Submission to the Inquiry for The National Commissioner for Defence and Veteran Suicide Prevention Bill 2020 and the National Commissioner for Defence and Veteran Suicide Prevention (Consequential Amendments) Bill 2020.

ONLINE SUBMISSION

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To Whom It May Concern,

RE: Submission to the Inquiry for The National Commissioner for Defence and Veteran Suicide Prevention Bill 2020 and the National Commissioner for Defence and Veteran Suicide Prevention (Consequential Amendments) Bill 2020.

Thank you for the opportunity to provide a submission on the critical issue of suicide prevention in our Defence and Veteran population. As clinical providers of trauma recovery treatment services to currently and ex-serving military personnel, we wish to address factors related to the functions of the National Commissioner, and highlight some important areas for consideration beyond which have been proposed in the Bill.

By way of backgrounds, Dr Andrew Khoo is a consultant psychiatrist, who as well as working in private practice, is the Director of Group Therapy Day Programs at Toowong Private Hospital (TPH) and Director of Medical Services for the hospital, which is recognised as one of Queensland's leading private mental health care facilities and is seen as a specialist service for treating currently and ex-serving military personnel with posttraumatic stress disorder (PTSD), alcohol use disorders, and anger management difficulties. Dr Khoo holds academic title with the University of Queensland within the School of Medicine and has co-authored a number of academic papers. Dr Khoo is a member of the DVA Clinical Reference Group; he holds the Psychiatrist position on the Open Arms Counselling Service (VVCS) National Advisory Committee; is the Psychiatric Advisor to the Gallipoli Medical Research Foundation (GMRF); and is a member of the GMRF Strategic Oversight Committee.

Dr Katelyn Kerr is a Clinical Psychologist, who holds the position of Senior Clinical Psychologist in the Group Therapy Day Programs at TPH. She holds academic title with Griffith University within the School of Applied Psychology, lecturing and course convening for the Australian Institute for Suicide Research and Prevention (AISRAP) in their Graduate Certificate and Masters of Suicidology program. Dr Kerr worked clinically for 12 years at the Life Promotion Clinic, the only outpatient clinic in Australia dedicated to the treatment of suicidality and self-harming in adults. Dr Kerr has co-authored a number of academic papers, and has published a children's book explaining military related PTSD. She also works in private practice; is a contractor for Phoenix Australia: Centre for Posttraumatic Mental Health on their RESTORE trial; is a member of the Australian Psychological Society; a Fellow of the APS College of Clinical Psychologists; and is an approved supervisor for the Psychology Board of Australia.

10. National Commissioner for Defence and Veteran Suicide Prevention

We would recommend there be explicit reference to the independence of the National Commissioner position from the Department of Veterans Affairs (DVA) and the Department of Defence (DoD). This is an important distinction to make, as there is mistrust, stigma, fear and anger related to services that are seen to be part of DVA and DoD.

11.1(e) To maintain a record of defence and veteran deaths by suicide notified to the Commissioner.

We would like to add, this data needs to be generally accessible so that the National Commissioner's role promotes a reputation for transparency and accuracy. Otherwise there is a risk of ongoing perception of secrecy around suicide related deaths of current and ex-serving military personnel.

11.1(f) To promote understanding of suicide risks for defence members and veterans and factors that can improve the wellbeing of defence members and veterans.

There have been a number of inquiries and Institute reports investigating suicide in currently servicing and ex-defence personnel in the past five years. The work that has been done in these reports needs to be synthesised to provide an overview of what the issues are and to provide a pathway forward, to focus the efforts of the National Commissioner and their team. For example, it is important to focus on risk factors for military/ex military personnel including age, rank, the medical discharge process and transition (Australian Institute of Health and Welfare, AIHW, 2018), reintegration into the general community and purposeful and meaningful occupational roles in civilian society (Kerr et al., 2018), and military related sexual abuse and bastardisation.

Other risk factors that have been identified in the literature in regards to general risk factors include previous suicide attempt, mental illness, chronic pain and comorbid physical illness, recent discharge from psychiatric hospital, comorbid drug and alcohol use, displacement from the home, social isolation, living in rural and remote settings, access to means (especially firearms), identification as ATSI, identification as LGTBI, relationship breakdown, high levels of aggression and impulsivity (over-represented in ex and currently serving-military cohorts with or without diagnosed mental illness), childhood neglect and abuse, family history of suicide, and domestic violence (Leske et al., 2019).

It is similarly important to examine the role of protective factors in this cohort which should include general protective factors for example education level, intelligence, employment status, social support, religious/spiritual beliefs, sense of connectedness, access to treatment for mental and physical illness, etc (Leske et al., 2019).

