effect on children

- Trauma refers to extreme psychological stress and physical issues – may effect families and children for a variety of reasons – children and infants are particularly vulnerable to that due to development and stress-related hormones – earlier a child is exposed to s stressor, the worse the possible effects - can effect brain

growth – even babies are galvanised to self-protect - better ID of trauma in children is important for planning supports and interventions

- Creates functional difficulty – poor response – hard to learn self-regulation and mood regulation – self-harming behaviour – mood swings – more likely to have contact with juvenile justice systems, substance abuse
- Need for thinking longitudinally about development – how to intervene to support families better to manage vulnerabilities and support children – this is on a continuum that changes over time – don't want siloed services
- Parents mental health matters to the child – parents own mental health is crucial to quality of care and emotional interactions that shape development – interventions may include parenting services in child/paediatric hubs
- Where there is suicide or suicidality in the family, serious consequences for children – children often very aware – creates intergenerational trauma – need intervention models, specialist practitioners for various ages of children, responsive and flexible systems, targeted programs for re-engaging with supportive systems – long-term care may be needed – silence is not the answer

Impact of domestic violence on a child

- If a witness, stress effects are equivalent to being a direct victim – same patterns of highly stressed, confused, repeating in peer relationships, disrupted development in relationships, highly figure, fear loss of attachment, don't understand violent behaviour, anger – large impact on development
- Unpredictability of behaviour stresses children – stresses relationship, school attendance, social circle – this also occurs in fundamentally mobile families
- Need consistent relationships in services and others to begin healing

Intergenerational trauma

- The ways a parents experiences impact parenting, childcare and child's experience – can be parents or grandparents – transmission process – if we can ID vulnerable parents and provide clear and proactive support, we can help them resolve it

Early intervention

- Earlier we can intervene, the less damage is done – can sometimes prevent severe disorders – want to be proactively preventive
- For children and families may look like addressing children and family difficulties together, sessions for children, sessions for parents' education – depends on context and severity of condition n- needs to be parental involvement
- When someone presents for treatment, children need to be identified and there is an outreach process – guilt of parents

Defence Personnel and Veterans with mental health concerns or suicidality, and with families

- High-risk situation – need to understand children's experience – support needed for the grieving parent – need basic assessments as soon as possible
- Defence could offer tools to assess parenting capacity – risk assessments for surviving parents to manage – fundamental explanation the family is in for children survivors – need clinical expertise available and a response process – ongoing and in-depth care
- Need greater awareness of children's needs and education is Services – ow to talk to children 'do you know what's happened?' – offer basic triage

Responsibility

- Unresolved as to who has responsibility for response in these situations – within existing frameworks in Defence? State and Territory Governments? Multi-sectoral response -Hub model would be ideal – dedicated services needed, because public access would be difficult