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Royal Commission into Veteran Suicide
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Submitted: *Online*

Relationships Australia's Submission to the Royal Commission into Veteran Suicide

Relationships Australia welcomes the opportunity to make a submission to the Royal Commission into Veteran Suicide. Relationships Australia provides support to veterans and their families through our broad range of services such as counselling, mediation, and family dispute resolution. In particular, we are sub-contracted by Open Arms to provide counselling, trauma and relationship services.

This submission has been developed with the support of insights from our staff who are involved in this service, and others. It has also been influenced by the submission we prepared with Suicide Prevention Australia and Mental Health Australia titled *Towards a Blueprint: Ensuring mainstream services are accessible and effective for veterans, defence personnel, and their families*. This submission is intended to provide insight into the issues affecting veterans and their families within our service specifically, as well as broader proposals into the changes needed to ensure family and relationship services are appropriate and effective for veterans, defence personnel, and their families.

Key Recommendations

1. Incentivise practitioners to work with veterans and defence personnel
2. Formalise and fund 'cultural competency' and empower practitioners to work with this cohort
3. Embed family counselling and family wellbeing models within the service spectrum
4. Increase access to veteran peer workers – allow peers to operate across mainstream services that support veterans and their families
5. Fund family and relationship counselling as a form of mental health and suicide prevention

Evidence of the role families and other supportive relationships play for veterans and defence personnel

There are certain aspects of the military family dynamic that contribute to suicide risk factors. For example, separation from family is understood as a suicide risk (Van Orden et. al. 2010) as is the experience of challenges with the partner relationship, which is exacerbated by frequent time apart (AIHW 2021). Additionally, it has been suggested that military families may experience heightened suicide risk themselves due to exposure to military culture (Peterson et. al. 2022). American research has found that family members are more likely to find the decedent's body and undergo stressful and traumatic military death investigations (Harrington-LaMorie et. al. 2018). This study also found that death by suicide can be understood in the military as a dishonourable death, increasing stigma for the family when compared to civilian families.

Research also demonstrates that many of the recognised suicide risks in the civilian population increase risk among veterans and defence personnel. For example, while suicide exposure is understood as a suicide risk (Peterson et. al. 2022), studies on military cohorts have found stronger correlations between suicide risk and more severe suicidal symptoms and a history of suicidal thoughts and behaviours (Hom, Stanley, Gutierrez & Joiner, 2016). Intimate partner violence (IPV) is also understood as a suicide risk factor and a systematic review of 56 papers found that the risks for IPV and suicide overlap for women veterans (Iovine-Wong et. al., 2019).

Alternatively, strong interpersonal relationships, social supports, and positive family functioning are protective against suicidality (Sales et al., 2019). In fact, most contemporary understandings of suicide consider linkages amongst wider family structures, either through social or interpersonal explanations or life stressors which implicate families and other relationships in the deceased's life (DuBois et. al., 2023). So, relationship challenges and breakdown can represent unique risk for this community, and the realities of military life make these more likely. As such, strengthening relationships should be considered integral to any interventions into suicide within veteran communities. Despite this, very few studies evaluating suicide prevention involve military/veteran families or explore the intervention potential of other relationships in veterans' lives.

Evidence for working with the family post-suicide

Postvention work for a military family can include bereavement counselling, particularly exploring the different ways people respond to grief, re-negotiation of family roles, appropriate and supported discussion of suicide with children (Ratnarajah & Schofield, 2007) and sometimes more practical connections to other forms of support including funeral arrangements, childcare and home support (Wilson & Clark, 2005). Given the increased risk of suicide among family members, and the potential for damaging implications for family communication and developmental processes, family work is a key response to suicide bereavement (Jordan, 2001). Jordan also cited the importance of monitoring for psychiatric disorder and suicidality in families after suicide. This is especially true in families who have moved multiple times and may find themselves separated from extended family or well-established social networks.

