Royal Commission
into Defence and Veteran Suicide

Executive summary, recommendations and the fundamentals

Volume 1

Final Report

Alex Seton

For Every Drop Shed in Anguish

made in Sydney, 2022–2023

Australian Pearl Marble

dimensions variable

Collection of the Australian War Memorial, acquired by commission in 2023

AWM2021.938.1

© Alex Seton

Together with veterans and their families, the Australian War Memorial commissioned this work of art to recognise and commemorate the suffering caused by war and military service. *For Every Drop Shed in Anguish* by Alex Seton provides a place in the Australian War Memorial's Sculpture Garden for visitors to grieve, to reflect on service experiences, and to remember the long-term cost of war and service.

Artist Alex Seton said, 'These rounded and abstracted liquid forms represent every drop of blood, sweat and tears ever shed by Australian military personnel and their families. It was very important that we create a different kind of memorial, not a singular heroic monument, but a grouping that acknowledges that there is a wider impact of mental and physical trauma. The large group of forms alludes to the suffering that radiates out from the individual, affecting their family, friends and communities.'

ISBN 978-1-921357-06-0 (print)
ISBN 978-1-921357-05-3 (online)

Royal Commission
into Defence and Veteran Suicide

Final Report

Volume 1: Executive summary, recommendations and the fundamentals

Content warning – discussion of suicide and suicidality

This report is about suicide and suicidality among serving and ex-serving Australian Defence Force (ADF) members. It includes information related to these topics as well as experiences that have contributed to people becoming suicidal. This report includes content that readers may find distressing, confronting, emotionally-laden or otherwise difficult to read. You may find that reading this report brings up traumatic memories or strong emotional responses. We encourage you to speak with someone you trust, or you may wish to seek professional support through one of the services listed here if needed.

It is important to write about suicide, suicidality, traumatic experiences and their ramifications safely and responsibly. In the past, talking about suicide and suicidality has been taboo. We aim to approach our discussion about them in a constructive way. This report was written in line with our trauma-informed approach and using guidance from the Mindframe program.[1] We have aimed to avoid using language that might stigmatise suicide or suicidality or that might inadvertently encourage suicide. We recognise that because this report includes evidence and information provided by other people and organisations, there may be times when the language used does not always meet best practice guidelines.

Urgent support

If you require urgent or immediate help, you can:

- call triple zero (000)
- go to your local emergency department.

1 Mindframe, *A guide for media reporting on defence and veteran suicide*, 22 December 2022.

Crisis support services

Suicide Call Back Service

1300 659 467

24-hour counselling service for suicide prevention and mental health. Available via telephone, online and by video chat.

Open Arms

1800 011 046

24-hour mental health support for Navy, Army & Air Force personnel, veterans and their families.

Defence Member and Family Helpline

1800 624 608

24-hour service providing a range of practical and emotional support programs for families facing emergency or crisis.

Defence All-hours Support Line

1800 628 036

24-hour service for Australian Defence Force members and their families providing help to access military or civilian mental health services.

Lifeline Australia

13 11 14 or text 0477 13 11 14

24-hour crisis support service.
Available via telephone, online and text chat.

Beyond Blue

1300 224 636

24-hour counselling service.
Available via telephone, online or email.

1800RESPECT

1800 737 732

24-hour counselling service for sexual assault, family and domestic violence.

Men's Referral Service

1300 766 491

24-hour counselling, information and referral service for men concerned about their own use of violence or abusive behaviour.

MensLine

1300 78 99 78

24-hour support for men with concerns about mental health, anger management, family violence, addiction, relationship stress and wellbeing. Available via telephone, online and by video chat.

13YARN

13 92 76

24-hour national support line for First Nations people in crisis.

QLife

Call 1800 184 527 or visit qlife.org.au

The QLife phone and webchat service is available 3pm to midnight every day, providing space for where LGBTQI+ people and their loved ones can talk about anything affecting their lives.

Acknowledgement of Country

We Commissioners and all Royal Commission staff wish to acknowledge the Traditional Custodians of Country throughout Australia. We pay our respects to their Elders past and present and extend that respect to all First Nations peoples including those who have served in the Australian Defence Force, and who have been impacted by defence and veteran suicide. First Nations people have a long and proud history of serving this country, and we honour their service.

Our head office was located on the lands of the Gadigal people of the Eora Nation. The Gadigal people are one of about 29 clans that make up the Eora Nation, and are a salt water people whose traditional lands include much of the area we now call Sydney. We acknowledge the Gadigal people's continuing connection to land, water and community, and pay our respects to Gadigal Elders past and present.

We held hearings around Australia on the lands of the Jagera people and the Turrbal people (Brisbane), the Gadigal people, the Ngunnawal people and Ngambri people (Canberra), the Bindal and Wulgurukaba people (Townsville), the Muwinina people (Hobart), the Larrakia people (Darwin), the Wiradjuri people (central New South Wales), the Whadjuk Nyoongar people (Perth), the Kaurna people (Adelaide), and the Wurundjeri people (Melbourne).

9 September 2024

Her Excellency the Honourable Ms Sam Mostyn AC
Governor-General of the Commonwealth of Australia
Government House
CANBERRA ACT 2600

Your Excellency

In accordance with the Letters Patent issued on 8 July 2021, as amended on 10 April 2022 and 7 December 2023, we have made inquiries and now submit to you the final report of the Royal Commission into Defence and Veteran Suicide.

Yours sincerely

Mr Nick Kaldas APM
Chair

The Hon James Douglas KC
Commissioner

Dr Peggy Brown AO
Commissioner

Contents

Statement of support

Serving and ex-serving members of the Australian Defence Force (ADF) make unique contributions and sacrifices on behalf of the nation – on behalf of all of us. As Commissioners and members of the Australian community, we want to acknowledge and honour those who have served or are currently serving in the ADF. We recognise the pride many of you have in your service and in being part of something bigger than yourself. We also recognise that many have been adversely impacted by experiences related to service that are outside their control. From recruitment to active service in its many forms, to transition from the ADF to post-service life, we thank you for your commitment to the Australian community.

We also pay our respects to the families and loved ones of serving and ex-serving ADF members who also make sacrifices, year in and year out. Service life, transition and post-service life affects all facets of family life and no one should have to face these demands alone. We also know that families do not always receive adequate acknowledgement or effective support.

We acknowledge every serving and ex-serving member of the ADF who has died by suicide – each life lived and each life left behind. We also recognise the experiences of those serving or former ADF members who have experienced suicidality. And we acknowledge the grief, the pain, the challenges, the resilience, the strength, and the love of families and friends of serving and former ADF members who have died by suicide or faced suicidality.

Commissioners' foreword

This Royal Commission was tasked with identifying systemic problems and proposing systemic solutions to prevent suicide and suicidality among serving and ex-serving Australian Defence Force (ADF) members.

Suicide is a complex phenomenon and risk factors for suicide and suicidality are equally complex and diverse. They can be physical, psychological, or psychosocial. They can exist at a personal level, or at the systems-level through the culture and operations of an organisation or institution. They are intersecting and interrelated, and cannot be considered in isolation. Risk factors affect people differently, and may take on greater or lesser significance at different times in a person's life.

We will remain forever changed by the personal stories shared by serving and ex-serving ADF members and their families, friends and supporters. Your contributions shaped our inquiry, and this final report was written with you in mind. We are inspired by your resilience, courage, and desire to change things for the better so that others do not experience what you have endured. We thank you for your faith in this Royal Commission.

An inquiry of this scale and complexity is an extraordinary undertaking. It would not have been possible without our experienced and dedicated staff who consistently demonstrated empathy, perseverance and professionalism. We thank every staff member who contributed to this Royal Commission. We also thank all who contributed to our inquiry through hearings, roundtables, submissions, responses to notices, community forums, base visits, reference and advisory groups, and by undertaking research and data analysis.

Though our inquiry focused on the ADF, the Department of Defence and the Department of Veterans' Affairs (DVA), we recognise that suicidal despair is experienced across society. Many people are failed by institutions who have a duty of care towards them. Many of the dynamics, practices, actions and failures to act that we identify in this report are also found in other organisations, albeit in different contexts and to different degrees. We hope that our analysis and recommendations will stimulate reflection and action across society, and help to mitigate the risk factors for suicide and suicidality that are present in workplaces and institutional settings beyond Defence and DVA.

In this report, we make many recommendations aimed at preventing harm and supporting early intervention and recovery; improving cohesion, collaboration and coordination in the delivery of support services; building institutional capability and capacity; and improving oversight, transparency and accountability across the ecosystem of agencies and institutions responsible for the health and wellbeing of serving and ex-serving ADF members and their families.

Whether the work of this Royal Commission will contribute to a reduction in rates of suicide and suicidality among serving and ex-serving personnel now largely depends on the Australian Government and its agencies: the Australian Defence Force, the Department of Defence and the Department of Veterans' Affairs.

As Commissioners, we insist that it is both necessary and possible to reduce the number of deaths by suicide and experiences of suicidality among serving and ex-serving ADF members. Our sailors, soldiers and aviators deserve to receive the protection and support they need to thrive, grow and heal, both during their time in service and beyond.

Executive summary

> [N]othing will take away what it does to a person to literally sign a piece of paper to say they will go anywhere at any time and do anything – including sacrificing their own life – in the defence of our country. And then for that country to turn around and say to them they are not worth anything to them broken. Not worth anything to them injured. That they see me as nothing.[1]
>
> – Ex-serving Air Force member

Our inquiry

Establishing the Royal Commission into Defence and Veteran Suicide

1. The Royal Commission into Defence and Veteran Suicide was announced on 19 April 2021, and formally established by Letters Patent issued on 8 July 2021. However, the need for a thorough, systemic inquiry into the national crisis of suicide and suicidality among serving and ex-serving members of the Australian Defence Force (ADF) was decades in the making.

2. In large part, the establishment of this Royal Commission can be attributed to the years of hard-fought and sustained campaigning by the families of military personnel who have taken their own lives, and the advocacy of former ADF members who have fought for better outcomes for their colleagues and friends.

3. The work of this Royal Commission rests on a body of more than 50 inquiries and reviews relevant to suicide and suicidality among serving and ex-serving ADF members. Previous inquiries and reviews have examined the legislative frameworks, structures, policies, practices, culture and operational dimensions of the ADF, the Department of Defence, and the Department of Veterans' Affairs (DVA). Many of these reports were limited in scope, seeking to address significant but discrete issues. Many were initiated in response to a particular event or perceived crisis. In totality, however, they demonstrate a sustained concern about Defence and DVA.

4. Actions taken in response to more than 750 recommendations of previous inquiries and reviews have resulted in some changes and improvements, but not the level of reform envisaged or needed. Importantly, there has been no sustained reduction in the high rates of suicide and suicidality among serving and ex-serving ADF members over the last 20 years.

5. Suicide is a complex public health issue and despite several decades of research, the processes underlying suicide risk are still not well understood. It also continues to be difficult to reliably predict suicide behaviours. However, much is known about the risk and protective factors for suicide and suicidality, meaning that any organisation with a duty of care must do everything in its power to recognise and mitigate the risks that its people may be exposed to.

6. The establishment of this Royal Commission can be seen as a clear signal of the failure of successive governments, the ADF, the Department of Defence and DVA to learn from the lessons of the past, to implement the reform required to effect real change, and to adequately address the needs of those who serve our country.

7. This Royal Commission was needed to interrogate and reflect on the standards of conduct that we consider acceptable in contemporary Australian society, the priority we place on mental health and wellbeing, and the steps we are willing to take to protect those who protect us.

8. The final report of this Royal Commission should not be viewed as an indication that we have reached the end of the road. Rather, it is an indication that we have started down the correct path.

Our methodology

9. Our terms of reference were wide-ranging and broad in scope, developed following consultation with the defence and veteran community and states and territories.[2] We were directed to focus on cultural, structural and systemic issues, be informed by an understanding of individual experiences, and make findings and recommendations to address the persistently high rates of suicide and suicidality among serving and ex-serving ADF members.

10. Over the course of our inquiry, we:

- held 12 public hearings totalling more than 100 days, including at least one hearing in each of the eight capital cities, and the garrison towns of Wagga Wagga and Townsville
- received oral evidence from more than 340 witnesses, including the most senior leaders of the ADF and Ministers for Defence and Veterans' Affairs, and more than 60 lived experience witnesses
- held 897 private sessions, sitting one-on-one with people with lived experience of suicide, suicidality or military service, and hearing their personal stories, experiences and perspectives
- received 5,865 submissions from serving and ex-serving ADF members, and their families, carers and advocates, as well as organisations and institutions
- read and analysed documents received in response to more than 2,000 compulsory notices to give or produce

- held numerous roundtables and workshops with subject matter experts, senior ADF leaders, and representatives from Defence and DVA
- undertook research and data analysis including internal qualitative research, and quantitative research in partnership with the Australian Institute of Health and Welfare
- commissioned nine external research projects from academics, universities and specialist research organisations, including a review of the most current academic literature on the risk factors, trends and evidence-based prevention strategies relevant to suicide and suicidality among serving and ex-serving ADF members
- conducted 26 visits to military bases across Australia and heard from current serving personnel about the challenges and opportunities of life in the ADF
- travelled to the United States, Canada, the United Kingdom and New Zealand, and heard from approximately 300 key informants as part of a cross-jurisdictional comparison of how our Five Eyes partners are responding to the issues of suicide and suicidality in their own military communities
- released our interim report,[3] and a lived experience publication titled *Shining a Light: Stories of Trauma & Tragedy, Hope & Healing*.[4]

A trauma-informed approach

11. This inquiry is anchored by the personal stories, experiences and perspectives of serving and ex-serving ADF members and their families, friends and support networks, shared through submissions, oral and written evidence, and private sessions. While lived experience accounts did not constitute formal evidence, they helped inform our lines of inquiry.

12. In a royal commission concerned with suicide and suicidality, it was critical to have a framework that prioritised the safety and wellbeing of those who engaged with us. This framework required Royal Commission staff to recognise people's individual experiences of trauma, how this presents in a service-based setting, and the importance of adopting a stepped care, person-centred model to respond to the unique needs of each individual.

13. It required us to recognise and acknowledge that many people who engaged with us had prior negative experiences of navigating administrative processes in government and non-government sectors. For some people, this manifested as a lack of trust in institutions, including ours, and as a cynicism about the prospects of this Royal Commission to effect meaningful change. Royal Commission staff worked diligently to proactively address barriers to engagement and to build trust through prompt and consistent communication and transparent practices.

14. Our objective was to ensure that the dynamics of abuse, trauma and neglect experienced by serving and ex-serving ADF members, their families and supporters were not replicated in their interactions with this Royal Commission.

The unique nature of military service

15. The ADF comprises three services – the Royal Australian Navy (Navy), the Australian Army (Army) and the Royal Australian Air Force (Air Force). While most members serve in a single service, some transfer from one service to another. Personnel may serve in the permanent or reserve forces, or a combination of both, over their service careers.

16. Public and political attention can at times focus on the acquisition of high-profile military equipment. However, Australia's defence capability is primarily dependent on personnel – the working professionals who put on their Navy, Army or Air Force uniforms each day. According to recent data from Defence, the ABS Census 2021 and the Defence Annual Report 2022–23:

    - There are 89,395 current serving permanent and reserve members, including 19,352 Navy members, 48,766 Army members and 21,277 Air Force members.[5]
    - More than 6,000 Australians enlist in the ADF on average each year.[6]
    - More than half a million living Australians (581,139) have served or are currently serving in the ADF.[7]

17. Military service is unique. We recognise that many of the features that distinguish military service from other occupations are necessary to achieve Defence's mission of maintaining our collective security and defending Australia's national interests.[8]

18. The primary purpose to defend the nation from threat defines and shapes the core functions of Defence and the operation and management of the ADF, including how members are trained, equipped and employed.[9]

19. On enlisting, aspiring ADF members undergo drill and weapons training, endurance exercises, and education on military justice and history.[10] This is supplemented by what Defence itself has described as 'an indoctrination process' that realigns the values, beliefs, behaviours and language of new recruits to those required by military service.[11] Inherent to this process is developing the capacity to suppress emotion. As Dr Jon Lane, Senior Lecturer in Psychiatry at the University of Tasmania and an ex-serving Army member, explained:

> You are put under physical, mental and emotional pressure with significant time constraints and people yelling at you and lots of things designed to knock you down, basically, and then build you up in a way that's more desirable for that organisation …
>
> So, a big part of military training is … learning to tolerate distress but then, secondly, managing and tolerating that stress and distress by putting it in a box, by learning to ignore emotions because they just get in the way of doing the job.
>
> In terms of the cultural context and frame for that, it's really important to recognise that the better you can squash distressing emotions, the better you can do your job. If you're anxious or scared or afraid, you ignore that and you just jump off – jump out of that aeroplane …[12]

20. According to Defence, the process of developing military character is reinforced 'through deliberate, intentional and habitual practice over time'.[13] Research has found that the values and behaviours prioritised by military culture may be hardwired into members during service through changes in the brain, including changes in mood regulation, sense of agency, and appraisal of threat.[14]

21. Additionally, serving members commit to a service contract with the ADF under which they voluntarily surrender some of their independence and many of the liberties they would otherwise enjoy as Australian citizens. As a current serving Navy member described in his submission:

> soldiers enter into the ADF lifestyle, knowing that the ADF controls attire, posting localities and restricts timings for hobbies and visiting family/friends … In the end, a soldier's body, uniform, gestures, emotions and social behaviours must reflect the values of the Defence as an institution, even when off-duty/in civilian environments.[15]

22. As part of this contract, serving members are subject to a regulated and controlled environment, and a hierarchical structure of command under which they are required to follow orders and submit to military law and discipline.[16] The then Vice Chief of the Defence Force (now Chief of the Defence Force), Admiral David Johnston AC, explained that:

> the justice system is part of the command function. It is a relationship between a commander and the people they are leading and commanding. It reinforces command by the application of justice to it.[17]

23. As described by Dr Nikki Jamieson, a suicidologist and lived experience witness whose son died by suicide while serving in the ADF, one of the core military moral values and beliefs is 'utmost trust and loyalty for Chain of Command'.[18]

24. We heard from numerous serving and ex-serving ADF members about the unique team ethos that operates in the ADF. As an ex-serving Army member described in his submission, 'a team mentality becomes your focus … your personal wellbeing plays second fiddle to the needs of "the Green Machine" and those around you'.[19]

25. The bonds of trust formed between serving personnel are essential to functioning as a coordinated military unit and building capability at a collective level. The sense of personal responsibility and accountability towards others is profoundly important, given the inherent dangers of military service. This was also echoed in the submission of an ex-serving Navy member who said, '[M]y fellow service personnel became my extended family, who I literally trusted with my life'.[20]

26. The distinguishing feature of military service that definitively sets it apart is the requirement and authority of its members to use lethal force, not just in the protection of self or others, but also in identifying human targets and killing an enemy. We heard from serving and ex-serving ADF members about their transformation from civilians into sailors, soldiers and aviators with the capacity to prosecute violence. As an ex-serving Air Force member expressed in his submission:

> My introduction to service life at age 17, came with a very clear message from the CO [commanding officer] at recruit training to be under no illusion – you are being recruited into the military to kill people and, if necessary, be killed in the service of your country.[21]

27. ADF members are often placed in high-risk environments, expected to live and work in physically and mentally demanding situations, and exposed to prolonged and often extreme levels of stress. This extends beyond war and combat-related deployments to include domestic and international terrorism responses, natural disaster responses, and humanitarian and international peacekeeping operations.

28. Even during peacetime, serving members are exposed to risks and hazards through physically intense training, live fire exercises and the use of explosives, and training that simulates war-like conditions. This is intended to ensure that members retain the level of skill, reaction, response and operational readiness required to support the Defence mission.

29. As previously stated by Defence: 'Almost every aspect of uniformed life comes with a risk or cost to the member and/or to their families'.[22] Serving members voluntarily accept the risks posed by military service, and for some members, these risks result in lifelong physical and mental injury.

30. In undertaking their service to this country, Australia's defence personnel embody the most positive of human traits. They demonstrate loyalty and dependability, professionalism and self-discipline, and the strong internal character and resolve to continuously adapt, improvise and overcome adversity. The selflessness of their sacrifice is unparalleled. It is not something we take for granted.

Positive perspectives of military service

31. Over the course of our inquiry, serving and ex-serving members reflected on the extensive range of skills, abilities and attributes they developed during their military service.