14. (b) Persons engaged by, or on behalf of, the Commonwealth as contractors to perform functions or duties.

The Commissioner will require regular access to clinical experts (from the areas of psychiatry and psychology) in the areas of military and veteran mental health, suicidology, military culture, as well as engaging suitability qualified and experienced statisticians to correctly quantify, interpret and communicate data. As such, and it is likely this may already be happening, we would support an advisory group being formed with representatives from the above categories at a minimum.

Other Areas for Consideration.

The effect of suicide on spouses, parents, children, siblings, and close friends.

We would like to emphasis the known impact of suicide on those left behind, specifically spouses, children, parents, siblings, and close friends (eg. the bereaved survivors). There is research evidence that the bereaved have increased risk of suicide attempts, increased completed suicides, and increased mental ill health following the death of a loved one by suicide (Pitman et al., 2014)

There are important distinctions in how the bereaved by suicide suffer, compared to those bereaved by other causes of death. Those bereaved by suicide report that they:

- Feel a strong sense of stigma which underlies the following:
- Feel shamed and blamed for not preventing the death, and for having someone close to them die by suicide
- They feel they have to keep the cause of death a secret, which interferes with gaining support and processing the death. There was an association between perceived suicide stigma and suicidality and grief, partially mediated by secrecy (Peters et al., 2016, as cited in Evans & Abrahamson, 2020).
- Psychological distress - perceived stigma was significantly related to depression and global psychological distress. Stigma was linked to suicidality, including thoughts and attempts. (Evans & Abrahamson, 2020)

In the National Commissioners role we highly recommend that there is awareness of the suffering of the bereaved and the downstream mental health consequences on the bereaved. We recommend that in this role, the National Commissioner involves the bereaved in the process (as much or as little as the bereaved choose to be), there is provision of information and education about symptoms of psychological distress, and that there is information on how and where to access professional help, and that ideally there is pathway of care for them (eg. Open Arms; Beyond Blue; Standby; Roses in the Ocean).

Stigma and Barriers to Accessing Mental Health Treatment.

Military employment is competitive, employing task/achievement based advancement with a focus on the ultimate goal of deployment. These factors result in entrenched views around dismissing difficulties, spurning perceived weakness in any form and “soldiering on”. Hence there is a magnification of both institutional and

individual stigma toward mental illness as compared with the general population. The perceived risk to ongoing employment as well as promotional and deployment opportunities posed by volunteering symptoms is a well documented barrier to mental health care, and therefore treatment before suicidal symptoms arise.

Primary prevention encompasses deterring symptoms before they arise, with targeted interventions delivered across the whole population of interest. Effective primary prevention programs that have been shown to reduce suicide rates in the general community include means restriction (eg. suicide barriers and helplines located at known jumping hot spots; firearms restrictions), media campaigns (eg. Are U OK Day), and mental illness literacy programs. Primary prevention campaigns are cost effective, as well as helping the largest number of people.

We therefore recommend that the National Commissioner consider implementation of some primary prevention initiatives across DoD, which would likely include mental health literacy programs, including measuring outcomes of such programs pre and post and including continuous evaluation. It is imperative that mental illness is dealt with from a rehabilitation/recovery focused approach, focused on returning the person to work as maintenance of employment is a recognised protective factor that protects the currently serving from the higher suicide rates which are seen in discharged personnel (AIHW, 2018). It is important that people are encouraged to self-identify symptoms and to be encouraged to seek help, whilst at the same time reducing the consequences for seeking help.

Thank you for your time, and we trust this has been of some use.

References

Australian Institute for Health & Welfare. (2018). *Causes of death amongst serving and ex-serving Australian Defence Force personnel: 2002-2015.* Australian Government. https://www.aihw.gov.au/reports/veterans/causes-of-death-in-adf-personnel-2002-2015/contents/summary

Evans, A., & Abrahamson, K. (2020). The influence of stigma on suicide bereavement: A systematic review. *Journal of Psychosocial Nursing & Mental Health Services, 58*(4), 21-27.

Kerr, K., Romaniuk, M., McLeay, S., Khoo, A., Dent, M., & Boschen, M. (2018). Increased risk of attempted suicide in Australian veterans is associated with total and permanent incapacitation, unemployment and posttraumatic stress disorder severity. *Australian and New Zealand Journal of Psychiatry, 52*(6), 552-560.

Leske, S., Crompton, D., & Kõlves, K. (2019). *Suicide in Queensland: Annual Report 2019*. Australian Institute for Suicide Research and Prevention, Griffith University.

Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *Lancet Psychiatry, 1*(1), 86-94.