Recommendations based on our experiences providing family and relationship services to veterans and defence personnel

1. Incentivise practitioners to work with veterans and defence personnel

The need to foster and support practitioners who are passionate about working with veterans and their families in mainstream services was evident throughout our consultations. We noted that our practitioners who worked in this area mostly had a personal connection to the military. However, they also noted that there are many benefits to working with this cohort that could be more actively promoted. For example, holistic work within this client group is both feasible and impactful, thanks to a robust support system that can be activated as needed. Nevertheless, funding models often lack provisions for comprehensive case management, including identification and coordination with general practitioners, or matching timelines to PTSD treatment. Aligning timelines and prioritising care coordination are critical steps to improving relationships, as untreated mental illness can exacerbate relationship issues and vice versa. While Open Arms provides 3 hours for standard care plans and service reviews, which is mostly appropriate, there may be room for flexibility, especially in complex cases involving serious violence, suicidality, or child protection concerns. Despite these limitations, practitioners felt that Open Arms' extensive resources offered the latitude to plan and tailor interventions over time and with a relatively wide support network, so more should be done to promote the benefits of working with a cohort that have such varied resources available to them and to support practitioners to access these supports in the most effective way. Finally, our practitioners noted that the complexities of this cohort required one to possess a deep understanding and extensive experience with trauma work, mental health and suicide prevention. They felt that with appropriate cultural training (see recommendation 3), many family and relationship practitioners are well placed to deliver this work, but are not often encouraged to move into veteran space, due to its segmentation through specialised service streams. As a result, veterans, defence personnel, and their families are not often promoted as a client cohort they could/should be upskilling with. Incentivisation could take place through a variety of formats. At the organisational level, directly funding family and relationship service providers to provide veteran services would encourage them to develop and maintain these workforces. Providing free or heavily subsidised trainings would encourage staff to upskill.[1] Pathways could also be developed for veterans to upskill as peer workers in family and relationship services, as peer workers often play a key role in educating other staff in the organisation. Additionally, pathways towards counselling and family therapy could also be developed.

2. Embed family counselling and family models within the service spectrums

Recognising the role of family models of care outside relationship counselling

There has been an increasing demand for family counselling and relationship issues that may not specifically relate to military service, but are imbued by the experience of service. Relationships Australia's connection to veteran family work has predominantly come through sub-contracting work with Open Arms. Veterans and their families are referred into Relationships Australia, often for couples counselling but are then referred into a variety of our other programs including gambling support, children's programs, mediation, conflict coaching and broader family and relationships counselling. Our practitioners reported that veterans and their families benefited from the whole-of-family

[1] These trainings could be based on the RANZCP training pilot – which trained a limited number of psychiatrists in veteran and military health – by providing additional funding to train more psychiatrists in these areas.

approach our services have, as it supported the entire family to re-integrate into civilian life, which in turn strengthens the veteran's relationship to their family.

Our services also have the capacity to connect veterans and their families to the civilian community. For example, our group for teenagers who experience domestic and family violence, Got Your Back, is designed to enhance relationships for children in challenging environments, especially within peer communities. Services such as these play a pivotal role in combatting the insularity that often develops among military children and families.[2] This is quite distinct from many other individualised therapeutic interventions.

While considerable effort has been dedicated to aiding veterans in their employment and transition to civilian life, building and nurturing connections within the entire family and to the community are equally vital. Despite growing demand, it is predominantly occurring through sub-contracting and so requires the family to have an issue that is recognised as in need of relationship-focused therapy by Open Arms. As such, if they believe the issue to be more issues based, they may refer them to another service that is more individually focused and cannot address the whole-of-family concerns that the presenting issue often masks. For example, gambling counselling that has a relationship lens is extremely effective for veterans because the entire family is affected by the experiences of service and its repercussions.

Practitioners spoke of a persistent need to embed the importance of family counselling into care plans, often needing to prove the need for these kinds of interventions when reporting back to contractors. To provide more effective and holistic support, a relational approach is needed, one that encompasses not only the veteran but also their family, recognising that the well-being of one profoundly impacts the other.

Other opportunities to embed family models for veteran support

Veteran families could also be more wholeheartedly embedded into the service spectrum through a more robust mental health model. As has been outlined in a variety of our other submissions to mental health enquiries, the government needs to develop and fund the implementation of a mental health reform roadmap. A robust mental health service delivery model should include family functioning and relationships in the stepped care model, both as a 'step' towards acute care, as well as in recovery.

Similarly, the current digital mental health space in defence was described as 'corporate'. We believe there is space for a friendlier, family-orientated online presence, of which Head to Health is a good example. Mental health models and interventions that focus on the veteran as an individual fail to provide support that embed the veteran within a family and community system, two integral aspects of recovery.