32. We heard from many who were passionate about their work and spoke of finding an affinity with the Defence mission. This included an ex-serving Air Force member who 'relished the regimentation and rigour',[23] and an ex-serving Army member who said, 'I had intended to leave Defence when my 3 years was up, but I fell in love with soldiering and decided to stay'.[24]

33. Serving and ex-serving members commonly described the ADF as a dynamic workplace. As an ex-serving Navy member wrote in his submission:

> [T]here were excitingly good times of pushing the limits of my efficacy, adventure and the privilege to serve my country alongside some of Australia's finest men and women. The challenge of searching unknown waters so as to make them known and the excitement of navigating through uncharted waters are wonderful and rewarding memories. These opportunities of service formed my character to be disciplined and face hardships that life throws at us.[25]

34. Many serving and ex-serving ADF members reflected on the positive changes they saw in themselves and the expanding awareness of their own potential by virtue of being a part of Defence. As one ex-serving Navy member shared:

> I don't regret my time in the navy, I joined as an introverted child who rarely spoke unless he knew people and didn't know how to stand up for himself. I left with much more of a sense of self worth and confidence.[26]

35. Similarly, a current serving Navy member stated:

> I have told everyone that I have spoken to about the Navy that joining at 23 years old was the best decision I could have made at the time. I was a very shy person that still lived at home. University had made me very intelligent, but I wasn't very smart … The Navy gave me the confidence to be a leader, to control my own life and take care of my own problems. I have both a broad understanding of trade work and many specific qualifications that give me more personal satisfaction than anything I learned at university … The Navy has truly given me so much. I wouldn't be the man I am today without it.[27]

36. Serving and ex-serving ADF members often spoke positively about their colleagues, including the 'privilege to serve with other like-minded people who upheld values like courage, honour and responsibility'.[28] As an ex-serving Army member described:

> In my military career I had the opportunity to deploy three times. Like all deployments they are stressful, sometimes long and come with many challenges. But everyone that got deployed went willing to die for their country, their mates, and sometimes not fully understanding why. This I think is an amazing quality that veterans possess that is not fully recognised, understood and acknowledged.[29]

37. Some serving and ex-serving ADF members singled out examples of mentors who were inspiring and supportive of their growth and development. One ex-serving Army member spoke of having 'had an amazing mentor that [they] looked up to, and still do to this day',[30] and another ex-serving Army member spoke positively of having leaders who 'knew we could push ourselves physically and mentally beyond what we thought were our limits'.[31] These sentiments were echoed in the submission of another ex-serving Army member who stated:

> I had good mentors around me who shaped me in my priorities. They prioritised people and treated me like a person not a number. We held ourselves to high standards.[32]

38. We also heard about the strong friendships that formed during service, and members who 'thrived within the culture of mateship and teamwork'.[33] As two ex-serving Army members and the wife of a former soldier wrote in their joint submission:

> soldiers [share] a unique experience of [the] theatre of war and have very deep connective bonds that provide enormous support, comfort, confidence and love, and is best described as a brotherhood.[34]

39. Similarly, an ex-serving Navy member said:

> One of the key elements to me having enjoyed my time so much was the friendships made, the camaraderie formed and the care shown by shipmates for each other, whether at sea or on a base. I was well paid, well supported, had great moments and great friends who, in a time of emotional need, would reach out with a helping hand and drag me back to my feet. Relationship breakdowns, the loss of my parents, those sort of life events that can really wear a person down, were eased by the fact that I had a group of people around me that cared and supported me.[35]

40. Many serving and ex-serving members expressed gratitude for both the opportunity to serve in the ADF and the opportunities that their service has provided.[36] They often reflected on how proud they felt about their service. One ex-serving member of both the Army and Air Force said, 'I absolutely loved my time in the military and it has defined me forever'.[37] Similarly, a current serving Air Force member wrote of having 'found [his] calling with military service; finding it an honour and a privilege to wear the uniform and have an opportunity … [to fly] representing the nation'.[38]

41. Serving and ex-serving ADF members commonly spoke of the value of feeling 'a part of something bigger' than themselves,[39] and a 'part of a community that has meaning'.[40] As was summarised by an ex-serving Air Force member in his submission, 'military life is unique, different, and hard, yet very rewarding'.[41]

Understanding suicide among serving and ex-serving ADF members

42. Many of the positive aspects of military service outlined above operate as protective factors against suicide and suicidality, including a feeling of belonging, support from peers and mentors, and a sense of purpose and meaning. These sit alongside other positive factors, including regular employment and accommodation.

43. However, the experience of military service varies. Many serving and ex-serving members told us that their negative experiences equalled or outweighed the positives. For others, the negative experiences were so significant that they coloured every aspect of service life.

44. Risk and protective factors interact in complex and unpredictable ways in people's lives. Similarly, exposure to known risk factors for suicide and suicidality does not affect everyone in the same way.

45. In evidence before this Royal Commission, Defence put forward that the protective factors 'tend to dominate, to overshadow the risk factors at play while in service'.[42] However, we wish to question this assertion and its implications.

46. As outlined in the following sections, this Royal Commission has revealed that serving in the ADF may be associated with an increased risk of death by suicide for some cohorts. The data demonstrates that both serving and ex-serving populations face higher risks of suicide than comparative cohorts in the general Australian population. Further, the persistently high rates of suicide and suicidality among serving and ex-serving ADF members over time speaks to the entrenched nature of the problem and the need for systemic change in the approach taken to address it.

47. Additionally, some of the characteristics that are protective during service, and build military character and capability at a collective level, can become risk factors when the context changes; that is, after separation from the ADF. For example:

    - A strong military identity can exacerbate the military–civilian divide and increase the challenges of adjusting to civilian life.
    - Stoicism and extreme self-reliance can inhibit people from seeking help for injury and illness, and exacerbate the stigma around perceived weakness.
    - The capacity to suppress and compartmentalise emotions can make emotional regulation more difficult when those emotions eventually surface.
    - A strong sense of belonging associated with the military unit can make leaving the ADF difficult, particularly when a member has not chosen to do so voluntarily.

Prevalence of suicide and suicidality

48. The number of deaths by suicide among those who serve or have served in the ADF is unacceptably high. Between 1 January 1985 and 31 December 2021, there were 2,007 confirmed suicide deaths of individuals who had served at least one day in the ADF since 1 January 1985.[43] An average of 78 serving or ex-serving ADF members have died by suicide each year for the past 10 years.[44] This equates to an average of three deaths every fortnight.

49. As large as these numbers are, they underestimate the scale of the problem. These figures do not include deaths by suicide of veterans who separated from the ADF before 1985, thereby excluding many Vietnam veterans. In addition, these figures underreport suicide deaths before 1997, as death records from this time were not as comprehensive. These figures also only include deaths officially recorded as suicide, and therefore exclude deaths where the intent of the deceased could not be determined.

50. The rate of suicide among serving and ex-serving ADF members has persisted over time. The suicide rate for males serving in the permanent forces was 13.9 per 100,000 population per year in 1997–99, and 14.4 per 100,000 population per year in 2019–21. The suicide rate for ex-serving males was 26 per 100,000 population per year in 2005–07, and 28.4 per 100,000 population per year in 2019–21.[45]

51. In previous data analyses, rates of suicide among members serving in the permanent forces were compared with rates of suicide among the general Australian population. However, the general population includes many people who are unemployed or underemployed, whereas serving members in the permanent forces are employed. To be consistent with the approach commonly taken by researchers into specific occupations, we have therefore compared outcomes for serving ADF members against those of *employed* Australians.

52. According to our research, males serving in the permanent forces are 30% more likely to die by suicide than Australian employed males. Additionally, males serving in the permanent forces in combat and security roles are twice as likely to die by suicide than Australian employed males.[46]

53. Research conducted for the Royal Commission by the Queensland Centre for Mental Health Research using data for Queensland veterans revealed that current and ex-serving ADF members were 1.24 times more likely to have suicide-related contact with police or paramedics than the general adult population.[47] Further, current serving permanent ADF members were 5.84 times more likely to have suicide-related contact with police or paramedics than current serving reserve and ex-serving ADF members.[48]

54. Alongside the increased risk of suicide faced by serving members, our analysis revealed equally troubling findings concerning the rates of suicide and suicidality among ex-serving ADF members.

55. Ex-serving males who served in the permanent forces are 42% more likely to die by suicide than Australian males, and males who served in the permanent forces in combat and security roles in the Army are over twice as likely to die by suicide than Australian males.[49]

56. A recent data analysis revealed that ex-serving male patients (aged 17+) who served in the permanent forces were 90% more likely to be admitted to a public hospital for a self harm–related injury than Australian male patients (aged 17+).[50] Similarly, ex-serving male patients (aged 17+) who served in the permanent forces and presented to an emergency department were 1.3 to 1.6 times more likely to present for self-harm or suicidal behaviour compared to Australian males of the same age group who presented to an emergency department.[51]

57. These risks are even higher for ex-serving females who served in the permanent forces, who are 110% (or 2.1 times) more likely to die by suicide than Australian females in comparable populations.[52]

58. Recent data analysis revealed that ex-serving female patients (aged 17+) who served in the permanent forces were 2.6 times more likely to be admitted to a public hospital for a self harm–related injury than Australian female patients (aged 17+).[53] Similarly, ex-serving female patients (aged 17+) who served in the permanent forces and presented to an emergency department were 1.2 to 1.9 times more likely to present for self-harm or suicidal behaviour than Australian females of the same age group who presented to an emergency department (where results were available).[54]

59. The data also revealed that ex-serving ADF members who served in the permanent forces had higher rates of long-term mental health conditions, and 'deaths of despair', which refers to deaths caused by suicide, drug or alcohol poisoning, chronic liver disease, or cirrhosis. Males and females who served in the permanent forces are 21% and 81%, respectively, more likely to die by deaths of despair than Australian males and females.[55]

60. The Transition and Wellbeing Research Programme, which has been described as the most comprehensive Australian study of the impact of military service on the health of serving and ex-serving ADF members, estimated (based on data from 2015) that over 20% of former members of the permanent forces who had separated or transitioned into the reserves had experienced some form of suicidality in the previous 12 months. Specifically, that:

    - 28.9% reported feeling that life was not worth living
    - 21.2% felt so low they thought about dying by suicide (compared to 3.3% for the general population)
    - 7.9% made a suicide plan (compared to 1.2% for the general population)
    - 2% reported having attempted suicide (compared to 0.3% for the general population).[56]

Theories of suicide and suicidality

61. The research and academic literature on suicide and suicidality has moved away from 'single factor' theories that suggest a single causal factor can lead to suicide. More recent theories identify the complexity, fluidity, and uncertain nature of suicide risk.

62. Some of these theories emphasise an individual's vulnerability to suicidality, usually expressed as having a 'high baseline risk', for whom exposure to stressful life events can trigger an escalation to suicidality and suicide. Other theories examine the links between suicidal ideation and suicide.

63. For example, it is theorised that intense or prolonged experiences of physical, psychological or emotional pain combined with a sense of hopelessness can generate suicidal desire. While this may lead to suicidal ideation, a person's capacity to attempt suicide may be influenced by dispositional factors (for instance, biological or genetic factors) or practical factors (for instance, knowledge and/or access to suicide means),[57] or may be acquired through experiences that reduce an individual's fear of death.[58] Dr Kairi Kõlves, Principal Research Fellow and Associate Professor at the Australian Institute for Suicide Research and Prevention, characterised this as 'developing fearlessness, seeing death' and normalising 'the feeling of being capable to die'.[59]

64. While no theory has been found to accurately predict an individual's risk of suicide, we have uncovered powerful insights through data and research findings, and in hearing the stories of thousands of people. We have found that:

    - Suicide is not a reflection of the character of an individual or indicative of an inherent deficit in their psyche or moral framework.
    - Risk factors for suicide and suicidality are diverse. They can be physical (for example, the onset of pain or injury), psychological (including mental ill health, substance abuse or poor emotional regulation) and psychosocial (including problems within relationships, troubled family history and a lack of connection with community).
    - Risk factors can exist at both the group level and the personal level. For instance, organisational culture, operational stressors and the structural dynamics of how agencies deal with people can strongly affect mental health and wellbeing and act as risk factors for suicide and suicidality.
    - Risk factors cannot be considered in isolation and are highly contextual. It is the interaction between – and often compounding of – many intersecting factors that contribute to a person dying by suicide.
    - Risk factors for suicide and suicidality affect people differently.
    - The level of risk of suicide and suicidality is dynamic. Risk factors may take on greater or lesser significance at different times, and can be counterbalanced or influenced by protective factors that alleviate risk.

Preventing suicide and suicidality

65. Suicide and suicidality in a military context are extremely complex and multifaceted phenomena. Though suicide may not be predictable for every individual, it must be viewed as preventable. An understanding of risk factors can help guide prevention and intervention efforts.

66. In the following sections, we identify the systemic drivers operating at an institutional level across Defence and DVA that give rise to risk factors for suicide and suicidality. We also outline the unique occupational stressors and experiences of military service that can contribute to suicide risk, and the key transition points across service and post-service life that contribute to the risk of suicide and suicidality among serving and ex-serving ADF members. We acknowledge that the unique nature of military service gives rise to some risk factors that are unavoidable.

67. Following this discussion, we introduce our recommendations for changes across the 'ecosystem' of agencies and institutions responsible for the health and wellbeing of serving and ex-serving ADF members and their families.

Institutional drivers of suicide and suicidality in Defence and DVA

68. Our inquiry has found that numerous institutional drivers within Defence and DVA contribute to the persistently high rates of suicide and suicidality among serving and ex-serving ADF members. These have created the conditions for risk factors to emerge and have affected the institutional capacity to address and reduce the prevalence of suicide and suicidality.

Culture in the ADF

69. Culture has been defined by Defence as the 'aggregation of individual values, behaviours and actions that create the daily experience for each person and Defence's overall performance'.[60] As the 2021 Defence Safety Behaviour Review noted, the 'root cause' of behaviours that are prevalent in a culture are elements that sit 'below the surface; the unconscious beliefs, values, assumptions, stories and the unwritten ground rules'.[61]

70. There is emerging evidence that military values may be associated both directly and indirectly with suicide risk.[62] The same cultural norms and positive attributes that are fundamental to building and sustaining military capability – including loyalty, sacrifice and self-reliance – can manifest in suboptimal outcomes 'if applied narrowly or excessively'.[63] According to a 2011 review, the 'shared identity, clear norms and role requirements' in the military can lead to social stratification with 'winners' or 'insiders' who conform to the cultural ideal, and 'outsiders' who are 'judged to fail in or pose a risk for the culture or are not accepted as part of the winning group'.[64]

71. Perceived failures to align with the dominant culture and the embodiment of 'the ideal soldier' can significantly affect members' health and wellbeing.[65] As Associate Professor James Connor, a sociologist at the University of New South Wales, Canberra, explained, there is an enormous sense of loss and betrayal '[w]hen you let other people down, when you become the ostracised one, the difficult one, the targeted one'.[66] He further stated:

> Our survivors are so strong on this point about the loss of connection and identity and feeling separate and different, and like they have nowhere to go and nothing to be and no one to support them, all because of this exclusionary component, this flipside to loyalty and cohesion.[67]

72. One of the most significant cultural drivers contributing to an environment of risk in the ADF is what is often referred to as the 'code of silence'. As the then Sex Discrimination Commissioner, Ms Kate Jenkins AO, explained, it is seen as 'almost disloyal and [as if one is] stepping outside the team to be complaining'.[68] She described the 'expectation that people working in Defence should be resilient, they should tolerate unacceptable behaviour in some ways', and that this becomes 'part of a test of their quality' and ability to work in Defence.[69]

73. Similarly, cultural norms related to self-sacrifice and self-reliance have the potential to stop people from seeking help when they need it and can result in members failing to disclose injury or illness, and avoiding medical treatment until an issue becomes intolerable. Research has identified the 'pervasive culture of poor help-seeking and concealment of mental and physical health issues' as a significant service-related risk factor.[70]

74. These behaviours are often learned through training and the process of adopting a military identity. Features of a military context that can influence a member's decision to maintain the code of silence in certain circumstances include:

- organisational factors, such as the fact that disclosing an injury can have significant career implications
- other military cultural factors, such as the pervasive stigma around perceived weakness and vulnerability
- psychological factors, such as the need to compartmentalise negative emotions in high-risk situations, and to maintain group belonging by continuing to 'pull one's weight'
- factors related to people's previous experiences and their perceptions of the experiences of others, including that there may be little value in requesting support because they have done so in the past and support was not provided.

75. Additionally, a culture of 'tribalism', which is an 'extreme expression of group cohesion' and often associated with a hyper-masculine culture, can contribute to the marginalisation of minority groups in the ADF, including women.[71] A 2023 report found that: 'Over the last decade women have reported lower levels of well-being, morale, workplace support and inclusion'.[72] This was attributed to interrelated cultural and systemic issues, including:

> [t]he lack of a critical mass of women in the ADF, career structures that limit participation, occupational segregation, lack of flexibility and support for ADF families, and a culture still marked by gendered sexual misconduct …[73]

76. Multiple reviews have sounded the alarm on these elements and other aspects of ADF culture that contribute to risks of suicide and suicidality. However, while there has been a significant amount of activity directed towards culture change in the ADF, the focus has remained on implementing activities without adequately monitoring and determining the outcomes of those activities, and ADF culture has not sufficiently improved over the last decade.

77. Defence's primary initiatives to reform its culture have suffered from systemic problems including a failure to clearly articulate known cultural issues that require attention, and a lack of clear and measurable targets that define success and how it is to be measured over time.

78. For example, Defence's Pathway to Change 2012–2017 strategy explicitly acknowledged that there are aspects of Defence culture that 'serve us poorly, which limit our performance, hurt our people and damage our reputation'.[74] The original Pathway to Change strategy outlined 175 actions to improve Defence culture and was followed by the Pathway to Change 2017–2022 strategy, which had six enterprise-wide cultural reform priorities, including 'health, wellness and safety'.[75]

79. An independent review of Pathway to Change undertaken in 2023 found that 'there was no clear delineation between "what" change was being sought and "how" this was to be achieved', resulting in 'no clear basis for measuring outcomes and monitoring progress'.[76] Similar issues affect the Defence Culture Blueprint Program 2023, which Defence has now undertaken to address.

80. In 2022, Major General Andrew Hocking CSC (Retd) highlighted that vulnerabilities in the ADF's culture:

> are not often discussed internally and generally do not feature in ADF doctrine, training or education. This may be due to a concern (conscious or otherwise) that acknowledging inherent vulnerabilities might undermine military capability or weaken esprit de corps. It may also be based on a misguided and insecure notion that to do so would be 'woke'.[77]

81. As Associate Professor Connor stated, 'research has demonstrated time and time again … that the ADF is very bad at changing'.[78] It is clear that significant reform is necessary to create an ADF culture that delivers on its aspiration to support a high-capability military force that values its members' safety, health and wellbeing.

Leadership in the ADF

82. Leaders play a critical role in shaping an organisation's culture through their actions, how they model appropriate standards of behaviour, and their change management skills. Leadership practices and behaviours take on considerably greater importance in the ADF, given its inherently hierarchical structure.

83. Personnel in positions of command in the military exercise a high degree of power over those they lead. This authority is reinforced through offences related to disobeying a lawful command of a superior officer and insubordinate conduct against a superior officer, both of which are punishable by imprisonment.[79]

84. The then Chief of the Defence Force, General Angus Campbell AO DSC, explained |that 'command is a function' that 'can be held at a range of levels, starting at a junior non-commissioned officer level and rising up through the officer levels'.[80] This emphasises the critical role of ADF leaders of all levels in influencing the values and behaviours that should be displayed as a unit, team and organisation.

85. As the Hon Len Roberts-Smith RFD KC, former Chair of the Defence Abuse Response Taskforce, said, 'I will talk about soldiers just for the moment but I include the other services … the commanding officer, the Lieutenant Colonel, is God'.[81] He explained that from the soldier's perspective, all the power of the commanding officer is exercised by the hierarchy of commissioned and non-commissioned officers.[82] He stated:

> These are the people with whom soldiers, sailors and airmen and women engage with on a daily basis and that is who they are going to be learning their culture from. They are the people who are going to be defining the culture by how they treat their subordinates and how they treat each other and how they respond to or refer to senior officers.[83]

86. Poor behaviour from leaders, including the abuse of power, can have a considerably negative effect across the organisation. It can sanction the development or perpetuation of toxic subcultures in the ADF and affect opportunities for genuine cultural reform.

87. Further, as was identified by the then Sex Discrimination Commissioner, Ms Kate Jenkins AO, a command-and-control leadership structure can undermine a culture of healthy disclosure and the willingness to speak up when factors that affect member health and wellbeing arise. She stated:

> [P]eople who work in [a command-and-control] system are required to follow the directions of people in more senior roles, without question in some situations …
>
> In terms of culture then, it can have a counterproductive influence in that people feel that they may not be able to raise issues further up the line through the chain of command, and also that they have to tolerate a certain level of behaviour from others who may be more senior …[84]

88. Numerous ADF doctrines and directives explicitly state that leaders are responsible for shaping culture and workplace experiences, promoting compliance with work health and safety policies, empowering people to optimise their wellbeing, and taking appropriate action to mitigate and manage risk.[85] However, there are few formal processes by which leaders can be held accountable for meeting these obligations.

89. It is therefore unsurprising that recent Defence evaluations have identified a range of issues with leadership performance, including that the 'role modelling of leadership behaviours from some leaders has been inconsistent with Defence values'.[86] For example, in 2022, Defence's Safety Behaviour Review reported that while Defence roles 'reference accountability for safety decision making', leaders at all levels 'often failed to display consistent actions, communications, and training regarding safety'.[87]

90. Effective systems for evaluating leaders' performance can help address and correct poor leadership practices, and recognise and reward good practices. However, the ADF has resisted fully implementing previous recommendations aimed at improving leadership accountability through the performance appraisal system. As a result, there are no measurable or data-driven indicators that are used to assess senior officer performance against accountabilities for culture, health and wellbeing, and objectives are not expressed as clear and measurable targets.

91. As the Commander Special Air Service Regiment outlined in his statement to the Royal Commission, it is 'very rare for a commander to be held accountable for negatively impacting [the] organisation's effectiveness or culture'.[88] He explained further:

> [T]his is because the existing processes lack transparency and are focused on either responsive mechanisms (incident management) or general pillars of governance practices (auditing). While these are important, there is little in terms of transparent reporting or assessment of a commander's impact on unit culture aligned to the unit's mandate or the impact on the unit's wellbeing.[89]

92. As recent Defence evaluations confirm, change is needed to move away from a leadership culture in which 'compliance is an unspoken core value',[90] towards an approach that promotes continuous improvement and is underpinned by accountability, curiosity and appropriate risk management. The environment must also encourage reporting, provide space for contesting decision-making appropriately, and welcome feedback.[91]

Governance in Defence

93. Governance refers to the structures, frameworks and processes that direct and control how an organisation operates. Functions of governance systems include setting strategic direction, managing and treating issues and risks, defining responsibilities, allocating resources in line with priorities, and monitoring performance against objectives. The way these functions are performed in Defence directly affects how member health and wellbeing are managed, including with respect to suicide prevention.[92]

94. In a statement to the Royal Commission, the Secretary of the Department of Defence, Mr Greg Moriarty AO, explained:

> As Secretary, the actions I take to monitor and understand suicidality, the risk factors in relation to suicide by ADF members, and the health, mental health and wellbeing of ADF members and the APS Defence workforce occur through enterprise accountabilities, governance responsibilities and the Defence enterprise committee structures.[93]

95. However, numerous deficiencies in Defence governance mechanisms reduce the organisation's ability to identify, escalate and address areas of risk to health and wellbeing.

96. In Defence, three tiers of enterprise committees operate as forums for decision-making and provide a way of informing senior leaders about risk across the organisation.[94] The 2022 Proximity Review, initiated to assess the effectiveness of enterprise committees, found that they lack a strategic function, rely on a bottom-up approach, and are not efficient or effective decision-making forums.[95] It also found that follow-through on accountability for decisions or outcomes is lacking.[96]

97. The same review highlighted that discussions in enterprise committees failed to raise risks and provide guidance back to business lines about appropriate risk considerations.[97] Other previous reviews have noted that decision-making in Defence is unnecessarily directed to enterprise committees,[98] and have found that enterprise committees are 'sites where accountability becomes diffused'.[99]

98. Previous reviews have also:

- highlighted entrenched limitations in Defence's accountability mechanisms[100]
- critiqued Defence's 'complex accountability system'[101]
- called for improved individual accountability for performance and project management[102]
- highlighted 'recurring issues with a lack of accountability, ill-defined authority, unclear allocation of responsibility and great difficulty measuring and monitoring real performance'.[103]

99. We have found that Defence's failure to recognise and articulate suicide prevention as an enterprise-wide priority in core governance frameworks contributes to a lack of attention on minimising harm.

100. When organisations are well governed, enterprise-wide priorities are reflected in corporate, operational and risk plans, as well as individual performance agreements. This alignment aids performance monitoring and reporting, as it creates explicit links between planned outcomes and actual performance.

101. Defence has repeatedly stated that its people are its greatest asset.[104] The health and wellbeing of ADF members should therefore be recognised as paramount to the achievement of Defence's goals. However, risk factors for suicide and suicidality are not adequately named as enterprise strategic risks, and are missing from the various strategic planning documents that should identify suicide prevention as a priority.

102. For example, the One Defence operating model and associated governance frameworks were developed to provide 'clear direction [and] contestability of decision-making, along with enhanced organisational control of resources and monitoring of organisational performance'.[105]

103. In How One Defence Works 2023, Defence highlighted that 'Our People are intrinsic to the One Defence Operating Model', and stated that Defence's ability to defend Australia and its national interests is 'contingent on the expertise, resilience and adaptability of our people'.[106] Personnel are conceived of as 'Fundamental Inputs to Capability' and as assets in the achievement of enterprise goals.[107] There is limited recognition of the negative effects of military service on personnel, and Defence's corresponding responsibility to support the health and wellbeing of its workforce.

104. The absence of a specific focus on suicide or suicidality in either the Portfolio Budget Statement or Corporate Plan reduces the likelihood that these issues will be identified as enterprise risks, and means they are not subject to the same degree of governance oversight or accountability as enterprise risks that are formally identified.

105. Further, though numerous strategies have been developed in the areas of health, wellbeing and safety,[108] it is unclear how the associated documents relate to each other or fit within the broader Defence strategic plan. Most of these strategies do not contain measures of success from which to assess the achievement of objectives and intended outcomes regarding preventing suicide and suicidality.

106. Until these limitations are addressed, Defence's governance structures will continue to provide an enabling environment for risk factors associated with suicide and suicidality among serving and ex-serving ADF members.

Use of data and research by Defence and DVA

107. The value of data is realised through its capacity to produce insights, contribute to good decision-making and support actions that are grounded in evidence.[109] Data is relevant at both an individual and organisational level. It can be instrumental in understanding a given member's history of suicidality and experience of risk factors, while also enabling population-level visibility of suicidality, self-harm and deaths by suicide.

108. Data monitoring and the surveillance of incidents of suicide and suicidality can provide crucial information for effective interventions, including the development of policies and programs, and the implementation and evaluation of measures to reduce deaths by suicide.[110] Trends in data analysis can help to monitor progress on organisational reforms. As the Associate Secretary of the Department of Defence, Mr Matt Yannopoulos PSM, acknowledged, data is 'critical' to monitoring and evaluating progress.[111]

109. Though Defence and DVA collect a range of data, it has not been used effectively to identify, understand and monitor the impact of risk and protective factors for suicide and suicidality among serving and ex-serving ADF members. Nor has it been used to adequately monitor the effects of exposure to critical stressors in order to mitigate the risk factors for suicide and suicidality. The data that is available is also insufficient for monitoring and evaluating suicide prevention programs and initiatives in Defence.[112]

110. As recently as February 2023, Defence identified 'pain points' related to data sharing, data capability, data platforms, data quality, data accountability, and data inconsistency.[113]

111. The Chief of Army, Lieutenant General Simon Stuart AO DSC, told us that 'Defence's health and people data is siloed across separate systems, applications, databases and owners'.[114] Further, many of Defence's datasets are not connected;[115] different data systems house data on similar topics, meaning that records are duplicated;[116] and data sources on suicide, self-harm, suicidality and risk and protective factors are owned and managed by different areas across Defence.[117]

112. A recent internal assessment of data management in Defence found that there is a 'reluctanc[e] to share data' internally and that '[p]ersonnel have to fight for access to data'.[118] It concluded that there is a 'very problematic culture surrounding the collection, sharing and storage of data in Defence'.[119]

113. Defence's fragmented approach to data management and sharing limits its capacity to know what data it holds, where data is located, how data can be accessed, and whether it is of sufficient quality to provide a reliable evidence base to make decisions.[120]

114. Similar deficiencies impact DVA's ability to use and share data to monitor risks of suicide among serving and ex-serving ADF members, and to better understand and respond to the contextual factors associated with suicide and suicidality.

115. DVA's capacity to make use of its data, particularly historical data, is limited. Prior to 2001, record keeping in DVA was predominantly paper-based and supporting documentation for claims continued to be stored as paper files until 2016.[121] Where electronic records do exist, records relating to DVA client suicide deaths may be located in various data assets, reducing DVA's ability to search for and find documents related to a particular client.[122]

116. DVA has not historically recorded the suicide deaths of DVA clients in a systematic way. DVA is unable to identify how many suicide deaths of veterans it was notified of prior to 2018.[123] Questions about the consistency and reliability of DVA's client data have also been raised.[124]

117. We have also found that a more transparent, collaborative and sustainably resourced research program is required to improve Defence and DVA's understanding of the risk and protective factors associated with military service and post-service life.

118. We heard from Dr Jennifer Wild, Professor of Military Mental Health at the University of Melbourne, who said that Defence has historically had an ad hoc approach to conducting health research.[125] There is clearly scope for Defence and DVA to do more to expand their understanding of suicide and suicidality through sustained research projects. Research and evaluation should also be coordinated across Defence and DVA.

119. In the absence of robust research and data analysis, Defence and DVA will remain hindered in their ability to identify and implement evidence-based strategies to address the risks of suicide and suicidality among serving and ex-serving ADF members.

External oversight of Defence and DVA

120. External oversight enables transparency and greater accountability. When subject to independent scrutiny, public bodies tend to operate more effectively and prioritise continuous improvement. As General Campbell said, 'big organisations gain benefit from a careful consideration about how external oversight pushes them, drives them, demands of them'.[126]

121. Oversight responsibilities are currently fragmented across numerous external bodies, such as the Office of the Commonwealth Ombudsman and the Defence Force Ombudsman, and the Australian Human Rights Commission, among others. This means that some agencies, programs, or issues that contribute to suicide and suicidality are examined in isolation, while others risk not being subject to interrogation or oversight at all.

122. The existing oversight infrastructure does not support a systems-level monitoring of suicide and suicidality, nor does it enable system-wide visibility over what is and is not working across suicide prevention initiatives.

123. Existing oversight bodies may check to see whether an agency has implemented the recommendation of a particular inquiry or review. However, they rarely focus on whether the actions taken in response to a recommendation have produced the outcomes intended or have been effective in generating positive change.

124. These limitations have contributed to suicide prevention efforts not being given the priority they deserve by Defence and DVA, with other operational and organisational priorities given precedence. It has also resulted in a focus on resourcing and prioritising short-term responses, rather than those that require longer-term action and commitment.

125. It has also made it possible to shift blame and responsibility within and between agencies, rather than emphasising collective responsibility for addressing risk factors for suicide and suicidality among serving and ex-serving ADF members.

Service-related risk factors for suicide and suicidality

126. Serving and ex-serving ADF members are a part of the broader Australian community and experience the same risk factors for suicide and suicidality as the civilian population, including abuse, injury, financial hardship and family breakdown.

127. However, some risk factors are unique to military service, and others may be exacerbated by the stressors, interpersonal dynamics and particular contexts of military life. As discussed in the previous section, failures associated with culture, leadership, governance, the use of data and research, and external oversight have contributed to an environment of risk, and have affected the institutional response to suicide and suicidality.

128. Additionally, risk factors can take on greater significance at different times in a person's military career, which has a number of distinct phases. These include the transition from civilian life into service; initial training; being posted to a new ship, unit or base; deployment; and the transition from service back to civilian life. Many of these phases carry particular risks and therefore require increased attention and supports.

Risks associated with ADF service life

129. Serving members are exposed to a diverse range of military-related operational and organisational stressors throughout their careers. However, employment in the ADF is not a homogeneous experience. The career paths, duties undertaken, experience of ADF culture, postings and deployments, and relationships with leaders and peers all vary significantly among serving members, as do their lives and connections with family, friends and community outside the ADF.

130. As outlined earlier, data analysis undertaken by this Royal Commission has revealed that serving in the ADF may be associated with an increased likelihood of death by suicide for some cohorts. As the then Chief of Air Force, Air Marshal Robert Chipman AO CSC, conceded during our final public hearings:

> I think the biggest revelation for me has been that the issues of suicide and suicidality that affect our veterans community arise as a result of their service. I think historically … we saw incidents of suicide in Defence as being less than the national average … we saw suicide and suicidality as being an issue for the Department of Veterans' Affairs more than for the Department of Defence, and I think the Royal Commission has shifted our thinking on that.[127]

131. In the following sections, we outline the unique occupational stressors and experiences of military service that give rise to risk factors for current serving members, and can contribute to ongoing suicide risk for members who have separated from the ADF. We also explore how workforce shortages have contributed to decision-making across the organisation that has increased pressure on serving members, reduced their access to protective factors, and exposed them to risk of burnout, injury and ill health.

Separation from family and family disruption

132. Serving members and their families will typically experience numerous career-related separations and relocations. Through the postings cycle, Defence allocates personnel to fill vacant positions, undertake training or professional development, or otherwise satisfy operational requirements in locations around Australia and overseas.[128] Similarly, members can be assigned for duty away from home and posted to locations through deployment on government-authorised military operations, including active combat, humanitarian aid and disaster relief.[129]

133. The requirement to undertake postings and/or deployment is a core function of military service; however, it is also a significant stressor that can affect members' interpersonal relationships, connection to community and psychological wellbeing.

134. Research demonstrates that higher levels of social support and connectedness with family are associated with fewer symptoms of psychological disorder and can be protective against suicidal ideation among military personnel.[130]

135. However, the prioritisation of military capability can create a personal–professional conflict, and what researchers have termed the 'second-class prioritisation' of family.[131]

136. This aspect of military life can be extremely challenging and disruptive to families who are not only required to accept and accommodate a serving member's work-related absence from home, but must also deal with the logistical and interpersonal stresses of having to relocate due to postings.[132] As an ex-serving Army member described in his submission, 'During my career, I had 27 moves, 19 whilst married, and each of my children attended 10 different schools in 3 countries and 3 different Australian states'.[133] Another serving Army member described the 'turmoil and unknowns' associated with postings, stating:

> We never have any idea of what's next, and postings often result in my civilian spouse having to [quit their work] and try [to] find employment creating financial stress, my children are uprooted causing psychological and cognitive impacts as they change curriculums and have become people pleasers trying to establish new relationships every 1–2 years within tight school cliques and relocate and adapt to new locations without my support as I may be deployed or travel soon after arriving … life is dictated based on the perceived needs of Army, no plan beyond two years and without any consideration to individual and family wellbeing.[134]

137. These pressures are amplified when serving members and their families are required to accept postings within very short timeframes. As the same serving member quoted above stated:

> postings are often released at the 11th hour creating further undue stress with the difficulties of preparing … a house for sale, and removal – finding a new home and getting access to childcare and schooling.[135]

138. Defence has acknowledged that 'relocations can have a disruptive effect on family life'.[136] Further, Defence policies identify a need to balance capability requirements against a member's preference for the type, locality and timing of a posting and to accommodate their personal and family circumstances.[137]

139. However, Defence appears to prioritise capability requirements without routinely considering whether they can be met through alternative arrangements that do not impact a serving member's familial or geographical stability.

140. We received numerous submissions suggesting that member preference is given inconsistent and often insufficient weight. Members described having limited agency or opportunity to influence posting decisions, as well as an unwillingness by Defence to accommodate their personal and familial circumstances. This practice was described by a serving Army member as akin to 'a dictatorial parent–child relationship'.[138] As the wife of an ex-serving Air Force member stated in her submission:

> My husband was suicidal at one stage in his life. Our child had been diagnosed with Autism and my mother was dying. I had no family support. My husband received a posting away from us for 3 years. He begged to stay with us for one more year until my mother passed and my son was stabilised. This was denied. There was a telephone conversation in relation to this that my husband had on speaker. The posting officer said to my husband's pleading … 'yeah, yeah. Dying mothers, disabled kids. I've heard it all mate. Suck it up'.[139]

141. In other submissions, members described being faced with disparaging and dismissive attitudes towards their families. For example, we heard that one serving member was told by a superior officer, 'it's Army first, family second … if you were meant to have a family we would have issued you with one'.[140]

142. The experience of long-term separation from family and other significant relationships can be psychologically detrimental for serving members, with social isolation as a commonly recognised risk factor for suicide and suicidality. These impacts are not limited to serving members with families; in some cases, they can be amplified for single members who do not have children. For example, a current serving Army member described the psychological toll of repeated deployments overseas and postings to five different states over an eight-year period, stating:

> Weekends are the worse. You try to leave the house, but realise you don't have anything to do, nobody to see, nowhere to go, so you just wander, hoping something will happen. Maybe you have a few drinks, maybe you go to the casino. It doesn't matter, you don't fit in at either. So you stay home. Waiting for Monday when you can finally go to work. Not that you necessarily enjoy what you're doing, but it's better than being alone.
>
> Every time you move, you think you'll start afresh, but the sad fact is, you're not going to be there long enough, so you don't try. [They] don't care about single members, we have no family, it's easier to move you around the country. Less complaints.[141]

143. There is a clear opportunity for Defence to demonstrate a consistent internal practice of working to alleviate these occupational stressors and minimising their impacts on serving members and their families.

Relationship breakdown

144. A 2023 study commissioned by DVA and undertaken by the Australian Institute of Family Studies (AIFS) found that current and ex-serving ADF members and their partners commonly experience a range of challenges associated with postings. They include: frequent separation and the challenges of relationship adjustment on return, the impacts of relocation on the civilian partner's employment and domestic load, and feelings of isolation, a lack of intimacy and a lack of support due to time apart.[142]

145. These realities of military life can contribute to increased conflict in the family unit, strained relationships and relationship breakdown. Relationship breakdown is a known risk factor for suicide generally, and has been recognised as a key risk factor for serving ADF members.[143] Around 41% of ADF males (serving, reserve, and ex-serving) and 38% of ADF females (serving, reserve, and ex-serving) who died by suicide between 2001 and 2020 were identified as having spousal relationship problems.[144] As a former special forces member expressed in his submission:

> I believe in the future continued combat service will be recognised as the biggest fundamental hardship of my serving generation. To continue time and time again to volunteer to return to combat, leaving your family, knowing you may or may not return, not only plays havoc on the serving members wellbeing and mental load, but it tears at the fabric of many families, my own included. With multiple separations, the eventual dissolution of my marriage came … after a final period of strain from a six-month deployment.[145]

146. Defence has previously agreed that 'providing more preventive strategies to assist members manage relationship stress may be of benefit'.[146] Further, as advised by Relationships Australia in their submission to this Royal Commission, strengthening relationships should be considered integral to any suicide prevention initiatives for veteran communities.[147] We believe that much more can and must be done to support serving and ex-serving ADF members and their families to navigate the unique pressures caused by military life.

Exposure to unacceptable behaviour

147. We have heard detailed historical and contemporary accounts of bullying, harassment, discrimination, misogyny, and physical and sexual violence experienced during training or throughout service life. These accounts reinforce the findings of countless previous inquiries and reviews into the entrenched dynamics that give rise to interpersonal violence, abuse and other forms of unacceptable behaviour in the ADF.

Bullying, harassment and physical abuse

148. In submissions to this inquiry, current and former ADF members described having been belittled, verbally abused, and ostracised by their peers.[148] We heard from members who were targeted for harassment on account of their race, gender identity or sexual orientation. This included being subjected to racial slurs and discriminatory treatment, offensive and derogatory comments, and threats of violence and threatening behaviour.[149]

149. We also received numerous accounts of senior officers abusing power, including by threatening to stall career advancement, deliberately interfering with work, burdening subordinates with extra duties, and subjecting them to unofficial disciplinary sanctions due to perceived slights.[150] This also included many accounts of physical violence in which members described being kicked, dragged along the ground, punched in the head, having their face smashed into a sink, and having a knife held against their throat.[151] One serving Navy member told us that she has 'lost count' of the different forms of bullying and physical abuse she has experienced at the hands of her superior officers, stating that she had been 'physically dragged' and 'man handled' by chief petty officers, 'picked up by the cuff of [her] neck' by a warrant officer, 'shaken against a bulkhead' and threatened that 'both [her] legs will be broken'.[152]

150. As Professor Ben Wadham, Director of the veteran research hub Open Door at Flinders University, explained in research we commissioned, violence and abuse in military contexts 'is not simply interpersonal. It is a systematic enduring institutional disposition'.[153] He described how the military, as an institution, 'is of and for violence' relayed through its 'overarching purpose – tactical dominance'.[154] This means that interpersonal violence and other forms of abuse may serve to reinforce and strengthen military identity, to instil a sense of hierarchy, and to informally 'sanction' members who do not conform to military cultural norms – including members with a perceived weakness, or those who break the 'code of silence' by reporting unacceptable behaviour or speaking up against it.

151. Bullying, harassment and physical abuse can be severely traumatising and are known to have longstanding, highly negative impacts on mental health. The correlation between victimisation during military service and suicidal ideation has been established in international literature, and is supported by broader research linking workplace bullying with known risk factors for suicide including post-traumatic stress, depression and anxiety.[155]

152. Similarly, when leaders perpetrate, ignore or condone abuse against members under their command, or fail to take sufficient or appropriate action in response to unacceptable behaviour, it can have devastating consequences and contribute significantly to suicide and suicidality.[156] This can constitute what is called a 'second assault' or 'secondary abuse', 'compound[ing] the initial trauma and wound[ing] the ADF member's sense of self or identity'.[157] This form of institutional betrayal can result in 'moral injury', which is discussed further below.

153. Many members who experience bullying, harassment, violence and other forms of abuse during service do not report it. Between 2018 and March 2023, fewer than three in 10 (29%) permanent ADF members who participated in the Defence Workplace Behaviour Survey and had experienced unacceptable behaviour said they had made a formal complaint about the most serious incident. Over the same period, an average of 28% said they took no action in response to the most serious incident of unacceptable behaviour they had experienced.[158]

154. The devastating effects of unacceptable behaviour were shared by Angela McKay, whose son, Captain Paul McKay, joined the Army Reserve in December 2004, transferred to the permanent forces in January 2010, and died by suicide in January 2014 at age 31. She stated:

> Our son was medically evacuated from [Afghanistan] in Jan 2012 and told me that during his deployment the bullying was so intense that at one point he had seriously considered shooting himself with his pistol.
>
> I would hope that you can appreciate that the last few years [were] a very traumatic experience for our family. We not only knew that Paul had been subjected to unacceptable behaviour at 1 RAR [1st Battalion, Royal Australian Regiment], he had also been bullied while on deployment. We then saw our son live in a world of silence and sorrowful memories for the last 2 years of his life. He had gone to a place where no-one could reach him – there was no life in his face and no light in his eyes. For our family, it was desperately sad to watch him virtually disintegrate before our eyes. He lost weight and became gaunt to the extent that when my husband [and] I flew to Canberra to see him for his 31st birthday in Nov 2013, we walked passed him in the airport because we did not recognise him. A month later, when he came home to see us briefly for 2 days over Christmas he was like a dead man walking, he was just a shell of the person that we knew as our son.[159]

Military sexual violence

155. We commissioned qualitative research from Professor Wadham and others based on life course interviews with ex-serving ADF members and the families of those who had died by suicide. It found that while both women and men experienced military sexual assault, men were principally assaulted in unit hazing or initiation incidents by other men, while women were primarily assaulted by male peers or commanders.[160]

156. While there are differences between women and men's experiences of sexual violence in the ADF, it is disproportionately experienced and reported by women.[161] Defence data on the gender of victims and alleged perpetrators of sexual misconduct from 1 January 2018 to 1 October 2023 revealed that the majority of victims (over 80%) were female, and the majority of alleged perpetrators (over 90%) were male.[162]

157. The ADF has implemented a range of reforms over the past decade to respond to sexual misconduct, including establishing the Sexual Misconduct Prevention and Response Office (SeMPRO) and Sexual Offence Response Teams, and introducing a dedicated policy for reporting and responding to sexual misconduct that adopts a victim-centric approach.