[2] Got Your Back is a weekly community of support for young people who have been impacted by family and domestic violence. Young people aged 12-25 can connect with each other, share ideas and discuss the challenges they are facing. Domestic and family violence is not just physical – it also refers to a range of power and control behaviours. Those witnessing these behaviours can be just as impacted as those experiencing it. Got Your Back offers a caring and confidential space for young people to take ownership of the group and choose what they wish to discuss. Programs such as this are beneficial for children within military families to attend.

3. **Formalise and fund 'cultural competency' and empower practitioners to work with this cohort**

A side effect of the sub-contracting model is that rather than using funding contracts to upskill whole sectors to work with communities, individual counsellors gain competency, sometimes through trial and error.[3] As a result, there is a skills deficit within the family and relationship sector for veteran specific support. To facilitate healing and provide effective support, it is imperative to address and repair the relationships strained by the effects of service by supporting the whole family. But to keep veterans and their families within the service, more must be done to upskill practitioners to work effectively with this cohort.

Practitioners spoke about the need to formalise cultural competency. Practitioners spoke about simple aspects of mainstream services that when misinterpreted for this client group can have significant effects. For example, risk screening assessments often include questions related to weapon use as an indicator of anger or violence, which out of context could be interpreted incorrectly. Similarly, avoidant behaviour when completing these types of questionnaires may be exemplary of PTSD as opposed to the presence of violent behaviors within the family dynamic.

Currently, cultural competency often comes from family connections to the military, or through trial and error with clients. Recurrent and accredited training should be provided, establishing standardised pathways for skill development.

Cultural competency training not only contextualises client behaviour, but it can also support practitioners to develop confidence to engage skills they already possess that may be beneficial to a client group. Deployment leaves its mark, often manifesting as individual and collective trauma within military families. Those trained in trauma-informed work are particularly adept at supporting this cohort. For example, trauma-informed care supports practitioners to clearly articulate the therapeutic benefits of a proposed therapy. It also encourages the clear communication of care plans, to ensure clients are fully informed and empowered to make choices, particularly when dealing with individuals who may have experienced significant trauma.

Despite this, several challenges exist in adapting a trauma-informed service model to accommodate military administrative processes, practices and behaviours. Trauma-informed service is founded upon 5 key themes: safety, choice, collaboration, trustworthiness and empowerment. Many aspects of the military sit at odds with these therapeutic practices. For example, one practitioner spoke about the challenges when addressing domestic violence, especially where individuals may be hesitant to involve law enforcement. While the military pushes for police involvement, best practice stipulates supporting the client to make their own decision, which can create pushback and challenge the client-practitioner relationship. Another example is the disempowering focus on the service member, which often serves to reassert power dynamics within military families and stymy therapeutic work. Currently, all financial resources, information, and housing arrangements are channelled through the service member, even if they are geographically separated from their family. Firstly, this can lead to family members feeling excluded from the support system. Secondly, it limits the ability to enable the family to enact choice and empowerment. A third example, is the arduous reporting requirements required for engaging with

[3] For example, Relationships Australia used our funding contract with the Disability Royal Commission to improve our accessibility by upgrading buildings, staff skills and cultural competency for the entire workforce, not just those working directly with clients in this service.

this cohort, which have led clients to feel they are being monitored or cannot trust the practitioner, despite accessing mainstream services 'outside' the military system.

Cultural competency training should explore these concepts and draw upon the strengths practitioners already possess to overcome the challenges faced by, and provide effective support to, veterans, defence personnel and their families.

4. **Increase access to veteran peer workers – allow peers to operate across mainstream services that support veterans and their families**

Peers are critical to the success of services such as ours. Providing a mainstream option for a culturally specific group brings challenges to the work. Trust is critical for engagement with services. Veterans, defence personnel and their families may mistrust services, but often trust each other. The immense value of military peer workers has been recognised across the service spectrum, for example, peer workers are invaluable workforces within the mental health and suicide prevention sectors. Among Relationships Australia's services, peers have already proven successful in fields like gambling and disability support, however they usually do not have military experience. Our clients who have been provided with a veteran peer worker through Open Arms (for other services) have described their firsthand understanding of the challenges in military life, and have proved very useful for effective engagement with General Practitioners and other allied health workers. They *can* create stronger connections and bridges to counselling services, help clients understand the purpose of counselling and foster trust in mainstream organisations. However, currently veteran peers are limited to other services funded under Open Arms and due to limitations in the use of family counselling within this funding stream, peers are only able to enhance trust if they happen to be supportive of family counselling approaches. Enhancing the peer workforce should be a particular priority of government. The term "peer" can cover a wide variety of roles, such as that of mentoring, semi-formal support networks, or paid peer workers with peer work qualifications. We encourage diversity in the peer workforce, and to ensure mainstream services are most effective for veterans, veterans peer workers should be available. For further information on how we believe it would be best to grow and train this peer workforce, please refer to our previous joint submission *Towards a Blueprint*.