158. However, we remain concerned that Defence does not have a reliable, integrated dataset for sexual misconduct. As a result, the ADF remains unable to accurately quantify the prevalence of sexual violence in the workplace, and cannot measure the effectiveness of policies aimed at responding to or preventing it.[163] The ADF has also been unable to quantify how many serving members have been convicted of sexual offences in civilian courts.[164]

159. We received countless submissions detailing sexual misconduct experienced during service. This included the following account shared by an ex-serving Army member, who described:

> Numerous instances of sexually explicit comments by Trainees, CPL's [Corporals], SGT's [Sergeants] and Officers on a daily basis, at all locations across Singleton including the dry mess, wet mess, firing range, PT [physical training] classes, swimming pool, dorms, whilst marching.
>
> [There was] graffiti written on bathroom mirrors and on notice boards near the female lines, including 'c***s don't belong here' and 'fuck the c***s up'.
>
> [There was] indecent assault of physical groping taking place by males, in front of groups of males, with the group cheering them on for every time they grabbed a female breast or 'ghost' humped a female from behind by grabbing their hips and thrusting. This included in front of CPLs.
>
> [There was] sexual assault occurring – being unwanted sexual intercourse whilst [the] female was repeatedly saying no.
>
> [There were] groups bragging about the sexual assaults they had performed, loudly and easily able to be overheard by passers-by.
>
> [There was] my hip being damaged from the brutality of the assaults, to the point I could not walk and ended up (post Army) requiring surgery to fix the damage.[165]

160. Serving and ex-serving members described the debilitating effects of these experiences on their wellbeing, often exacerbated by the trauma of living and working on bases alongside their alleged perpetrators. This included an ex-serving Air Force member who described being sexually harassed for more than 18 months by an engineer at her workplace. She said, 'I would often be so distressed that I would vomit on the way to work and not be able to sleep'.[166] Some women described having been 'stuck in hell' with 'no escape'.[167] We heard how this experience can be particularly challenging for women in the Navy, where the geographic isolation results in members being physically trapped at sea for months on end.[168]

161. The research we commissioned from Professor Wadham and others concluded that 'rape and sexual assault placed the service member at risk of self-harm and suicidality',[169] supporting a body of international research that has drawn links between the experience of military sexual trauma and suicide and suicidality.[170] Exposure to military sexual trauma has been related to greater adjustment difficulties, and evidence suggests that the recovery from sexual trauma can be more difficult for military personnel than civilians 'due to repeated exposure [to the perpetrator/s], barriers to accessing formal and informal support, and conflict between feelings of "victimization" with military values and ideals'.[171]

162. As expressed by an ex-serving Air Force member who described her experience of sexual assault during an early posting:

> I was conditioned by the RAAF to put up and shut up …
>
> Looking back, this was the beginning of the complete shattering of my confidence, my self esteem and my self worth. Every fibre of my personality was damaged so severely that the abuse I carry with me to this day infiltrates every aspect of my life even when I thought I had buried it so deep.[172]

163. The experience of sexual misconduct has been described as so pervasive and widespread in the ADF that it led an ex-serving Army member to conclude:

> I can't in good consciousness recommend the Army as a place to work for any female, which truly saddens me as someone who has many grandparents and great grandparents that were veterans and that I want to honour.[173]

Interaction with the military justice system

164. Another known risk factor for suicide and suicidality among serving and ex-serving members is interaction with the ADF military justice system.

165. While the ADF military justice system is complex, it is broadly comprised of two streams, 'disciplinary' and 'administrative', under which different kinds of incidents and behaviour are managed. As distinct from some workplaces, serving members' conduct and behaviour when they are not on duty is subject to scrutiny as well as their actions in the workplace.[174]

166. The disciplinary system is used when member conduct constitutes an offence under the *Defence Force Discipline Act 1982* (Cth) (the DFDA), such as theft, assault and sexual offences. Penalties can include imprisonment.[175] The administrative system is for managing sub-standard performance or conduct that does not comply with Defence values, standards or policies.[176] Breaches of ADF codes of conduct can have serious repercussions, including administrative termination.

167. Unlike the disciplinary system, the application of the administrative system is not restricted to a list of specific offences. Commanding officers have significant discretion in taking administrative measures.[177]

168. In some cases, both disciplinary and administrative action may be taken against a member for the same behaviour or incident.[178]

169. Research in civilian contexts has demonstrated that involvement with justice systems can cause distress and trauma, and can lead to 'deteriorated mental health' for both victims and accused.[179] Studies have found that 'the longer the exposure to the justice system … the greater the deterioration of health'.[180]

170. For victims of misconduct in the ADF, involvement in a military justice process can mean a protracted period of high stress and uncertainty in which the member can feel exposed for having broken the code of silence by speaking up. For alleged perpetrators, the military justice process can result in administrative termination, a form of separation that is associated with poor mental health outcomes and an increased risk of suicide and suicidality.

171. In November 2022, the ADF Military Justice Steering Group (MJSG), the primary governance group for military justice, acknowledged the association between being subject to disciplinary action under the military justice system, and mental ill health and suicidality. According to meeting minutes, it was said to be 'logical that a member's mental health would suffer once they were subjected to disciplinary action', and 'if mental health is not considered, managed and support provided, there is a risk to Defence of suicide and reputational issues'.[181] The minutes also noted the risk to 'Defence as a whole' of failing to take action.[182]

172. However, until recently, there has been little focus on the correlation between interactions with the military justice system and poor mental health, and reforms aimed at improving the mental health outcomes of those involved in military justice processes have been delayed.

173. There is a clear need for Defence to determine the effects of exposure to the military justice system on mental health and wellbeing. However, deficiencies in governance, accountability and assurance mechanisms have reduced Defence's ability to monitor, manage and respond to risks that arise in the administration of military justice. This was noted in a 2022 update briefing to the Chiefs of Service Committee on the military justice system, which stated:

> Although there are defined and appropriate governance and assurance activities occurring, the military justice system currently lacks the broader system governance structure required to integrate these disparate activities and form a coherent system picture. This is needed to effectively manage and assure the system, enable timely responses to scrutiny, and drive confidence in the system.[183]

174. Our inquiry has identified many factors in the military justice system that can cause or aggravate poor mental health outcomes and contribute to risks of suicide and suicidality. These include a lack of fairness and transparency in the administration of military justice, inconsistencies in the use of the administrative system, opportunities for the 'weaponisation' of administrative sanctions against serving members, and inconsistencies in the quality and availability of legal and welfare support. While risk factors in themselves, these issues take on greater significance in the context of suicide and suicidality, as they can influence the likelihood of administrative termination.

Issues with fairness, transparency and consistency

175. Real or perceived issues with fairness in the administration of military justice can contribute to psychological distress. Research we commissioned from Professor Wadham and others found that 'the more that veterans talked about grievances and a lack of fairness, the more that they also evidenced psychological stress and lower well-being'.[184] This finding aligns with previous reviews, one of which found that 'an inconsistent (and in many cases, flawed) application of the military justice procedures' contributed to disillusionment and under-reporting of abuse.[185]

176. We hold concerns about the fairness, transparency and rigour of internal investigative processes, including fact-finding and administrative inquiries that are conducted to determine whether incidents should be managed under the administrative or disciplinary system.

177. Issues with fairness can arise due to the broad discretion afforded to command in deciding whether to initiate an inquiry and/or implement its recommendations.[186] They can also arise due to inherent opportunities for bias and conflicts of interest, since the officers conducting these inquiries are generally under the same chain of command as complainants.[187]

178. The varying capability of inquiry officers can lead to inconsistencies in how investigations are undertaken, which can also potentially undermine the fairness of the military justice system. An audit by the Inspector-General of the Australian Defence Force (the Inspector-General) between 2020 and 2022 identified numerous issues with inquiry reports, including findings that were 'not supported by evidence', the 'insufficient analysis of [the] credibility and reliability of witnesses', the selective interviewing of witnesses, processes that lacked procedural fairness, and 'manifest unfairness in outcomes'.[188]

179. We are also concerned that complainants are not routinely informed of the progress of an investigation or complaint, or whether disciplinary action or administrative sanction has resulted. Though ADF policy requires that affected parties be notified of outcomes,[189] we are concerned that this is not happening consistently in practice.

180. Annual reports from the Inspector-General demonstrate that fewer than half of surveyed members believe the military justice system provides sufficient feedback to complainants and respondents, and this figure has trended downwards since 2019.[190] As Reverend Dr Nikki Coleman, a former Air Force chaplain who experienced unacceptable behaviour including sexual misconduct during her time in service, stated:

> I can't judge how seriously my complaint was taken if I don't know what the outcomes are and, [the issue] more broadly, systematically … [is that] not being transparent about outcomes for substantiated, serious UB [unacceptable behaviour] encourages the hiding of it.[191]

181. The lack of visibility of outcomes under the administrative system was raised as an area of risk in a 2021 inquiry initiated by the Inspector-General into the implementation of military justice processes for dealing with sexual misconduct. It reported that:

> with the increasing trend towards the use of administrative action and away from the Defence Force Discipline Act, the consequent opacity is a cause for concern; the enterprise is unaware of how consistently and rigorously administrative action is applied and the deterrent effect is further undermined by the failure to publicly report even anonymised outcomes.[192]

182. We acknowledge that the application of military justice processes may result in different outcomes, given the varied circumstances of each case.[193] However, Defence itself has identified that one of the 'greatest challenges to the administrative sanction system … [is] the inconsistent application of sanctions across the ADF'.[194]

183. In evidence before the Royal Commission, the then Vice Chief of the Defence Force (now Chief of the Defence Force), Admiral David Johnston AC RAN, explained that where there appears to be inconsistent application of administrative sanctions 'either in perception or reality', this 'creates a lack of confidence amongst the workforce for the application of that system'.[195]

184. Similarly, MJSG minutes from 2023 acknowledge that inconsistent application of sanctions 'can have negative impacts on the mental health of individuals and their motivation for continued service' and 'erode trust and support for the Defence organisation'.[196]

Potential for abuse of the administrative system

185. The administrative system can be applied much more broadly and with greater discretion than the disciplinary system.[197] This level of discretion means that commanders are able to use the administrative system to bully, intimidate, harass and undermine more junior ranked personnel by inconsistently enforcing rules and standards, and selectively targeting members with harsh sanctions. Known as 'administrative violence', this misuse of power and abuse of command discretion is a risk factor for suicide and suicidality for those subjected to it.[198]

186. The abuse of the administrative system to unfairly target individual members and the subsequent effects on their mental health was identified as a strong theme in recent research by Professor Ben Wadham and Associate Professor James Connor. After analysing interviews and written statements from ex-serving members and stakeholders engaged in matters involving abuse in Defence, the researchers reported that:

> Administrative Violence (AV) was identified as a secondary trauma by many of our survivors … AV typically followed the reporting of abusive incidents, where the survivor was then targeted, using administrative rules, to punish them for speaking out.

> Survivors found it very difficult to challenge AV as they were already traumatised, lacked institutional knowledge to argue their case and were often left with no or ineffective representation and/or support. The outcome of AV on the member was a complete break in trust of the ADF.[199]

187. There is a clear need for Defence to identify and monitor the misuse and abuse of the administrative system; track trends in complaint type, investigation outcomes and categories of offences; identify members subject to repeated military justice processes; and similarly, identify commanding officers who apply disproportionately high rates of administrative sanctions.

Risks of inadvertently punishing people with mental health symptoms

188. We are concerned that members exhibiting signals or warning signs of mental health distress may find themselves involved with the military justice system. Behaviours including absenteeism, reduced work performance, disengagement, problematic anger, increased alcohol consumption, and difficulty performing everyday tasks can attract administrative sanctions or constitute a service offence under the DFDA.[200]

189. Serving members who are unable to perform optimally at work due to mental health symptoms may spiral further if they are subsequently disciplined for changes in behaviour, which can in turn lead to further deteriorations in their mental health. This vicious cycle can lead to involuntary discharge, either for medical reasons due to mental ill health, or on the basis that their continued service is 'not in the interests of the Defence Force'. Both of these modes of separation are risk factors for suicide and suicidality, and are discussed further below.

Problems accessing support services

190. Access to independent and competent legal support is a necessary aspect of procedural fairness, and important to safeguard the wellbeing of members interacting with the military justice system. The availability and quality of legal assistance are factors known to impact on an individual's experience of justice processes, particularly when those systems are complex, difficult to navigate and adversarial in nature.

191. Defence has stated that ADF members generally receive free legal assistance through Defence Counsel Services to deal with internal service-related matters, and an hour of legal assistance for non-service related matters.[201] While Defence does not have quality assurance processes in place to monitor the effectiveness of this service, we were told that a survey was being developed to better understand members' experiences and satisfaction with the legal assistance provided.[202] We heard that some members have experienced difficulties accessing legal support during military justice processes, while others have been dissatisfied with the quality of legal support made available to them.[203]

192. Similarly, we have concerns regarding the quality and provision of welfare and psychological support. The Director-General of the Military Legal Service, Air Commodore Patrick Keane AM CSC, told us that while commanders may refer members for psychological support when interacting with the military justice system, this does not always occur in practice. He explained that it is up to the member to request support, or their commander to exhibit curiosity about their wellbeing.[204]

193. This is inherently problematic in an organisational environment where there is stigma around seeking help for psychological distress, where it has been reported that commanding officers are not always well equipped to identify and support members to access welfare services, and where in some cases, the commanding officer themselves is accused of having committed the abuse.[205]

194. We heard that Defence has failed to provide adequate welfare and psychological support for some members during their interaction with the military justice system.[206] Additionally, since January 2020, Defence has not evaluated the effectiveness of mental health support provided through numerous programs for members subject to military justice processes.[207] As a result, Defence cannot confirm whether these services are achieving the outcomes intended and appropriately meeting members' needs.

Administrative termination

195. Commanders may recommend that a serving member be involuntarily discharged from the ADF through the process of administrative termination if retaining the member is deemed 'not in the interests of the Defence Force'.[208]

196. Administrative termination may occur as a result of a member's behaviour, including being convicted of a criminal or service offence.[209] Other grounds for administrative termination are broad and open to subjective interpretation. A member's service can be terminated for a range of reasons, including reasons related to their performance and their 'suitability to serve'.[210] We heard from Judge Douglas Humphreys CSC OAM, an Army veteran and former member of the Veterans' Review Board, who stated that '[t]he grounds that are set out for the basis of termination are so wide they are virtually impossible to challenge',[211] despite the fact that administrative termination can have 'incredibly damaging impacts' on a member's wellbeing.[212]

197. Administrative termination from the ADF is one of the most significant risk factors for suicide and suicidality arising in the military justice system. Our data analysis has revealed that ex-serving males who served in the permanent forces and who separated involuntarily for the reason 'retention-not-in-service-interest' are 2.97 times (197%) more likely to die by suicide than Australian males, and almost six times (499%) more likely to die by suicide within a year of separating from the ADF than Australian males.[213] Ex-serving females who served in the permanent forces and who separated involuntarily for the reason 'retention-not-in-service-interest' are 3.45 times (245%) more likely to die by suicide than Australian females.[214]

198. Given the significant risks associated with administrative termination, we are concerned by the limited safeguards for ensuring due process and procedural fairness, and the limited opportunities for members to appeal a negative decision and pursue a meaningful review of the merits of their case.

199. Members subject to administrative processes have fewer protections than members subject to the DFDA for service offences under the disciplinary system. This was highlighted in the submission of Professor Pauline Collins, Professor of Law at the University of Southern Queensland, who stated:

> The administrative sanction that can result in a termination is attended by no more than a notion of procedural fairness. It does not attract any rights to a hearing, normal evidence requirements, [the requirement to specify] where or how the evidence of the alleged conduct arose, or ability to question any witnesses or informants.[215]

200. A primary mechanism for procedural fairness is that members have the opportunity to provide a written response to a Notice to Show Cause (NTSC) demonstrating why their service should not be administratively terminated. Under Defence policy, members are to be given at least 14 days to provide that response before any final decision is made.[216] However, as Professor Collins pointed out:

> putting a person in the pressured position of responding to a Notice to Show Cause may result in an unacceptable erosion of their rights to a presumption of innocence or fair process.[217]

201. We are also alarmed by accounts that Defence have issued NTSCs to members while they were undergoing treatment for mental health issues. For example, the partner of an ex-serving Navy member told us that Defence served an NTSC the day after he was discharged from hospital, and stated:

> The fact that my partner [had] only just been released from inpatient treatment, for depression and suicide ideation, had recently started new medication which affected his ability to concentrate and focus, did not seem to be taken into consideration or a care factor for Command. My partner was by no means better or really in the right headspace to receive that information. To present a NTSC at this time, to expect the member to try and respond in an appropriate manner and to try and fight an administration discharge, placed an, in my opinion, an unnecessary strain and stress on my partner … Responding to the NTSC whilst still undergoing active mental health treatment, would often result in my partner wanting to give up. Give up on trying to draft a [response] and give up on life!!! I spent a significant proportion of that time, convincing my partner not to commit suicide – that he was not the 'piece of shit' that his Command was trying to tell him he was.[218]

202. We note that decision makers in command positions are not bound by similar timeframes. This can lead to members waiting for lengthy periods before receiving a final decision on their prospective termination.[219]

203. In 2021, an independent review by the Australian Commission on Safety and Quality in Healthcare found that the prospect of military discharge was a source of 'tremendous distress' for many serving members and contributed to suicidality and suicide attempts. This was evident in the number of deaths by suicide that occurred immediately prior to or after the date of discharge. The 'extreme despair' and distress experienced by some members was also related to 'a sense of failure that [they] could not succeed in the workplace they esteemed and worked hard towards'.[220]

204. Given the inherently stressful nature of justice processes and that administrative termination is a known risk factor for suicide and suicidality, there is an urgent need for more robust safeguards relating to stronger governance, assurance, oversight and member support in the military justice system.

Experience of moral injury

205. The concept of 'moral injury' is relatively new and is not yet widely acknowledged as a risk factor for suicide and suicidality among military personnel. While there is no universally agreed-upon definition of moral injury, it is associated with four core constructs, including betrayal, guilt, shame, and self-condemning behaviours. Moral injury has been described in the context of defence and veteran populations as the:

> lasting psychological, biological, spiritual, behavioural, and social impact of perpetrating, failing to prevent … bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.[221]

206. Moral injury can be experienced by people who are victims of actions that go against their moral code, whether they are the actions of another person or an organisation. In these instances, moral injury can be bound up with the experience of institutional betrayal and the belief that the system itself has let them down, as discussed further below.

207. It can also occur when a person feels responsible for perpetrating, or failing to intervene or report actions that cause injury to others. For example, military interpersonal violence can cause moral injury to members who are drawn into those dynamics as perpetrators and bystanders, as well as those who are victims of violence. According to research we commissioned from Professor Wadham and others:

> The character of military abuse is such that it creates morally challenging dilemmas for the ADF member. The contexts are principally about inclusion and exclusion, in-group and out-group dynamics that could leave the ADF member caught between being a victim or a perpetrator.[222]

208. Several ex-serving members who participated in that research reflected on the psychological impact of having perpetrated or witnessed abuse during their time in service. For example, an ex-serving Navy member spoke of having taken on the role of abuser to avoid being the target of abuse from others, stating, 'I'm so upset that I … didn't have the strength or character at the time [to resist]'.[223] Similarly, another ex-serving Navy member reflected:

> I was made to sit outside and watch while these new mates of mine were in the ring and getting beaten up. The beating to me I could handle. I never dobbed. But seeing new-made friends being beaten up … I've lived with that.[224]

209. Moral injury can leave a person in great inner turmoil with feelings of guilt, inadequacy, shame and disgust. As a former infantry commander and padre explained:

> I don't see many people with suicidal ideation that want to kill themselves because of their post-traumatic stress. [Moral injury] has been described by people [as]: 'I feel like I have a wounded soul, that I've done something really wrong or I witnessed something that was really wrong and I didn't do anything about it'. And this is my life experience: these are the things that lead to veteran suicide.[225]

210. 'Self-stigmatising beliefs' following moral injury can significantly effect personal wellbeing and interpersonal relationships, and heighten suicidal behaviours. Members who have experienced moral injury can feel disconnected from who they thought they were, and can seek to numb their feelings by misusing drugs and alcohol, disconnecting from personal relationships and support services, and self-isolating, with suicide being the 'ultimate disconnect'.[226]

Institutional betrayal

211. The concept of institutional betrayal is integral to this Royal Commission. Lived experience witnesses in our public hearings and authors of submissions commonly reported feeling betrayed when ADF leaders and members committed wrongs, when the ADF failed to prevent wrongdoing or injury, when the institutional response to wrongdoing was inadequate, and when there was a lack of transparency and equity in how they were treated during their time in service. As an ex-serving Air Force member stated in her submission:

> Whilst Defence has been an important part of my life and identity, it has also been at the epicentre of some of the worst treatment I have ever experienced or witnessed. These negative unacceptable behaviours, toxic culture and lack of action have resulted me in losing trust in the organisation.[227]

212. Dr Jacqueline Drew, Associate Professor in the School of Criminology and Criminal Justice at Griffith University, emphasised the importance of a workplace environment that is perceived as 'fair, just and unbiased'.[228] She stated that '[o]rganisational injustice is pivotal in predicting psychological distress and burnout',[229] and further explained:

> [W]hen we think about first responders, police and Defence, they often have very clear sense of right and wrong and we ask them to implement that sense of right and wrong within our communities … It's then a significant disconnect when they don't see that same application of justice, that same application of right and wrong and the reward for good behaviour within the very agency that they work.[230]

213. Similarly, in a statement to the Royal Commission, Ms Chrystina Stanford, Chief Executive Officer of Canberra Rape Crisis Centre, described how poor institutional responses to sexual misconduct can lead to 'a loss of faith in the ideal, the institution as well as trauma impacts'.[231] She wrote:

> Most survivors of sexual violence disclose sexual violence because they 'do not want what happened to them to happen to anyone else.' A need based within integrity. When this fails, the consequences for the victim/survivor are catastrophic and where the person is connected to an institution, where they may be reliant on the institution … there is also a higher risk of loss of faith and hope in the institution. This is a significant issue where the institution is the Defence Force and risks leaving people ill equipped to manage what is occurring for them and isolated from seeking help. Suicide becomes the solution to overwhelming impact.[232]

214. This is supported by international research involving survivors of military sexual trauma that found that feelings of being 'betrayed' by the military – including by the institution's failure to prevent or respond effectively to the wrongdoing – were associated with a range of mental health conditions and an increased risk of attempting suicide.[233]

215. Betrayal from leadership is also a significant contributing factor to moral injury in the military.[234] As Dr Nikki Jamieson explained, many members join Defence with the expectation 'that Defence will have their back, leadership will take care of them'.[235] When their experience of the organisation falls short of these expectations, their mental health can suffer. Dr Jamieson described these dynamics by sharing the story of her son, Private Daniel Garforth, who enlisted in the Army in November 2012 and died by suicide in November 2014 at age 21. She stated:

> His loyalty and commitment to Defence was also his Achilles' heel … Like many others, Daniel was committed to his service but because of the constant belittling and demoralisation that he felt, and as reported by him as feeling, by his chain of command, he felt incredibly betrayed by those who were supposed to protect him, that didn't have his back – and this is one of the core mechanisms and indoctrination processes in Defence, you have to really understand the Defence and military ethos and training [that] goes with that and how loyalty and commitment, you put your team first against all odds, everybody will have your back, you are dependent on them for survival. When that doesn't happen, mental health declines …

> [I]t is not difficult to see how and why Daniel's mental health declined, when his values were so severely violated through betrayal and distrust. This violation led to his moral trauma and is consistent with the literature on moral injury and trauma, and how leadership betrayal leads to significant mental health impacts, withdrawal, isolation and distrust, and heightened his suicidal behaviours and ultimately his death.[236]

Exposure to traumatising events

216. The risk of exposure to traumatising events is inherent to military service. We received numerous submissions detailing disturbing and traumatic events that were witnessed and experienced by ADF members during their time in service.