5. **Fund family and relationship counselling as a form of mental health and suicide prevention**

Relationships Australia believes that the mental health and suicide prevention sectors require a more complex understanding of the role that family, community and other relationships play in people's mental health and wellbeing, which is appropriately reflected in our service system. Australia's mental healthcare system is currently predominantly situated within a biomedical understanding of mental health. This means the patient with the presenting problem is the primary focus of intervention and the alleviation of that person's symptoms is the goal. The mental health concern is managed within the health system, with the treating professional as the intervention expert. The emphasis on the biomedical approach is still prevalent, despite the rhetoric for many years acknowledging the importance of relationships and client-centered practice. It also persists in the face of evidence that the patient is likely to work with colleagues, attend social events in community or live with parents, a partner, children, friends or housemates. These people will all be implicated, in positive and negative ways, in the outcomes for the person with mental health concerns. Further, all these people may have different roles in caring. From the friend who says, "Let's go out and I'll cheer you up", to the employer who is concerned but has a duty to company outcomes, to the parent monitoring a family member living in a darkened room. It is these people who the treating professional could arguably activate as

key resources in change and for the sustainability of that change in the presence of mental health concerns. But due to the biomedical model of intervention, are unlikely to. It is difficult to develop long-term, effective care plans without engaging these relationships, yet there is a consistent assumption that mental illness and suicidality will be 'dealt with' by professionals, placing enormous strain on the system.

This is true across the broader mental health and suicide prevention landscapes but has particular relevance to the veteran cohort. As the research suggests (discussed in section 1), there are unique elements of the military lifestyle that place veterans and their families at particular risk of relationship challenges or breakdown, which in turn present risk factors for suicidality. The ongoing conceptualisation of veterans as individuals in need of individualised interventions is concerning.

For example, while Open Arms excels in providing military-aware and trauma-informed care, its original and primary focus is on current and former serving members in need of mental health support, counselling and trauma therapy. Over time this has expanded to include families and a broader spectrum of presenting issues that may not have a direct military connection. Relationships Australia has been sub-contracted to address some of these presenting issues but is usually conceptualised as a partner-relationship service and is predominantly only called upon in discrete regions across Australia. As such, our interventions are still understood as outside the mental health and suicide prevention spectrum, or indeed, as secondary to these interventions.

However, relationship counselling often operates as an alternative front-door to other biomedical interventions for mental illness. The idiomatic understanding of relationship breakdown as an extremely disruptive event creates barriers to help-seeking. While loved ones usually raise the alarm in regard to the mental health of a loved one, relationship breakdowns among these relationships can lead family members to consciously or unintentionally downplay the symptoms of their loved one's mental health. For example, some symptoms can be put down to someone being "difficult", "eccentric", "emotional" or "having a bad day". People adapt to and accommodate behaviours and can lose perspective on what might be a signal of mental ill-health, especially during such stressful periods. Further, mental health problems, being of a deeply personal nature, are often not visible to others, and individuals can often conceal or downplay their symptoms too, perhaps to preserve relationships (Robinson et al., 2008, p.6-7). As such, relationship services play an integral role in identifying psychological distress, mental ill-health and mental illness. During especially stressful relationship breakdowns, individuals may not have the time, capacity or funds to attend to their mental ill-health, however the need to seek relationship services may be more pressing. As independent, and perhaps the only, witnesses of these experiences, our practitioners' insight is vital.

Relationships Australia recommends proper recognition of the integral role that family and relationship services play in the mental health and suicide prevention sectors. The persistent conceptualisation of mental illness as a medical issue not only limits how funding is allocated, but also how sub-contracting occurs. More must be done to shift into a relational approach to mental health and wellness and the shift must come from all directions, including funding streams.

Thank you for your consideration of this submission. Should you wish to discuss any aspect of it, or the services that Relationships Australia provides, please do not hesitate to contact me (ntebbey@relationships.org.au) or our National Research and Project Manager Claire Fisher (cfisher@relationships.org.au) or by telephone on 02 6162 9300.

Kind regards

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