217. We heard that one ex-serving Army member had witnessed 'numerous suicides, horrific injuries, a baby … killed'.[237] Many serving and ex-serving ADF members described the frenetic chaos and inherent danger of deploying to an active war zone, including an ex-serving Army member who wrote:

> On my third tour to Iraq we were exposed to a high threat environment where we suffered multiple casualties. Our detachment was involved in several shootings … and we were attacked on multiple occasions … It was very bloody and very confronting.[238]

218. An Army veteran of four operational deployments including Bougainville and East Timor, wrote of having been confronted with 'blood and chaos' during both war-like and non-combat deployments. He stated that 'some of the worst experiences' he encountered were on non-war-like operations, in addition to witnessing several fatal and serious accidents during training.[239]

219. Many serving and ex-serving ADF members described being exposed to traumatising events during training exercises, including a long-serving special forces member who reported having seen numerous colleagues die and many others 'maimed or wounded' during live fire and explosives training.[240] Another submission detailed the psychological impacts of witnessing a plane crash during a training mission, after 'the engine started to fail and the aircraft struck a tree bursting into flames'. All four of its crew members were killed.[241]

220. We also heard from serving and ex-serving ADF members exposed to traumatic incidents during domestic deployments involving natural disaster response. This included an ex-serving Navy member who described an incident that occurred during efforts to control a bushfire, in which 'fire jumped the road and jumped over our open truck, injuring, burning and scarring all the young sailors involved'.[242]

221. Exposure to traumatic events can be a predictor of psychological distress. Research conducted in Australia, the United Kingdom and the United States has consistently demonstrated a link between exposure to combat and adverse mental health outcomes,[243] of which post-traumatic stress disorder (PTSD) is the most commonly demonstrated outcome.[244] Studies acknowledge that '[m]ental disorder is a known significant risk factor for suicidal ideation and [death by] suicide',[245] with PTSD linked to higher rates of suicidality and suicide attempt.[246]

222. While some members exhibit symptoms during or immediately on return from postings or deployment in which they have been exposed to traumatising events, others may not experience effects on their mental health until years later.

223. As an ex-serving Army member previously deployed to Afghanistan wrote in his submission, 'One single moment of lived experience at war can undoubtedly change you'.[247] The psychological impacts of these experiences were shared by the wife of an ex-serving Army member who deployed to Iraq and Afghanistan. She described how her husband left Australia as 'an intelligent, articulate, clever man' and returned:

> distant, hyper-vigilant, fragile, angry, aggressive, incredibly emotional, depressed, having nightmares and night sweats, drinking to excess, totally shut down and unable to get off the couch for weeks on end …
>
> He's forgetful, frightened of the dark, anxious when driving in traffic, easily startled, constantly fatigued, impatient, wary of strangers, anti-social, unable to function on a daily basis and often suicidal …
>
> He has broken into a million little pieces and is a mere shadow of himself often engulfed by shame and guilt. His war experience will never be truly known by me. I can only see the deep, detrimental, life-long impact that it has had on him and in turn on us.[248]

Experience of burnout

224. Workforce shortages caused by high separation rates, a failure to meet recruitment targets, and personnel who are unavailable for medical reasons have resulted in a 'hollowing' of Defence capability and an environment that is not conducive to supporting wellbeing.[249] As the Associate Secretary of the Department of Defence, Matt Yannopoulos PSM, outlined in his statement to this Royal Commission:

> The hollowness is made up of the approximate 10 per cent vacancy rate and 15 per cent medically unavailable. As at November 2023, the organisation is 4259 [personnel] (6.8 per cent) below AFS [Average Funded Strength] guidance.[250]

225. These pressures are experienced across the Navy, Army and Air Force.[251] Workforce shortages can result in decision-making across the organisation that deprioritises member health and wellbeing in order to meet the ADF's capability requirements.

226. As Brigadier Duncan Hayward CSC, Director General of Defence Force Recruiting, stated, '[w]hen we have hollowness, we have people working harder and longer'.[252] This increased tempo can result in exhaustion and burnout for the existing workforce, which may be risk factors for suicidality, and can contribute to suicidality if certain environmental and personality factors are also present.[253] It can also elevate the risk of service-related injury and illness, and thereby increase the likelihood of medical separation from the ADF.

227. A review of the Defence Workforce Fatigue Management Approach found that a lack of personnel has a cumulative impact across the workforce, with burnout, medical downgrade, and retention issues noted as outcomes.[254] Additionally, fatigue was described as 'constant' by the majority of members who participated in focus groups undertaken as part of the review. The review stated:

> The reported experience of fatigue reflected a complex and multifaceted psychological and emotional response. Emotional exhaustion was a critical factor that strongly indicates fatigue as not just a physical sensation, but one that was emotionally taxing, leading to feelings of emptiness and depletion.[255]

228. In submissions to this Royal Commission, many serving and ex-serving ADF members reflected on the psychological toll of sustained high-tempo work environments that gave them minimal opportunity for rest and respite. For example, a serving member with over 20 years' experience in the Army and Navy, including deployments to East Timor, Afghanistan, and Iraq, identified the catalyst for his first mental health episode as 'the conduct of three short-notice operational deployments, marriage breakdown and [being] posted into a high-intensity work environment'.[256]

229. The submission of a former Air Force member who served as an air traffic controller described the experience of chronic workplace stress alongside exposure to traumatic events:

> Living at such a heightened state for so long was continuing to deteriorate my mental state … We were all overworked, constantly fatigued, and under-manned as a unit … Specifically I witnessed, and was responsible for controlling aircraft during emergencies, aviation incidents and crash landings. The nature of the high-pressure environment also exposed me to repeated aversive details of severely traumatic events through both my own experience and that of other air traffic controllers. On average, we could experience approximately one to three emergencies per day, every day, mostly military, but some civilian too.[257]

230. If member wellbeing is not adequately prioritised alongside operational objectives, these risks and their impacts will remain. As the wife of a current serving Navy member wrote in her submission:

> The discrepancy between capacity (numbers in category) vs capability (those able to participate in sea postings) means that personnel who are healthy and compliant with individual readiness requirements are often undertaking multiple sea postings back to back, working in a demanding and stressful environment with little or no reprieve from the high tempo, often stressful environment …
>
> I am certainly concerned about the long-term impacts of being in an environment that churns through its people just to keep Ships manned with appropriate numbers.[258]

Service-related injury and illness

231. Serving members are required to maintain high standards of physical and psychological fitness. Injury or illness can have a direct consequence on a member's employability through the military employment classification (MEC) system. Every serving member is assigned a MEC, reflecting their fitness to be deployed on active duty or otherwise employed in the ADF.[259] A member's MEC is subject to periodic and 'as required' reviews, which may result in movement up or down a grading system of 24 categories with corresponding employment restrictions and/or medical support requirements.[260]

232. The assessment of a member's medical fitness can significantly affect their career, affecting decisions related to employment, postings, training opportunities, occupational rehabilitation, transfers between employment categories, payment of specialist allowances and retention in the ADF.[261]

233. Our inquiry has found that the ADF does not sufficiently prioritise injury prevention, despite the risk of injury inherent to military service and the obvious impacts of workforce injuries on operational capability. Coupled with aspects of military culture that disincentivise members from seeking medical treatment, these factors create increased risk of chronic injury and illness. These may eventually result in medical separation, which is associated with an increased risk of suicide and suicidality.

234. An analysis by the AIHW has found that ex-serving males who served in the permanent forces and separated involuntarily for medical reasons are 2.84 times (184%) more likely to die by suicide than Australian males.[262] Ex-serving females who served in the permanent forces and separated involuntarily for medical reasons are almost five times (398%) more likely to die by suicide than Australian females.[263]

235. Medical separation is also linked with poorer outcomes following a member's transition into civilian life, across domains including health, education, employment, income and housing. This includes a range of negative outcomes for lifetime wellbeing including financial stress and lower income, an increased likelihood of experiencing homelessness, poorer self-perceived satisfaction and quality of life, social isolation and a lack of identity, and a reduced sense of agency and security.[264]

236. We are therefore alarmed by the high and growing number of medical separations from the ADF. In 2022–23, almost two thirds of separations from the permanent forces were involuntary medical separations.[265]

High rates of preventable injury

237. The rates of preventable injury in the ADF are unacceptably high. In evidence before this Royal Commission, Dr Rodney Pope, Professor of Physiotherapy at Charles Sturt University and former Director of the Defence Injury Prevention Program, estimated based on current research that the rate of injury in the ADF is likely to be 394 injuries per 100 personnel per year.[266] This amounts to approximately four injuries per person per year.

238. We accept that some hazards of military service cannot be avoided, especially during combat-related operations. However, the most common causes of physical injuries in the ADF are physical training, combat training and sport.[267] Further, Defence has reported more than 81,000 notifiable work health and safety incidents from 2016–17 to 2022–23.[268]

239. Submissions from many serving and ex-serving ADF members detailed injuries they believed were either caused or exacerbated by failures in ADF procedures.[269] For some, the knowledge that their injuries could have been prevented has had a compounding negative effect on their mental health. For example, an ex-serving Air Force member told us:

> I am angry because I feel my injury could have been prevented in the first place and that there is a lack of care about fundamental occupational health and safety in the military workforce. I have experienced continuous depression; life is miserable now for me. Each day I feel exhausted and in pain. I have struggled with thoughts of suicide most days.[270]

240. We are also concerned by recent changes to recruitment policy that may increase the risk of injuries being sustained early in a member's military career.

241. The 2023 Defence Strategic Review identified recruitment and retention as one of its six key priorities,[271] and Defence have stated that 'the ADF's risk appetite in recruiting has increased'.[272] This means that the ADF is more willing to recruit people who may not have the physical fitness and psychological resilience needed to succeed in service life. In practical terms, this has played out in the relaxing of physical and psychological recruitment entry standards, and the granting of more medical waivers that allow candidates who do not meet those standards to enlist.

242. Candidates typically undergo a pre-entry fitness assessment (PFA), which must be passed no more than six weeks before entering the ADF. The PFA is designed to 'ensure candidates have the minimum level of fitness required to train safely and effectively'.[273] However, the Army and Air Force are reducing their PFA standards for specified cohorts, while the Navy is trialling the removal of the PFA.[274] As the Director General of Defence Force Recruiting, Brigadier Hayward, explained, 'physical fitness standards have been relaxed in many instances for entry, but the graduation standards, or the exit standards from training institutions or into the force, have not changed'.[275]

243. This means that recruits who enlist under reduced entry standards carry a proportionately greater burden – and risk – associated with endeavouring to increase their physical fitness during training. Research suggests a direct relationship between fitness standards and the physical and mental health of recruits. Dr Pope told us that fitness standards protect candidates from harm. His research has found that people with very low fitness levels had about a 30% risk of being discharged during training and a 50% chance of injury.[276] Dr Pope explained that:

> implementing barrier testing [minimum fitness standards] … meant that we actually protected those people from that very catastrophic situation of coming in, knowing that they had only a 70 per cent chance of success of getting through the program if they didn't get injured, but they had a 50 per cent chance of being injured, which would then increase their risk of being discharged ten-fold.[277]

Military culture influences injury and illness

244. Aspects of military culture playing out at both an organisational and individual level not only contribute to high rates of physical injury and psychological health issues, but also discourage members from seeking medical attention or support from leaders and peers when they are injured or become ill.

245. We are concerned that negative attitudes towards help-seeking, and seeing injury-prevention strategies as undermining resilience, are ingrained in members from the start of their military careers. For example, the messaging delivered during Army recruit training at the 1st Recruit Training Battalion frames the 'requirements for soldierly conduct' in terms of endurance and working through physical pain, stating that:

> Soldiers are expected to operate day or night, on little rest and in arduous trying conditions.
>
> You are expected to be able to cope with the rigours of soldiering.
>
> You will be tired, sore, uncomfortable. Set an achievable goal and work towards it.[278]

246. Research we commissioned from Phoenix Australia found that while the military value of self-reliance and the related values of selflessness and sacrifice 'support … the military mission', they can have the negative affect of potentially discouraging members from seeking help when they need it.[279] At the same time, new recruits are readily made aware of the career implications of harbouring injuries. This was evident in submissions we received, including from an ex-serving Army member, who stated:

> During my training I developed bilateral stress fractures of the tibia and was warned I would be back squaded if I could not get out of the medical centre and back to my platoon. I sucked it up and managed to convince the doctor that I was no longer in pain and was allowed to return to my platoon.[280]

Stigma attached to injury and illness

247. In an organisational culture that valorises personal sacrifice and commitment to the team, a member's injury or illness can be viewed as a sign of weakness, and considered a serious transgression. A member who is unable to meet physical or mental health standards risks being labelled a 'malingerer' by their peers. This was described during our public hearings as 'incredibly stigmatising' and 'the worst possible form of threat somebody can put on another person [in service]'.[281] It is given further legitimacy by the service offence of malingering under the *Defence Force Discipline Act 1982* (Cth).[282]

248. We heard that the fear of being labelled a malingerer results in members failing to disclose physical and mental health concerns, avoiding or delaying medical treatment, and feeling pressure to 'speed up' their healing process, without taking the time or precautions medically necessary for their recovery.[283]

249. In this environment, it is unsurprising that serving members would seek to conceal symptoms of injury and illness. As an ex-serving ADF member described in his submission:

> During my entire 38 years of full-time service and an additional 8 years of part-time service, the common theme was that you did not want to be the 'weak link' due either to physical or mental injury or impairment. We were all guided to hide such things and provide the desired answers or responses when interviewed. The hidden threat of not being selected for promotion, courses or desired postings always loomed.[284]

250. We heard from many serving and ex-serving ADF members about the significant physical and psychological challenges of trying to work at full capacity with reduced capability. They described experiencing feelings of hopelessness, shame, and suicidality when their injuries prevented them from participating fully in ADF life. For example, an ex-serving Army member and Iraq veteran described facing the choice of seeking medical help for an ongoing, undiagnosed and debilitating medical condition, or being branded a 'malingerer':

> I started to feel that I had failed myself and my mates because I could not do what they were doing. There was no counselling or effort to help me … I considered taking my own life on a number of occasions; anxiety and depression was setting in …
>
> I did not seem to get better and felt I was letting down my mates and the unit. One day, the situation got the better of me. I did not want to continue living, I was so sick of my life. I curled up on the floor and cried.[285]

251. Similarly, the wife of an ex-serving Army member who was severely injured during training for a deployment described how her husband told her he 'wanted to die'. She said:

> He felt hopeless because his whole support network had gone to Afghanistan, and he was unable to be there with them and felt that he was 'useless' and had no purpose.[286]

252. We are greatly concerned about the ongoing stigma attached to mental ill health in the ADF. Submissions we received described how mental health conditions are 'treated more as a lack of character or a character flaw',[287] and that PTSD is 'a label (according to my peer group) associated with shame, weakness and failure'.[288] As the mother of an ex-serving Army member diagnosed with PTSD following his second deployment to Afghanistan outlined in her submission:

> [Our son] did not leave the Army – the Army left him. He was abandoned – not on the rocky and dusty battlefield of Afghanistan but in the capital of Australia, Canberra …
>
> From the day that our son advised his command that he had been diagnosed with PTSD, his career took a significant downturn. This was despite the fact that the ADF Chiefs were publicly advising serving members and their families to come forward with their diagnosis with assurances they would be cared for and looked after … The failure of the Army to provide the professional care and support for our son and our family fell far short of the commitments made and headlined by the Army and ADF Chiefs who misled their personnel and families on the support that was promised and expected … [Our son's] workplace became a noxious environment for him where he was deliberately isolated, ignored, intimidated, and bullied.[289]

253. We heard consistent accounts from lived experience witnesses and expert evidence during our public hearings that disclosing mental health difficulties is 'career-altering … and sometimes career-ending'.[290] As a current serving ADF member described in her submission:

> There is no safe place for people struggling with mental health issues, if they leave they're weak, if they take a sick day they are malingering (lingers), if they seek help they are a burden, and if they take their own life they are replaceable. Worst of all, nothing is treated as private or confidential.[291]

254. Mental health issues experienced by some serving members can be amplified by the stress and anxiety of associated career limitations, including the risk of medical downgrade, removal from operations or being withheld from deployment. We heard that for serving members, not being able to deploy is like 'having trained to be a surgeon your entire career and never setting foot in a theatre to operate'.[292] These pressures were contextualised by Louise O'Sullivan, Expert Panel Member for Women Veterans Australia, who reflected on her time working as a psychologist within the military:

> I used all kinds of strategies to normalise communication with me as a mental health practitioner and reduce the stigma of mental health support. But I also knew that regularly the same people who called and told me their struggles late at night after they had consumed many drinks, then lied to me in formal settings. They told me they were okay because they wanted to be okay. Seeking help would have precluded them from deploying again and [they] thought [that] was more threatening to their mental health than going back to war.
>
> They were trained to be there for their mates no matter what … They would rather die than let their mates die without them, whether that's at war or at home.[293]

Healthcare provision

255. According to evidence we received, physical and psychological injuries are often poorly managed in the ADF. Serving and ex-serving ADF members, as well as current or former clinicians working in the ADF health system, disclosed a range of problems with healthcare provision. These problems included issues with clinical and non-clinical capabilities of contracted healthcare providers; challenges in accessing timely and appropriate medical care; and the understaffing and under-resourcing of some bases, which affected the continuity of care for members suffering from injury and illness.[294]

256. We heard that some injuries were exacerbated by poor healthcare provision during service. As the wife of an ex-serving Air Force member described in her submission:

> I strongly believe the Defence medical system failed and contributed to the extremeness of his injuries. The contributions include excessive wait times to see a doctor, seeing different doctors constantly and his visits to medical not being taken seriously or treated correctly. This became more evident after speaking to his neurosurgeon, who found there were plenty of signs prior to his career ending injury, as early as 2 years prior. He first had scans showing a bulging disk and was treated with Panadol/ibuprofen and no time off work. He then pulled both his hamstrings, on separate occasions … In one of the many scans of his back there was a visible fracture in his spine which medical failed to advise at the time of the scan, this was picked up by a DVA doctor when submitting claims.[295]

257. Other deficiencies identified across the ADF health system include insufficient clinical governance systems. We observed the need for improvements to performance monitoring and reporting on health service and clinical care outcomes, including rehabilitation outcomes. Similarly, inadequacies in the approach to mental health screening means the identification of potential risk factors does not routinely occur, or is not acted upon, and therefore opportunities for intervention, referral and monitoring of symptoms are missed.

MEC review

258. The ADF's ability to conduct operations depends on the medical fitness of its personnel.[296] According to the Defence Health Manual, the allocation of an individual military employment classification (MEC) is the mechanism by which the ADF 'determines medical fitness and administers the employment of Defence members'.[297] The MEC system is a personnel or resource management tool; it is not a health care tool.[298]

259. A MEC may be determined by a medical officer or nurse practitioner who will conduct a medical assessment of the member, considering both their diagnosis and occupational requirements.[299] Complex cases may be submitted to a MEC Review Board chair for determination.[300]

260. We have found that systemic shortcomings in the MEC Review Board process undermine institutional trust and may contribute to poor mental health outcomes, including risks of suicide and suicidality.

261. We are concerned by a lack of procedural fairness in the assessment and determination of a member's MEC by MEC Review Board chairs, and the minimal opportunity afforded to serving members to meaningfully participate in a decision-making process that can have enormous impacts on their career, including the termination of their employment.

262. A member can provide input into the review process via the Member Health Statement, prepared early in the review process. However, they are subsequently denied an opportunity to participate in, or even observe, MEC Review Board meetings, have no opportunity to access or review the full package of documentation available to the chair of the MEC Review Board in making their decision, and are not able to respond to the case that is presented against them. They cannot give evidence, call witnesses or make submissions – all of which would normally be expected in processes seeking to afford procedural fairness and natural justice in administrative decision-making.[301]

263. Additionally, we are concerned by the level of discretion available to decision-making delegates in the MEC Review Board process, and the lack of clarity on how medical and non-medical advice is weighed and conflicting medical opinions are resolved. All these elements contribute to a system that is neither transparent nor accountable.

264. Defence acknowledges that the process of revising a member's MEC status or deliberation by a MEC Review Board 'may cause uncertainty or concern for the individual'.[302] We believe this significantly understates both the inherently disempowering nature of the process, and the distress and anxiety experienced by most serving members facing the prospect of medical separation.

265. As an ex-serving Army member described in his submission, the MEC Review Board process is 'extremely stressful … The constant fear of the unknown, if you are going to keep your career or be medically discharged constantly played on my mind'.[303] Additionally, the Director of Strategic Clinical Assurance and Ethics in the ADF's Joint Health Command, Dr Darrell Duncan, agreed that in some cases the stress of the review process could be traced back to the time when a mental health condition emerged for some members.[304]

266. Despite these risks, there are currently no specific psychological, legal or financial supports for members undergoing a MEC review process.[305] The primary responsibility for supporting the member through this process sits with their chain of command, meaning that the level of support provided to members varies significantly.[306]

267. We are alarmed by accounts describing circumstances in which the ADF has pursued MEC review when serving members have been particularly vulnerable. For example, the wife of an ex-serving ADF member wrote in her submission:

> I had to fight to stop the military from discharging my husband while he was still in the mental ward having his brain electroshocked. He had no capacity to fight or be at the medical board. It was me – me alone. He is still today after 2 years of being in out of the mental ward still battling with this demon and he feels abandoned by the military.[307]

268. We note that many medical separations are implemented against members' wishes, in circumstances in which they could continue to make a positive contribution to the ADF if retained.

269. Given the significantly heightened risk of suicide and suicidality for ADF members who are involuntarily separated for medical reasons, there is an opportunity for Defence to take a more strategic approach to retaining members who are deemed to be medically unfit to deploy. At a minimum, this should include ensuring that the MEC Review Board process is fair and transparent, and that Defence systematically identifies avenues for members to retrain for a different role in the ADF. This would also go some way towards addressing a loss of skills and experience from the ADF at a time when recruitment and retention are a major challenge.

Risks associated with separation and post-service life

270. Between 5,500 and 6,500 members leave full-time ADF service each year.[308] Transition and separation and the early post-service period are characterised by instability and uncertainty, as well as social and psychosocial disruption. These reintegration challenges can expose members to risks of suicide and suicidality.

Separation from the ADF and transitioning to civilian life

271. As discussed earlier, risks of suicide and suicidality are heightened for members whose service is terminated involuntarily. Research we commissioned found that:

> Involuntary separations result in more negative outcomes than for those who choose and plan the end of their military career. When transition is also entwined with experiences of trauma – such as military administrative or disciplinary action – the risk compounds.[309]

272. Data demonstrates that ex-serving members who served in the permanent forces and who separated involuntarily have an increased risk of suicide compared to the Australian population.[310]

273. This is a matter of serious concern, as the number of involuntary separations has grown in recent years, with more than three times as many members having separated involuntarily than voluntarily since 2019.[311]

Social and psychosocial challenges

274. While military culture is essential for building capability in the ADF at a collective level, it can become personally unhelpful for members, especially on transition to civilian life. Our inquiry has explored how many of the factors unique to military service contribute to increased risks of suicide and suicidality during transition to civilian life and following separation.

275. Some ex-serving ADF members can find it difficult to leave the military mindset behind and adapt to civilian lifestyle and values. As an ex-serving Air Force member wrote in her submission:

> The purpose of military training is literally to take you, as a member of regular society, and to turn you into a soldier, a sailor, an airman. By breaking you down and building you up again. Into something different. It teaches you to think differently, can change your belief system, the way you make decisions, to operate at long periods of time at a heightened state, to react differently, even down to walking and carrying yourself differently. You are no longer a civilian, and in reality, you will never be one again. This poses one of the most difficult aspects of leaving the ADF, in that you no longer belong to your unit, your service, yet you are no longer truly a civilian either. It is impossible to return to what you once were. Parts of your brain, your psyche, your everything have changed.[312]

276. Additionally, neurophysiological changes associated with mental health conditions may make it particularly challenging for some members to adapt to civilian life, such as the cognitive, behavioural and emotional changes caused by PTSD.[313] Some ex-serving ADF members shared their experiences of hypervigilance – as both a potential consequence of exposure to combat environments, and an aspect of military training 'that encourages and rewards heightened attention and arousal to potential threat'.[314] For example, an ex-serving Navy member stated:

> The Navy programs you to be hyper alert, ready to respond immediately to anything that happens. What they do not do is deprogram you when you leave. They made me into a machine and never turned the machine back off again or gave me any help with the transition back to civilian life. All I received was some pamphlets.[315]

277. Psychosocial challenges can also arise from the loss of military identity, purpose and levels of social connection, and the corresponding experiences of isolation and loneliness.

278. In losing their access to a collective identity and the sense of purpose inherent in being a member of a unit, service, and Defence more broadly, an ex-serving member can face an uncomfortable and often isolating experience re-establishing a civilian identity. As an ex-serving Army member stated in his submission:

> When a person has their 'meaningful reason for being' removed from them a serious mental challenge is created that needs to be overcome and a meaningful purpose in life put in its place.[316]

279. Similar sentiments were expressed by another ex-serving Army member, who stated:

> On discharge after 34 years, I suddenly lost my identity. I was no longer a part of the ADF family … I was lost, confused, devastated all at once … It must sound strange but as a woman about to turn 60 I am trying to figure out who I am. Simple things as trying to figure out how I want to dress, what activities are within my medical limitations that I might enjoy. What are my interests and passions? I have found this journey uncomfortable, frustrating and at times, distressing.[317]

280. Additionally, Professor David Forbes, then Director of the Phoenix Australia Centre for Posttraumatic Mental Health, explained that 'there is significant risk around social disconnection and social alienation',[318] both of which are also risk factors for poor mental health, including suicidality. The experience of leaving the ADF can be particularly challenging given the unique personal bonds formed through military service. As an ex-serving Navy member stated:

> [I]t is not often in life where you will live, travel and work with your colleagues. To go from that environment and leave it so suddenly is really difficult.[319]

281. One ex-serving ADF member described this experience as ‘very traumatic’ and the equivalent of ‘a husband losing his entire family in a car accident. The shock and bewilderment overcome even the hardiest people, resulting in depression, loss, loneliness’.[320] Many ex-serving ADF members characterised this experience as being discarded by Defence and being ‘left with a sense of betrayal by the system as a whole’.[321] As an ex-serving Army member wrote in his submission:

> No thank you and no good bye. I headed to the Barracks front gate and exited and realised I could not get back in. I had a sudden feeling of abandonment, a feeling of being [cast] aside, a feeling of being on my own – my Defence family had just dropped me!! I believe these feelings of disillusionment and abandonment are not uncommon.[322]

282. The experience of social disconnection can be amplified by challenges forging new connections in the civilian community. Ex-serving ADF members can find it hard to relate to family, friends and a wider community, most of whom have not experienced military service and may not understand its impacts. As an ex-serving Air Force member outlined in her submission:

> Leaving the military with PTSD and everything that came with it has also considerably impacted my family. It has placed a strain on every relationship in my life, a strain that at times can be unbearable. I have lost jobs, have been unable to work for long periods of time, have disconnected from friends, have lost interest in social and sporting activities. I am no longer the person I once was. I still do not know how to get myself back. I struggle imagining the future, making plans, developing goals. Any day of any week can appear as a torturous struggle with no end …
>
> It has taken my professional life and turned it into something else. A sense of being unable. Unable to work, to be gainfully employed in things I fought to be, worked hard to be, overcame so much to be. And what it has done to me as a human, as a family member, a parent, a friend – it is almost indescribable.[323]

Employment challenges

283. Unemployment may be associated with an increased risk of suicide for ex-serving members. According to data from the AIHW, 21% of members who had served in the ADF and died by suicide between 2001 and 2018 were unemployed at the time of death.[324]

284. Research suggests that employment can positively influence adjustment to civilian life, and physical and mental health and wellbeing for ex-serving ADF members.[325] Participation in meaningful occupations is also likely to be important for:

> identity reconstruction, health and adjustment after military service. Participation in meaningful occupations may further support recovery from service-related trauma, and ensure fundamental needs, including mastery, self-expression, and connection to others, are met.[326]

285. Ex-serving ADF members should be well regarded by public and private sector employers across a diverse range of industries, given the extensive range of skills, abilities and positive attributes developed during military service. This includes those who have experienced poor physical or mental health due to their time in service.

286. We are therefore troubled by significant shortcomings in Defence's approach to supporting ex-serving members to gain meaningful and sustainable civilian employment following their departure from the ADF.

287. Training undertaken by members during service is often not readily transferrable into the civilian workplace, either because civilian qualifications are not awarded, the level of training falls short of that required for a civilian qualification, or the highly specialised military skills obtained are not relevant to civilian employment. Ex-serving ADF members would benefit from greater support to translate their skills and experience for civilian employers who may not understand the value ex-serving members can bring to workplaces.

288. Existing job readiness supports in Defence are fragmented and inconsistent. There is limited evidence of uptake by members leaving the ADF, and limited evaluation by Defence as to whether its investment in these supports is delivering better employment outcomes for ex-serving ADF members.

Impacts on families

289. As previous reviews have identified, 'families are deeply implicated in, and affected by, transition from the military'.[327] Not only do family members provide emotional support to ex-serving ADF members and aid in transition planning, but they also face a range of practical and emotional challenges as they navigate their own transition to being a civilian family.[328]

290. The 2018 Transition Taskforce found that transition to civilian life can be an uncertain time for families, with changing family dynamics due to new employment, housing and financial arrangements.[329] It identified 'unrecognised impact on families' as a key barrier to effective transition and noted that '[m]any family members feel unprepared and unsupported for the impact of transition and the consequent establishment of their lives in a civilian context'.[330]

291. Additionally, families with a transitioning member in poor physical or mental health tend to face more transition-related challenges, including strained family relationships and difficulty finding stable or satisfactory employment outside the ADF.[331]

292. These challenges can have a ripple effect on other family members, including impacting children's educational outcomes and mental health.[332] In 2018, the Australian Institute of Family Studies (AIFS) found that the partners of recently transitioned ADF members exhibited poor wellbeing in a range of areas, when compared with partners of serving members, and were significantly more likely to report problem drinking, drug use, and suicidality in the preceding 12 months.[333]

293. The AIFS found that psychological distress, either on its own or paired with poor physical health, increased the risk of being in an unhappy relationship and of abuse in that relationship, and reduced the level of relationship satisfaction.[334]

294. Research demonstrates that relationship breakdown, family violence and poor social relationships have a known association with suicidality, and inversely, that connectedness to family is a protective factor against suicidal behaviour.[335] As the wife of an ex-serving Army member expressed:

> Something I believe that is imperative to be addressed, to save veteran lives, is to recognise the role that their partners/families play in the healing process. The ones who are emotionally closest to them are ultimately the 'front line' to their recovery …
>
> It is difficult living with someone who feels nothing but heightened negative feelings that circulate to the point of exhaustion. Remaining by someone who only wants to give up, is almost always in a constant bad mood that lashes out at you, the only one who is there for them, the wife, the only one who has his back. It takes a significant toll, and that also needs to be kept silent, otherwise it will only make him feel worse, and me, and the family as a whole.[336]

Inadequacies in meeting the support needs of ex-serving members

295. The experience of transitioning out of the military and reintegrating into civilian society is inevitable for most ADF members. By establishing the Joint Transition Authority in 2020, Defence formalised its responsibility for the wellbeing of discharging ADF members. However, Defence has failed to make the substantive improvements necessary to deliver a transition support system that responds to the circumstances and needs of each veteran and their family, and that appropriately addresses the reintegration challenges known to affect wellbeing following separation.

296. According to Defence, there has been an institutional shift towards a 'needs-based' model of providing transition supports.[337] However, the translation from intention into action remains in its infancy.

297. The main tool used by Defence to identify member support needs and assess transition readiness has limited value as few members engage with it. It relies on transitioning members self-identifying their needs and physical and mental health concerns in the ADF environment where they have been socialised to avoid seeking help. While it considers relevant areas of need, such as housing, education and employment, it fails to assess other risk factors for suicide and suicidality, such as the experience of sexual abuse or trauma; nor does it explore whether members are prepared for the shock of re-entry into civilian culture, the potential loss of purpose and identity, and potential difficulty of connecting with civilians.

298. Similarly, we have found that Defence's transition coaches tend to apply a 'checklist approach' to delivering transition support, in a process that enables limited contact after a member has separated from the ADF.

299. The Productivity Commission had envisaged that the introduction of the Joint Transition Authority would be a catalyst for the reform of the transition service system, giving greater prominence to transition and improving coordination among the multiple agencies responsible for providing support services.[338] However, to date it has had limited impact: agencies in the transition service system have continued to operate in silos, and service gaps and poor quality of service provision have not been addressed.

300. Navigating the system of supports available imposes a significant burden on transitioning members, who must coordinate, manage, follow up and in some cases, advocate for access to the transition supports they need. Many members continue to have a poor understanding of the supports available and how to access them. In Defence alone, there are at least five entities and six people in different support roles who may be involved in delivering transition services, depending on a member's separation type, case complexity and the service to which they belong.

301. There remains a lack of shared responsibility between Defence and DVA in supporting transitioning members, and many members continue to fall into this gap.[339] Numerous witnesses in our public hearings spoke of the risks that arise when a person is unable to work and their access to DVA incapacity payments has not yet been determined. These include the risks of becoming homeless, experiencing financial instability and feelings of worthlessness.[340]

302. Incidents of suicide or suicidality that occur during transition should be a cause for deep reflection. However, in evidence before the Royal Commission, Lieutenant General Natasha Fox AO CSC, then Deputy Chief of Army and former Head of People Capability Division, told us there is no formal system for Defence to be notified of the death by suicide of a recently separated member.[341] It is not currently clear who is responsible for reviewing incidents of suicide and suicidality that occur during transition, when the member has formally separated from the ADF.

303. While DVA has a system for analysing the deaths by suicide of ex-serving ADF members who are DVA clients, there is no clear process for Defence and DVA to be jointly notified of incidents of suicide and suicidality that occur during transition. This is concerning as it reduces the capacity of both organisations to capture trends and identify opportunities to prevent future harm.

304. Transition is a critical period of intervention to reduce risks of suicide and suicidality. We believe there is a clear and pressing need for the rapid reform of the transition support system to ensure it meets the needs of separating members and their families, and appropriately addresses the magnitude of the psychological, emotional, cultural and social adjustments that arise as members journey out of the ADF.

The Department of Veterans' Affairs

305. The Department of Veterans' Affairs (DVA) delivers services and programs to support serving and ex-serving ADF members and their families, including access to income support, compensation and other financial entitlements, and health and other care services.

306. Between 2002 and 2021, 331 of the 1,154 ex-serving ADF members who died by suicide were clients of DVA.[342]

307. Since 2018, the number of DVA clients has steadily increased, and this trend is predicted to continue.[343] Additionally, DVA appears to support a large proportion of ex-serving members who are at heightened risks of suicide and suicidality, as they have medically separated from the ADF and are likely experiencing ongoing healthcare needs. As at 31 December 2021, 93% of men and 92% of women who separated involuntarily for medical reasons were clients of DVA. By comparison, only 40% of men and 34% of women who separated from the ADF voluntarily were DVA clients.[344]

Culture, processes and systems for claims determination

308. Aspects of DVA culture, processes and systems have been consistently highlighted in previous reviews as negatively affecting the mental health and wellbeing of ex-serving ADF members.

309. For example, in 2009, an independent review identified legislative complexity, an impersonal approach to clients, poor case management, 'ill-informed' staff and administrative problems as factors in DVA that contribute to client distress.[345] DVA's approach to clients was raised as 'needing urgent attention' in the Australian Public Service Commission's 2013 capability review of DVA, which also found that DVA faced 'significant challenges' in building its capability and workforce to allow it to meet government and community expectations.[346]

310. These concerns were repeated in 2017, when the National Mental Health Commission reported that the difficulties clients experienced in dealing with DVA on administrative matters including 'the length of time to process applications, the complexity of the processes, the frustration of lost paperwork and the need to constantly prove claims' could lead to 'significant aggravation and distress, and potentially a worsening in severity of a veteran's condition'.[347]

311. Similarly, research commissioned by DVA in 2019 found that 'DVA claims processes appear to have multiple features that could, for some veterans, contribute to the onset or exacerbation of a mental health condition'.[348] It found that while DVA compensation claims processes were 'unlikely to be the sole cause of psychological ill health in these cases, the consequences [of these processes] may be catastrophic and include multiple reported cases of suicide and self-harm'.[349] Three years later in 2021, the Interim National Commissioner for Defence and Veteran Suicide Prevention reported that 'challenges navigating DVA' contribute to increased risk of suicidality,[350] and that 'the claims process can be as traumatic as the original injury'.[351]

312. These issues were once again reiterated in evidence received during our public hearings, and raised in written submissions and private sessions.

313. Ex-serving members and their families described the compensation claims system as 'extremely convoluted',[352] 'like the system was geared to be so difficult that veterans would give up',[353] and said it required ex-serving members 'to jump through so many hoops that the process itself defeats them'.[354] As an ex-serving Army member wrote:

> There is a common saying that the paperwork loops and hurdles you must climb over [are] deliberately designed to be [so] hard [that] veterans will either just give up or do themselves in. Either way the problem goes away.[355]

314. We heard of inordinate delays in claims processing and decision making, and found that DVA was insufficiently resourced to process claims in a timely manner. While the number of claims lodged has increased substantially in recent years, this was not matched with a commensurate increase in departmental funding and claims processing staff on hand, contributing to a large backlog of unassessed claims and unacceptably long processing times.

315. We heard how these delays could be devastating to ex-serving members' mental health. As a former Air Force member wrote in his submission, 'Without reducing the time-frames for claims processing, there will continue to be veterans that become frustrated and disillusioned, leading to the contemplation of suicide'.[356] Similarly, an ex-serving Army member shared, 'I have friends who are sick of waiting for help and have taken their lives. I have lost at least 10 friends who have served overseas'.[357] As a former special forces member outlined in his submission:

> While pain and limitation associated with [my] injuries present a daily challenge, by far the biggest hurdle with my military injuries has been the process of having these service-related injuries recognised by DVA. This was a process that began in 2009 and is still ongoing today, 13 years later. The processes surrounding claims are … cumbersome and repetitive and lengthy; in some cases, months going into years of being transferred from area to area internally within DVA to try and decipher my entitlements and repeatedly retell my story.[358]

316. We heard about other issues in the claims determination process that contribute to psychological distress including poor communication between DVA staff and clients, varied levels of skill and training among the staff responsible for determining claims, and a lack of transparency in decision making. According to an ex-serving Navy member, DVA staff demonstrated: 'No care. No accountability. No transparency'.[359]

317. Submissions from ex-serving ADF members commonly described an adversarial culture in DVA, where staff applied 'an "insurance" mentality' in their assessment of claims.[360] An ex-serving Air Force member stated that 'DVA "fight" you on everything',[361] and an ex-serving Navy member told us:

> DVA hire lawyers and medical specialists from their allocated budget to assist them to deny veterans getting all their entitlements or by minimising their entitlements by using the 3 legislative acts against the veteran …
>
> Many veterans feel Delay, Deny, Die (wait until we die) is the DVA motto.[362]

318. Similarly, an ex-serving Army member wrote in his submission:

> It appears that Defence and DVA have nothing more than saving money on their [agenda] and rubbing it in your face when dishing out compensation payments for injury. As a justification for someone who sacrificed their lives for their government, to be given the bare minimum in compensation shows their belief in the value of a life.[363]

319. Ex-serving members described being treated with suspicion and distrust, having felt 'betrayed, judged, and belittled by DVA',[364] and needing to go to 'extraordinary lengths' to prove the connections between their time in service and injuries sustained.[365] Many described this process as retraumatising.[366]

320. For example, the wife of an ex-serving Air Force member who took his own life recounted how her husband 'was asked to relive those awful moments' that contributed to his service injury, adding that '[he] said it was awful being in the headspace of impending death when he was trying so hard to live'.[367] In reflecting on the psychological toll of her own dealings with DVA following her husband's death, she stated:

> [My husband] wrote a blank cheque up to and including the cost of his life to be in service and he did everything he was told to do. He would have done anything for Defence … My efforts with DVA were all about getting this acknowledged. I was not asking for millions of dollars, just some recognition and some cheap public transport …
>
> At the peak of my dealing with DVA I felt as though I wanted to 'lift out' and not be here anymore. Instead of assisting me at my darkest hour, DVA turned the screws on my suffering which led to my suicide attempt … these feelings are a normal response to the trauma that this system has created. I'm sick of each of us being told that we are the 'anomaly' or the 'exception to the rule'. There are too many of us anomalies. It's time for some new rules.[368]

Progress following our interim report

321. We identified many of these issues as requiring reform and urgent action in our interim report delivered to the Governor-General in August 2022.[369] We recommended that government simplify and harmonise the legislative framework for veterans' compensation and rehabilitation to enable more efficient and timely claims processing, and improve consistency and fairness in compensation outcomes. We also made recommendations designed to ensure that DVA could address the backlog in unallocated claims and prevent this from reoccurring in the future.

322. Progress has been made in response to our interim report recommendations. This includes a proposed reform pathway to simplify the legislation governing veterans' entitlements and the release of an exposure draft Bill in February 2024.

323. Other recent efforts to improve the administration of the claims determination system include the hiring of additional ongoing claims processing staff, changes to staff training and accreditation, expanding the conditions eligible for streamlined claims processing, and a modernisation program to replace DVA's legacy information and communications technology systems.[370] We also note additional measures announced in the 2024–25 Budget in May 2024, including a funding commitment of $477 million over four years to strengthen DVA's capacity to deliver services and supports to the veteran community, and respond to our recommendations.[371]

324. DVA informed us that it has cleared the enormous backlog of unallocated claims, and has now finalised over 93% of the original unallocated claims we identified in May 2022.[372]

325. DVA has also stated that it is focusing on reducing the time taken to process claims on hand, in order to 'sustainably deliver' claims determinations within legislative guidelines. DVA expects to meet its performance indicators for the time taken to process claims; that is, to process initial liability claims by 30 June 2025, and permanent incapacity claims by 30 June 2026.[373]

326. We note that demand for DVA's services is increasing, making it essential that recent improvements are sustained in the future. DVA has also acknowledged that it is 'processing more claims than ever before'.[374] In October 2023, 7,748 claims were lodged with DVA – an increase of 39% from the previous year.[375] In addition, DVA has projected that its number of clients will increase by 23% over the next 10 years – from 271,466 in December 2023 to a projected 333,700 in June 2033.[376]

327. In December 2023, DVA told the Royal Commission that the concerns we raised about deep-rooted cultural and systemic issues largely reflect 'historical performance'.[377] DVA has stated that there is 'significant evidence before the Royal Commission of considerable improvements to DVA's culture'.[378]

328. Among other measures, DVA cited the results of the Australian Public Service Commission's Trust in Australian Public Services survey as evidence of positive change.[379] In 2023, DVA achieved a satisfaction rating of 72 and a trust rating of 77, a relatively positive result compared with some other government departments including the National Disability Insurance Scheme (which was rated 66 for satisfaction and 69 for trust) and Services Australia (which was rated 63 for both).[380]

329. However, we note that DVA's ratings for satisfaction and trust have steadily deteriorated since 2019, with the exception of a marginal improvement in trust ratings over 2022–23.[381] It is too early to tell if this signals a shift in the longer-term trend.

330. DVA also shared the findings of an independent review that recently concluded that 'DVA does not currently have an adversarial culture with regards to its service delivery', and that claims staff are committed to serving veterans with empathy and compassion.[382]

331. While it is true that the reviewers did not identify an adversarial culture currently in operation within DVA, they also concluded that 'a range of internal complexities' and 'structural issues' potentially impact the ability of staff 'to effectively serve Veterans and their families'.[383] They also reported that 'significant cultural and operational issues remain'.[384] Far from providing definitive evidence of improvements to DVA's culture, this review made clear that cultural concerns persist in DVA and a significant reform agenda is still required.[385]

332. We also received numerous submissions from ex-serving ADF members and their families that continued to describe negative experiences and interactions with DVA as recently as 2021 through to late 2023.[386] These accounts directly challenge DVA's claims that it has 'changed' and that 'DVA is not the organisation it was 10 years ago or even three years ago when the Royal Commission commenced'.[387]

333. In light of ongoing concerns, this final report makes further recommendations to improve DVA service delivery. These include a claims process that places the veteran at the centre, with combined benefits claims processing, and expanding support for members who are medically discharging and need to submit claims; better access to professional compensation advocates; more choice and control for veterans with an accepted claim; ongoing funding for provisional access to medical treatment; and stronger accountability and transparency measures. Together, these reforms would directly improve client experiences and address some risk factors for worsening mental health and suicide and suicidality.

Poor engagement with veterans outside the claims process

334. As DVA have acknowledged, the unique physical and mental demands of military service create an 'ensuing need for a tailored, fit-for-purpose, comprehensive system of support for veterans and their families beyond that provided through the civilian system'.[388]

335. DVA has previously recognised the need to shift its focus towards supporting the wellbeing of veterans and their families 'rather than viewing just their claims or transactions'.[389] DVA identified 'prevention' as one of three core principles underpinning the strategic objectives of its Veteran Mental Health and Wellbeing Strategy (2013–2023), encompassing not only early intervention, but also treatment and services to prevent or minimise the negative impacts of mental health conditions.[390] Similarly, its Veteran Centric Reform Program (2017–2013) included program goals aimed at 'whole of life wellbeing'.[391]

336. Despite these intentions, DVA has struggled to engage with serving and ex-serving ADF members outside the claims process. The former Secretary of DVA, Major General Elizabeth Cosson AM CSC (Retd), acknowledged that DVA relies on a reactive model where the veteran has to come forward to access support.[392] Further, in evidence to the Royal Commission in 2023, DVA confirmed that it 'does not use specific methods to understand the experiences of veterans who have not initiated engagement with DVA and are not DVA clients'.[393] In a positive development, DVA has recently confirmed that it is commissioning research on the 'demographic, health and wellbeing characteristics' of veterans who are not DVA clients.[394]

337. DVA provides two types of fee-free health checks that can be accessed through general practitioners, and almost all ex-serving members can access non-liability mental health care through the White Card, with no requirement to submit a claim or demonstrate a link between a mental health condition and their service history. Under this program, DVA funds treatment costs for mental health conditions, including general practitioners, psychiatrists, psychologists, medication, hospital treatment and community-based treatment programs.[395]

338. However, we heard that it can be difficult to find and access clinicians who will accept DVA rates. The payments DVA makes to practitioners seeing DVA clients are often lower than those provided by the National Disability Insurance Scheme and other compensation schemes. This can result in a significant shortfall for practitioners. For example, in 2023, the Australian Physiotherapy Association reported that 91% of physiotherapists surveyed stated that the current level of funding does not enable them to sustain care for veterans, as the fee provided by DVA is less than half the market fee for general physiotherapy services.[396]

339. Additionally, although eligibility for non-liability mental health care has been progressively extended to almost all members (excluding some reservists) and now covers all mental health conditions, multiple reports have highlighted that veterans are often unaware of their entitlements.[397] A recent horizon scan commissioned by DVA reported that veterans and their families 'tend to lack knowledge' of the services and supports in DVA and how to access them, and 'experience difficulties obtaining referrals and navigating between services'.[398]

340. Similarly, DVA's Mental Health and Wellbeing Services Division was formed in 2021 to 'consolidate, integrate and streamline service delivery, wraparound support, referral, resource management, and governance' across the mental health and wellbeing support services available through DVA.[399] However, a 2023 review found that there was no 'single, identifiable and consistent source of truth' about the services provided, with 'no Service Catalogue articulating the name of each public-facing service, purpose, scope, eligibility, policies, processes and supporting activities'.[400] This contributed to inconsistencies in how staff referred to and understood services internally, and veterans' understanding of the services they were seeking or receiving.[401]

341. The review highlighted the need to improve the visibility of service offerings and 'the need to clarify the scope of the service itself, including eligibility requirements, and the processes involved in accessing the service'.[402] While several internal structural changes occurred in 2023 in response to this review, it is unclear whether or to what extent these changes have contributed to the required improvement in DVA capability.[403]

342. We note that in addition to veterans' lack of knowledge of the services and supports for which they are eligible, numerous other systemic issues affect the quality and availability of physical and mental health care for serving and ex-serving ADF members. These include the dilution of military health expertise, and a lack of military cultural competency among civilian health services. Other barriers include difficulties gaining admission to specialised facilities, and shortages in practitioners with specialised expertise in the treatment of conditions relevant to military personnel, such as PTSD.

343. As the former Secretary of DVA, Major General Cosson (Retd), stated, 'there is certainly more DVA could do in [the health] system to ensure veterans are accessing the support and services which they are eligible to receive'.[404]

344. DVA has also acknowledged that the broader veteran support system is fragmented, and there is a lack of clarity about the differing services, roles and responsibilities of DVA, veterans' organisations, nongovernment organisations and state and territory governments. This negatively impacts ex-serving members and their families seeking easy access to supports.[405]

345. State and territory governments have a critical role in supporting veterans' wellbeing across almost all domains, with responsibility for service systems including health, housing, education, justice, family and community services. Similarly, ex-service organisations (ESOs) provide a broad range of supports and services for ex-serving members and their families, including in the areas of employment, emergency and transitional housing and living assistance, and programs to foster greater social connection. While the diversity of the ESO sector is a strength, the number of different organisations can make a complex landscape even more difficult for veterans to navigate.

346. There is a clear need for more integrated service delivery and improved coordination to enable a more responsive and connected system of care for veterans and their families.

347. To address these shortcomings, we propose that a new executive agency be established in DVA to maintain a dedicated focus on service coordination and veteran wellbeing, and engagement with veterans beyond the claims process. The new executive agency would be responsible for proactively identifying veteran cohorts who are not accessing supports, empowering them to understand their entitlements, and assisting them to navigate the service system to achieve positive wellbeing outcomes. It should be staffed with people with specialist customer service capabilities, and those with knowledge and lived experience of military service.

348. We believe that establishing such an agency with distinctive branding, separate to DVA, would provide a fresh start to build trust among the veteran community, and enable veterans and their families to receive the help and supports they need.

Acknowledgement and apology from Defence leadership

349. The first step towards fixing a problem is to acknowledge that a problem exists. Appearing before the Royal Commission during our final series of public hearings, the most senior leaders in the ADF hierarchy publicly acknowledged the risk factors for suicide and suicidality that arise during ADF service, and apologised for previous failures.

350. In reflecting on learnings from this Royal Commission, the then Chief of Air Force, Air Marshal Robert Chipman AO CSC, stated:

> I think we now clearly understand the nexus between an individual's experience in service, particularly if they experience negative outcomes where they're involuntarily separated or they're a victim of unacceptable behaviour, and their wellbeing after they leave. And if we don't address those issues while they're in service, then it leads to negative outcomes for them once they leave. So it is a service issue. It is absolutely a service issue that we need to address and I think that is something that the Royal Commission has brought light on.[406]

351. The Chief of Navy, Vice Admiral Mark Hammond AO RAN, acknowledged that:

> leadership has been focused on different things … We've been seeing capability as through the lens of platforms and systems, not through the lens of the people that animate it.[407]

352. He rightly stated that this Royal Commission:

> is a once-in-a-generation opportunity to focus on the real capability of the Australian Defence Force, our people, and to build that support system to enable their wellbeing, to support their families to enable their wellbeing and to start reducing the risk factors that lead to suicide in the Australian Defence Force.[408]

353. He also spoke of the importance of normalising mental health challenges while serving, and acknowledged that Defence needs to better support serving members who are experiencing mental health issues. He stated:

> [W]e do have a challenge – we do place our people in challenging, risky and sometimes harrowing environments and it leaves a mark … We've got to find a better pathway to rehabilitate and manage mental health injury. Just an automatic transition or a leaning towards a medical separation is not the answer. It should be the path of last resort.[409]

354. The Chief of Army, Lieutenant General Simon Stuart AO DSC, apologised to members that the ADF had failed. He assured us that Army – and he as its chief – fully owned the problem, stating:

> [A]s the Chief of the Australian Army, past and present, I offer an unreserved and sincere apology to everyone whom we have failed …
>
> [T]o the point that Commissioners are seeking an assurance about ownership, I can give you that assurance. I own this problem, we own this problem and we are committed to doing something about it.[410]

355. Finally, the then Chief of the Defence Force, General Angus Campbell AO DSC, told this Royal Commission:

> Our people deserve and should rightly expect the wellbeing, support and care they need, both during and after their service. I acknowledge that this has not always been the case and has tragically led to the death by suicide of some of our people. I apologise unreservedly for these deficiencies. Defence is committed … to doing better.[411]

Recommendations: Lines of effort

356. Suicide is preventable and a reduction in rates of suicide and suicidality among serving and ex-serving ADF members is possible. Defence's acknowledgement of the problem and commitment to improve is a significant step in the right direction. However, a transformational approach is now required across the 'ecosystem' of agencies and institutions responsible for the health and wellbeing of serving and ex-serving ADF members and their families.

357. A full list of our 122 recommendations is outlined in the following section of this report.

358. Our recommendations are framed around five priority areas representing 'lines of effort' with enabling actions designed to address suicide and suicidality among serving and ex-serving ADF members. They are:

- prevent harm
- intervene early
- improve communication, coordination and collaboration
- build capability and capacity
- strengthen oversight and accountability.

1 Prevent harm

359. The ADF working environment can expose members to extreme physical and psychological stressors, and risk factors for suicide and suicidality. The physical and psychological effects of service are often carried into post-service life. Additionally, the specific stressors associated with separation, transition and post-service life, including accessing support and compensation, can cause and exacerbate suicide risk. While some members feel and exhibit symptoms of psychological distress immediately following exposure to risk factors, others may not experience the effects on their mental health until years later.

360. Many of our recommendations are directed towards harm prevention. These recommendations focus on:

- shifting from a reactive to proactive response to risk
- mitigating the risk factors associated with service and post-service life
- increasing the strength of protective factors against suicide and suicidality
- ensuring that personal wellbeing is prioritised alongside operational readiness and defence capability.

2 Intervene early

361. Numerous barriers prevent serving and ex-serving ADF members from accessing quality care and support that could reduce the severity of physical and mental health conditions, and the likelihood of poor wellbeing outcomes arising in the longer-term.

362. Many of our recommendations are directed towards early intervention and the provision of timely supports tailored to individual needs. They express a vision towards reducing psychological distress, and treating and rehabilitating physical injury with a focus on enabling recovery. These recommendations focus on:

- identifying warning signs for psychological distress at the earliest opportunity
- enabling access to supports across all stages of service and post-service life
- addressing aspects of military culture and institutional barriers to help-seeking that inhibit serving and ex-serving members from accessing support
- supporting the recovery of ill or injured serving members that enables their continued participation in the ADF
- actively monitoring exposure to known risk factors for suicide and suicidality, and periods of heightened risk (such as transition), as well as cohorts known to be at greater risk, including by improving data collection, sharing and trend analysis to inform early intervention efforts.

3 Improve communication, coordination and collaboration

363. Limited collaboration and coordination across the defence and veteran ecosystem has contributed to both duplication and gaps in service delivery, poor continuity of care, problems with case coordination, and challenges for families trying to support and care for their loved ones who are serving or have served in the ADF.

364. Many of our recommendations aim to improve the experience of accessing and receiving supports, and to build cohesion in the system of supports available, including among ex-service organisations. These recommendations focus on:

- improving communication, including by providing updates to serving and ex-serving members and their families when there are delays in administrative processes
- enhancing coordination to enable easy access to services and supports across all relevant domains including health, family, education and employment
- prioritising collaboration to improve visibility, minimise service duplication and achieve streamlined outcomes.

4 Build capability and capacity

365. Existing agencies in the defence and veteran ecosystem are ill-equipped to identify risk, prevent harm and support wellbeing. Additionally, structural and organisational impediments affect their capability and capacity to meet wellbeing needs.

366. Many of our recommendations identify the changes required in Defence and DVA to ensure that care is consistently provided and aligned with best practice. These recommendations focus on:

- building capability among staff and people leaders through training and mentoring to ensure they are equipped to identify and deliver harm prevention, early intervention and holistic, person-centred responses
- building military cultural competency and capacity for care across the health and service system (internal and external to the ADF)
- building the best practice evidence base by designating veteran health and wellbeing as a national priority area for external research and grants funding.

5 Strengthen oversight and accountability

367. There is no comprehensive oversight of the defence and veteran ecosystem and its performance in relation to suicide prevention. As a result, key players have not been held accountable for addressing systemic issues affecting the wellbeing of serving and ex-serving ADF members and their families.

368. Many of our recommendations promote a long-term perspective on suicide prevention, alongside transparency and accountability for improved outcomes. These recommendations focus on:

- strengthening existing governance and accountability mechanisms by introducing additional safeguards in Defence and DVA
- building person-centred performance metrics for leaders of all levels in the ADF, focused on culture and wellbeing
- centralising evaluation and research functions within Defence and DVA to ensure each agency has a coordinated and comprehensive approach to research and evaluation
- establishing a new independent entity with enduring responsibility for monitoring the defence and veteran ecosystem through the lens of suicide prevention.

A stronger defence force

369. This Royal Commission's recommendations seek to build a stronger, more resilient ADF, capable of meeting Australia's future defence challenges.

370. Addressing the entrenched cultural and systemic issues that affect the mental health and wellbeing of military personnel will help bring the ADF into line with the standards, values and expectations of a modern Australian workplace.

371. It will also help address the ADF's recruitment crisis and slow the revolving door of employee turnover, both of which pose a real risk to Australia's current and future defence capability.

372. At a Senate estimates hearing in February 2024, the then Chief of the Defence Force, General Campbell, revealed that the ADF had a shortfall of more than 4,300 personnel, putting the organisation under 'stress'. Additionally, in 2022, the Government announced a plan to increase personnel numbers by 30%, to close to 80,000 personnel by 2040.[412]

373. The link between member wellbeing and defence capability was identified as far back as 2000, with the Defence White Paper highlighting that:

> A key element of retention must be an increased focus on the health, safety and well-being of ADF personnel. This will also maximise their contribution, and hence ADF capability.[413]

374. Louise O'Sullivan, Expert Panel Member for Women Veterans Australia, suggested that the ADF's low recruitment and retention 'is the Australian community saying it's not okay for our veterans to die by suicide'.[414]

375. As a former special forces member outlined in his submission, the perception that military service is not sufficiently recognised and valued can influence people's willingness to enlist and support the Defence mission. He stated:

> The sacrifices of war are great; to lives, families, injuries and mental health. While over the last 20 years I have heard a lot of talk from our leaders at parades and memorial services, what I have seen from their actions is that veterans appear to becoming increasingly less important to the fabric of our society over time …
>
> The nation no longer appears to value what soldiers sacrifice to maintain our way of life, our freedoms and who we are as Australians. In fact, we are openly being crucified in public media and government forums. Who will sign up to defend our country moving forward? Our next wave of soldiers will not want to volunteer. Public perception is so poor, why would they? …
>
> While no one can predict the timeframe, to assume that no young Australian will ever be called on again to sacrifice their life for their country is naïve.[415]

376. At a time of heightened geopolitical risk where the strategic outlook of our region is increasingly uncertain, the ADF needs to be attracting and retaining the best and brightest – the right people, in the right numbers, at the right time. However, to do so, it must once again become an employer of choice and a workplace where people want to enlist and remain in service.

377. To achieve such transformational change, Defence must be receptive to external critique. It must actively address the beliefs and assumptions that have translated into structures, policies and practices that do not protect – and sometimes actively harm – its personnel. Most importantly, it must demonstrate an unwavering commitment to prioritise the health and wellbeing of ADF members. Doing so will not detract from Australia's defence capability, it will make our defence force stronger.

Beyond this Royal Commission

378. In his statement to this Royal Commission, Major General Jeffery Sengelman DSC AM CSC (Retd) described military service as 'based on two covenants'.[416] He explained that:

> One is with society, and it is based on a commitment to recognise and acknowledge the unique nature of military service, including the sacrifice of serving families. The second covenant is between soldiers and their leaders. It is an unwritten bond, and a commitment of accountability and responsibility to each other, the mission, and a pledge to care for the fallen, the wounded and their families.[417]

379. It is in this context that we address the roles of the people of Australia and our political leaders in carrying forward the legacy of this Royal Commission.

Our request of the general public

380. The ADF belongs to this nation and it is in our interests to ensure that our defence force is the strongest it can be.

381. This final report represents a blueprint for the long overdue cultural and system-wide reforms required to improve health and wellbeing outcomes for serving and ex-serving ADF members and their families. However, there is no quick fix to the problems we have identified and reform will take time.

382. We therefore ask you, the Australian public, to maintain an active interest in these issues, to hold government publicly accountable for delivering on our recommendations, and to help ensure that their implementation is properly planned, funded and sustained.

383. Joining the military is not a decision that every Australian would choose to make. However, the service that is undertaken by those who do enlist benefits us all. We therefore owe it to our sailors, soldiers, aviators and their families to ensure that they receive the respect, protection and support they deserve.

384. As the wife of an ex-serving Army member wrote in her submission, to 'understand and show compassion for these servicemen is really crucial. If they think the world has given up on them, they will give up on the world.'[418]

385. Two ex-serving Army members and the wife of a former soldier shared a similar sentiment in their joint submission, asking the public to give serving and ex-serving ADF members 'the sense that their contribution still matters', to make it known that '[t]hey have not been abandoned. That the "leave no man behind" motto can exist in the modern world'.[419]

386. We are all responsible for supporting serving and ex-serving ADF members in our community. We echo the plea of a current serving Army member, who wrote:

> To all: reach out, phone, text, email, [connect through] social media. Even if they don't reciprocate. They need it, and appreciate it, more than you will ever understand.
>
> I'm an Australian Soldier, and not dead – yet.[420]

Our request of our political leaders

387. Whether the work of this Royal Commission succeeds in reducing rates of suicide and suicidality among serving and ex-serving ADF members will depend in large part on the actions taken by government and its agencies: the ADF, the Department of Defence and DVA.

388. As the Deputy Prime Minister and Minister for Defence, the Hon Richard Marles MP, told this Royal Commission during our final public hearings:

> [W]hat is actually going to matter [is] what you recommend and what we ultimately implement. You know, history will be our judge and I just want the families to know that we are deeply mindful that in all that we do, we will not be able to escape the judgement of history and we are utterly focused on making sure that this – your work and our response to it – results in meaningful change.[421]

389. It is imperative that the issues identified in this report are not politicised. Success will take time and will require bipartisan commitment to ensure that the mistakes from the past do not continue into the future.

390. Strong leadership in all levels of government and the military will be required to build confidence among former, current and prospective ADF members and their families that their wellbeing will be prioritised. As General Campbell told this Royal Commission:

> [P]eople join our Defence Force in any of the services to commit to serve their nation and they do it voluntarily and in goodwill and they do it overwhelmingly with great enthusiasm, and I think that they, rightly and reasonably, have an expectation that their leaders will seek to ensure their care and wellbeing and that when they choose to leave the Defence Force, they will be doing so actually better able and better enabled, through the positive experiences of service, to be able to continue to contribute to life and society and community in any way they might choose.
>
> That has not always been the case, and it is the responsibility of leaders at all levels.[422]

391. In reflecting on the qualities of good leadership, we draw on the submission of one of our First Nations veterans, who wrote:

> [I]f there is one shining light I remember it's the voice of a very good and decent Australian Army Officer, my last CO [commanding officer], a Captain at [redacted] in Sydney. He said at times of great need, our history, tradition, legacy, courage, bravery and sacrifice are not what underpinned the values and foundations of an Australian soldier. These are things we do. He said above all else conduct was our foundation because without good conduct the previous was meaningless.[423]

392. History will indeed judge those who are in a position to make a difference at this critical moment. Having reached the conclusion of our inquiry, we send this final message to leaders in the government, military and public service:

393. Your conduct in fulfilling your responsibilities towards our serving and ex-serving ADF members and their families will speak louder than your words. The nation is waiting for you to demonstrate that people genuinely are Defence's 'greatest asset'.[424] The strength and capability of our country's defence force depends on what you do next.

Endnotes

1 Name withheld, Submission, ANON-Z1E7-QM48-H, p [8].
2 The Hon Scott Morrison MP, Prime Minister, the Hon Darren Chester MP, Minister for Veterans' Affairs, Minister for Defence Personnel, and Senator the Hon Michaelia Cash, Attorney-General, Minister for Industrial Relations, *Establishment of a Royal Commission into Defence and Veteran suicide*, media release, 19 April 2021 (Exhibit UU-01.002, DVS.6666.0001.5484).
3 Royal Commission into Defence and Veteran Suicide, *Interim Report*, August 2022.
4 Royal Commission into Defence and Veteran Suicide, *Shining a Light: Stories of Trauma & Tragedy, Hope & Healing*, June 2024.
5 Figures as at June 2023: Department of Defence, *Annual Report 2022–23,* September 2023, p 95, table 6.12 (Exhibit I-01.004, DVS.2222.0001.5087).
6 Exhibit 47-03.008, Hearing Block 6, Department of Defence, Response to Notice to Give, NTG-DEF-037, DEF.9999.0025.0008 at 0090, table 22.
7 Exhibit 101-03.058, Hearing Block 12, 2021 Australian Bureau of Statistics Census – Service with the Australian Defence Force: Census, STU.0000.0004.0219 at 0221.
8 Department of Defence, 'Defence mission', webpage, www.defence.gov.au/about/who-we-are/defence-mission, viewed May 2024 (Exhibit M-01.051, DVS.3333.0001.3489).
9 Transcript, Jeffery Sengelman, Hearing Block 12, 7 March 2024, p 89-8845 [38–44].
10 B Wadham and others, *Mapping Service and Transition to Self-harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, Report, August 2023, p 3 (Exhibit F-01.061, DVS.0011.0001.1192).
11 Exhibit 82-03.017, Hearing Block 11, Department of Defence, Response to Notice to Produce, NTP-DEF-196-01 DEF.1196.0001.1475 at 1489 [2].
12 Transcript, Jonathan Lane, Hearing Block 6, 4 August 2022, p 43-4244 [11–26].
13 Exhibit 101-03.003, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-299-01, Character in the Profession of Arms, DEF.1299.0002.0001 at 0015.
14 E Caspar and others, 'The Effect of Military Training on the Sense of Agency and Outcome Processing', *Nature Communications*, vol 11, 4366, 2020 (Exhibit 101-03.048, Hearing Block 12, STU.0000.0004.0613); H Lieberman and others, 'Female Marine Recruit Training: Mood, Body Composition, and Biochemical Changes', *Medicine and Science in Sports and Exercise*, vol 40, 11, 2008 (Exhibit 101-03.049, Hearing Block 12, STU.0000.0004.0642); A Steadman, 'Neuroscience for Combat Leaders', *Military Review*, May–June, 2011 (Exhibit 101-03.050, Hearing Block 12, STU.0000.0004.0664); H Lieberman and others, 'Positive Effects of Basic Training and Cognitive Performance and Mood of Adult Females', *Human Factors: The Journal of the Human Factors and Ergonomics Society*, vol 56, 6, 2014 (Exhibit 101-03.052, Hearing Block 12, STU.0000.0004.0631).
15 Name withheld, Submission, ANON-Z1E7-QQJC-P, p [2].
16 Transcript, David Johnston, Hearing Block 12, 4 March 2024, p 86-8472 [33–36].
17 Transcript, David Johnston, Hearing Block 12, 4 March 2024, p 86-8472 [14–16].
18 Exhibit 01-04, Hearing Block 1, Nicola Jamieson, Witness Statement, NJA.0000.0001.1200 at 1208.
19 Name withheld, Submission, ANON-Z1E7-QZVZ-2, p [2].
20 Peter Tedman, Submission, ANON-Z1E7-QW8Y-Z, p [2].
21 Alfred John Walsh, Submission, ANON-Z1E7-QMU9-K, p [2].
22 Productivity Commission, *A Better Way to Support Veterans*, No. 93, June 2019, Overview and recommendations, p 4 (Exhibit 01-01.09, Hearing Block 1, INQ.0000.0001.2216).
23 Name withheld, Submission, ANON-Z1E7-QZWW-Z, p [4] of supplementary material.
24 Name withheld, Submission, ANON-Z1E7-QZ7B-B, p [3] of supplementary material.
25 John William Paterson, Submission, ANON-Z1E7-QWV1-P, p [2] of supplementary material.
26 Name withheld, Submission, ANON-Z1E7-QQ7J-A, p [3].
27 Name withheld, Submission, ANON-Z1E7-QWNX-N, p [4] of supplementary material.
28 Name withheld, Submission, ANON-Z1E7-QQUE-3, p [2].
29 Name withheld, Submission, ANON-Z1E7-QZVH-G, pp [5–6] of supplementary material.
30 Name withheld, Submission, ANON-Z1E7-QZVH-G, p [2] of supplementary material.
31 Brendan Stent, Submission, ANON-Z1E7-QZ95-Z, p [1].
32 Name withheld, Submission, ANON-Z1E7-QZDS-9, p [2] of supplementary material.
33 Stephen Windahl, Submission, ANON-Z1E7-QQ4Z-Q, p [1] of supplementary material.

34 Peter Luffman, Ken McGowan and Heather Wuillemin, Submission, ANON-Z1E7-QMAR-R, p [3] of supplementary material.
35 Mark Pepper, Submission, ANON-Z1E7-QZPJ-C, p [2].
36 Name withheld, Submission, ANON-Z1E7-QWC3-5, p [3]; Leah Lawler, Submission, ANON-Z1E7-QWCP-2, p [2].
37 Leah Lawler, Submission, ANON-Z1E7-QWCP-2, p [2].
38 Name withheld, Submission, ANON-Z1E7-QZWU-X, p [9] of supplementary material.
39 Name withheld, Submission, ANON-Z1E7-QZDS-9, p [1] of supplementary material.
40 Name withheld, Submission, ANON-Z1E7-QQZC-6, p [2].
41 Name withheld, Submission, ANON-Z1E7-QZ3B-7, p [15].
42 Transcript, Angus Campbell, Hearing Block 5, 23 June 2022, p 35-3384 [21–23].
43 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, catalogue number PHE 327, 2022, p 58 (Exhibit K-01.123, DVS.2222.0001.3284).
44 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021,* supplementary tables, catalogue number PHE 327, 2022, Table S2.2 (Exhibit 55-01.010, Hearing Block 8, DVS.0008.0001.0356).
45 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985 suicide monitoring 1997 to 2021*, catalogue number PHE 327, 2022, p 11 (Exhibit K-01.123, Hearing Block 8, DVS.2222.0001.3284).
46 Appendix H, Comparative rates of suicide – current serving ADF members.
47 C Meurk and others, *Understanding and enhancing responses to suicide crises involving current serving and ex-serving members of the ADF: A data linkage study*, commissioned by the Royal Commission into Defence and Veteran Suicide, April 2024, p 11 (Exhibit 101-03.023, Hearing Block 12, DVS.0012.0001.2838).
48 C Meurk and others, *Understanding and enhancing responses to suicide crises involving current serving and ex-serving members of the ADF: A data linkage study*, commissioned by the Royal Commission into Defence and Veteran Suicide, April 2024, pp 69–70 (Exhibit 101-03.023, Hearing Block 12, DVS.0012.0001.2838).
49 Appendix I: Comparative rates of suicide – ex-serving ADF members; Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-008, AHW.9999.0005.0001 at Table 1 [C8].
50 Appendix J, Comparative hospital admissions for self-harm and mental health.
51 Appendix J, Comparative hospital admissions for self-harm and mental health.
52 Appendix K, Comparative suicide rates and select causes of death; Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-008, AHW.9999.0005.0001 at Table 1 [C44], [J44].
53 Appendix J, Comparative hospital admissions for self-harm and mental health.
54 Appendix J, Comparative hospital admissions for self-harm and mental health.
55 Appendix K, Comparative suicide rates and select causes of death.
56 Phoenix Australia, University of New South Wales, The University of Sydney, Monash University, *Transition and Wellbeing Research Programme Key Findings Report*, 2019, p 46 (Exhibit 21-01.002, Hearing Block 3, ACS.0001.0001.1492); ABS National Study of Mental Health and Wellbeing: Summary Results, 2020–2022 Lived experience – Suicidal thoughts and behaviours, 2023, Table 9.3 (Exhibit EE-01.012, DVS.3333.0001.6454).
57 E Klonsky and A May, 'The Three-Step Theory (3ST): A New Theory of Suicide Rooted in the "Ideation-to-Action" Framework', *International Journal of Cognitive Therapy*, vol 8, 2, 2015, pp 114, 119 (Exhibit Z-01.024, DVS.3333.0001.6325).
58 T Joiner, *Why People Die by Suicide*, Harvard University Press, 2005, p 136.
59 Transcript, Kairi Kolves, Hearing Block 1, 6 December 2021, p 6-538 [12–13].
60 Exhibit 87-01.013, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-269, *Defence Culture Strategy: Defence Culture Blueprint 2023–2033*, DEF.1269.0003.0024 at 0031.
61 Exhibit F-01.002, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-010-02, *Defence Safety Behaviour and Culture Review: Ethics Documentation*, DEF.1010.0001.8798 at 8803.

62 T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, p 61 (Exhibit L-01.026, DVS.2222.0001.0531); B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp viii–x (Exhibit F-01.061, DVS.0011.0001.1192).
63 A Hocking, 'Preparing for the Future: Key Organisational Lessons from the Afghanistan Campaign', *The Vanguard Occasional Paper Series*, no. 2, March 2022, p 40 (Exhibit 75-02.022, Hearing Block 10, STU.0009.00001.0498).
64 C Orme, Department of Defence, *Beyond Compliance: Professionalism, Trust and Capability in the Australian Profession of Arms, Report of the ADF Personal Conduct Review*, 2011, p 17 [29] (Exhibit 101-01.024, Hearing Block 12, DVS.3333.0001.0390).
65 Transcript, James Connor, Hearing Block 1, 29 November 2021, p 1-85 [22–25].
66 Transcript, James Connor, Hearing Block 1, 29 November 2021, p 1-85 [25–31].
67 Transcript, James Connor, Hearing Block 1, 29 November 2021, p 1-85 [33–36].
68 Transcript, Kate Jenkins, Hearing Block 4, 4 April 2022, p 24-2165 [44–45].
69 Transcript, Kate Jenkins, Hearing Block 4, 4 April 2022, p 24-2165 [35–38].
70 Australian Commission on Safety and Quality in Health Care, *Final Report – Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative analysis of coronial and Defence documents*, November 2021, p 93 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552).
71 Transcript, Elizabeth Broderick, Hearing Block 1, 3 December 2021, p 5-438 [9–21]; C Orme, Department of Defence, *Beyond Compliance: Professionalism, Trust and Capability in the Australian Profession of Arms, Report of the ADF Personal Conduct Review*, 2011, p 17 (Exhibit 101-01.024, Hearing Block 12, DVS.3333.0001.0390).
72 Department of Defence, *Women in the Australian Defence Force 2021–2022: Ten Years in Review*, August 2023, p 59 (Exhibit 73-01.039, Hearing Block 12, DEF.1167.0006.0939).
73 Department of Defence, *Women in the Australian Defence Force 2021-2022: Ten Years in Review*, August 2023, p 1 (Exhibit 73-01.039, Hearing Block 12, DEF.1167.0006.0939).
74 Department of Defence, *Pathway to Change: Evolving Defence Culture*, 2012, p 1 (Exhibit 32-01.059, Hearing Block 5, DEF.1044.0001.0773).
75 Department of Defence, *Pathway to Change: Evolving Defence Culture 2017–2022*, 2017, pp 8–12 (Exhibit 73-01.028, Hearing Block 10, DEF.1011.1000.2986).
76 Nous Group, Department of Defence, *Pathway to Change Review*, December 2023, p 11 (Exhibit 87-01.057, Hearing Block 12, DEF.1356.0001.1038).
77 A Hocking, 'Preparing for the Future: Key Organisational Lessons from the Afghanistan Campaign', *The Vanguard Occasional Paper Series*, no. 2, March 2022, p 40 (Exhibit 75-02.022, Hearing Block 10, STU.0009.00001.0498).
78 Transcript, James Connor, Hearing Block 1, 29 November 2021, p 1-89 [24–25].
79 *Defence Force Discipline Act 1982* (Cth) ss 26, 27.
80 Transcript, Angus Campbell, Hearing Block 5, 24 June 2022, p 36-3446 [25–27].
81 Transcript, Len Roberts-Smith, Hearing Block 5, 29 June 2022, p 39-3756 [38–40].
82 Transcript, Len Roberts-Smith, Hearing Block 5, 29 June 2022, pp 39-3756 [41]–39-3757 [2].
83 Transcript, Len Roberts-Smith, Hearing Block 5, 29 June 2022, p 39-3757 [2–6].
84 Transcript, Kate Jenkins, Hearing Block 4, 4 April 2022, p 24-2164 [14–21].
85 Exhibit O-01.034, Department of Defence, Response to Notice to Produce, NTP-DEF-269-04, Draft Joint Directive, Secretary and CDF: Accountabilities for Culture, DEF.1269.0006.0214 at 0218–0219.
86 Exhibit O-01.034, Department of Defence, Response to Notice to Produce, NTP-DEF-269-04, Draft Joint Directive, Secretary and CDF: Accountabilities for Culture, DEF.1269.0006.0214 at 0035.
87 Exhibit 73-01.014, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-167-03, Enterprise Business Committee, Defence Work Health and Safety Culture and Reporting, 2022/2835, DEF.1167.0009.0001 at 0018.
88 Exhibit 62-01.003, Hearing Block 9, Commander Special Air Service Regiment, Witness Statement, DEF.9999.0080.0080 at 0090.
89 Exhibit 62-01.003, Hearing Block 9, Commander Special Air Service Regiment, Witness Statement, DEF.9999.0080.0080 at 0090.
90 Exhibit O-01.015, Department of Defence, Response to Notice to Produce, NTP-DEF-161, Research Summary Report: Defence Culture Blueprint, DEF.1161.0001.0013 at 0031–0032.

91 Exhibit O-01.025, Department of Defence, Response to Notice to Produce, NTP-ACA-001-02, Afghanistan Inquiry Reform Plan, ACA.1001.0002.1541 at 1571.
92 Exhibit 87-02.013, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-298-01, Decision Brief for Secretary and CDF: Interim Possible Suicide Death Learnings Process, DEF.1298.0001.0001 at 0002.
93 Exhibit 87-01.006, Hearing Block 12, Greg Moriarty, Witness Statement, DEF.9999.0146.0030 at 0056.
94 Transcript, Matthew Yannopoulos, Hearing Block 12, 25 March 2024, p 99-10067 [11–15].
95 Exhibit 86-03.024, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-330-03, Noting Brief for the Secretary and the CDF: Independent Review of Defence Enterprise Committees, DEF.1330.0003.0561 at 0568.
96 Exhibit 86-03.024, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-330-03, Noting Brief for the Secretary and the CDF: Independent Review of Defence Enterprise Committees, DEF.1330.0003.0561 at 0568.
97 Exhibit 86-03.024, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-330-03, Noting Brief for the Secretary and the CDF: Independent Review of Defence Enterprise Committees, DEF.1330.0003.0561 at 0572.
98 Exhibit 65-01.029, Hearing Block 9, Department of Defence, Response to Notice to Produce, NTP-DEF-161, Initiative 1.2 – Evolve the One Defence Accountability Framework: Phase One – Baseline Review Summary Report, DEF.1161.0001.0082 at 0087.
99 Exhibit 101-01.012, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-AGD-001, Defence Culture Evaluation Framework, Deep Dive Two: Final Report, ONC.0000.0001.9167 at 9173.
100 Department of Defence, *First Principles Review, Creating One Defence*, p 14 (Exhibit 35-02.004, Hearing Block 5, EXP.0005.0010.0413); Exhibit 95-01.030, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-151-03, Review of the Defence Accountability Framework, January 2011, DEF.1151.0009.0035 at 0047; Exhibit 101-01.012, Hearing Block 12, The Attorney General's Department, Response to Notice to Produce, NTP-AGD-001, Leadership Accountability: Defence Culture Evaluation Framework Deep Dive Two: Final Report, ONC.0000.0001.9167 at 9171 and 9174.
101 Exhibit 65-01.029, Hearing Block 9, Department of Defence, Response to Notice to Produce, NTP-DEF-161, Initiative 1.2 – Evolve the One Defence Accountability Framework: Phase One – Baseline Review Summary Report, DEF.1161.0001.0082 at 0083.
102 Department of Defence, *First Principles Review, Creating One Defence*, pp 9, 21, 27–29, 40 (Exhibit 35-02.004, Hearing Block 5, EXP.0005.0010.0413).
103 Department of Defence, *First Principles Review, Creating One Defence*, p 14 (Exhibit 35-02.004, Hearing Block 5, EXP.0005.0010.0413).
104 Transcript, Richard Marles, Hearing Block 12, 7 March 2024, p 89-8892 [4–20]; Department of Defence, *National Defence Strategy*, 2024, p 33 (Exhibit R-01.026, DVS.4444.0001.0108); The Hon Richard Marles MP, Deputy Prime Minister, Minister for Defence, The Hon Matt Keogh MP, Minister for Defence Personnel, Minister for Veterans' Affairs, The Hon Matt Thistlethwaite MP, Assistant Minister for Defence, Assistant Minister for Veterans' Affairs, Assistant Minister for the Republic, *Albanese Government invests in our future Defence Force*, media release, 2 May 2023 (Exhibit 90-03.022, Hearing Block 12, DEF.1233.0003.0126).
105 Department of Defence, *First Principles Review, Creating One Defence*, p 5 (Exhibit 35-02.004, Hearing Block 5, EXP.0005.0010.0413).
106 Exhibit 87-01.015, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-269-01, How One Defence Works, July 2023, DEF.1296.0001.0008 at 0013.
107 Exhibit 87-01.015, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-269-01, How One Defence Works, July 2023, DEF.1296.0001.0008 at 0025.
108 Exhibit 97.02.015, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-399-02, ADF Health Strategy: Ready, Responsive, Resilient, 2023, DEF.1399.0001.0029; Exhibit P-01.012, The Australian Human Rights Commission, Response to Notice to Produce, NTP-AHR-002-02, Defence Enterprise Culture Strategy (Draft), AHR.0001.0002.0225; Exhibit 73-01.065, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-233A-02, Foundation for the Next Mental Health and Wellbeing Strategy, Summary Presentation, June 2023, DEF.1233.0002.0308; Exhibit P-01.013, Department of Defence, Response to Notice to Produce, NTP-DEF-221, Draft Defence Work, Health & Safety Strategy 2023–2028 Draft, June 2023, DEF.1221.0001.1055;

Exhibit P-01.008, Department of Defence, Response to Notice to Produce, NTP-DEF-246, Royal Commission into Defence and Veteran Suicide Interim Implementation and Reform Strategy, Version 2.0. Final, DEF.1246.0001.0019 at 0026; Exhibit 96-01.014, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-380, Defence Audit and Risk Committee 15 February 2024 – Update on Defence Workforce Planning and Strategy, DEF.1380.0001.0001; Exhibit P-01.014, Department of Defence, Response to Notice to Produce, NTP-DEF-376, Defence and Veteran Mental Health and Wellbeing Strategy 2024–2029, Consultation Draft, December 2023, DEF.1376.0001.1669.

109 Australian Institute of Health and Welfare, 'Suicide & self-harm monitoring data', webpage, last updated 24 October 2023, www.aihw.gov.au/suicide-self-harm-monitoring/data/suicide-self-harm-monitoring-data, viewed 29 November 2023 (Exhibit K-01.131, DVS.2222.0001.3468); Exhibit 73-01.051, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-197A-04, Defence Data Strategy 2021–2023, DEF.1197.0004.0290 at 0328; Exhibit 75-04.007, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-136, Enterprise Data Quality Framework Interim Guidance, DEF.1136.0001.0913 at 0916.

110 A Flego and others, *Suicide and self-harm monitoring of the serving and ex-serving Australian Defence Force member population – Part 1: The data landscape and short-term opportunities*, commissioned by the Royal Commission into Defence and Veteran Suicide, June 2022, p 12 (Exhibit D-01.040, DVS.0000.0001.6527); World Health Organization, *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm*, 2016, p 54 (Exhibit B-01.025, STU.0006.0001.3596).

111 Transcript, Matthew Yannopoulos, Hearing Block 12, 5 March 2024, p 87-8551 [14–17].

112 Exhibit 28-03.02, Hearing Block 4, Department of Defence, Response to Notice to Produce, NTP-DEF-001, Interim Report on the Suicide Prevention Program Monitoring and Evaluation Framework and Plan, Part B: Confidential Position Paper, March 2021, DEF.0001.0008.0073 at 0090–0091.

113 Exhibit K-01.060, Department of Defence, Response to Notice to Produce, NTP-DEF-200A, Defence Data Operating Model and Blueprint, Executive Overview, February 2023, DEF.1200.0001.0012 at 0034–0035.

114 Exhibit 98-02.001, Hearing Block 12, Simon Stuart, Witness Statement, SST.1001.0001.0001 at 0007 [24].

115 Exhibit 75-04.016, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-136, Draft Enterprise Data Maturity Assessment, Insights Report, DEF.1136.0001.0081 at 0102.

116 Nous Group, Department of Defence, Pathway to Change Review, December 2023, p 9 (Exhibit 87-01.057, Hearing Block 12, DEF.1356.0001.1038); Exhibit 75-04.016, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-136, Draft Enterprise Data Maturity Assessment, Insights Report, DEF.1136.0001.0081 at 0102–0103, 0107.

117 Exhibit 28-03.001, Hearing Block 4, Department of Defence, Response to Notice to Produce, NTP-DEF-001, Interim report on the Suicide Prevention Program Monitoring and Evaluation Framework and Plan – Part A: Interim Report, March 2021, DEF.0001.0003.0050 at 0067.

118 Exhibit 75-04.016, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-136, Draft Enterprise Data Maturity Assessment, Insights Report, DEF.1136.0001.0081 at 0102, 0129.

119 Exhibit 75-04.016, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-136, Draft Enterprise Data Maturity Assessment, Insights Report, DEF.1136.0001.0081 at 0132.

120 Exhibit 73-01.005, Hearing Block 10, Department of Defence, Response to Notice to Give, NTG-DEF-097B, DEF.9999.0069.0001 at 0009 [35].

121 Exhibit L-01.009, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-001, DVA.9999.0001.0001 at 0027 [5.4].

122 Exhibit L-01.009, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-001, DVA.9999.0001.0001 at 0005 [1.26].

123 Exhibit L-01.009, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-001, DVA.9999.0001.0001 at 0004 [1.24].

124 Exhibit 18-02.002, Hearing Block 3, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-001, AHW.9999.0001.0001 at 0022; Exhibit K-01.028, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-052A, DVA.9999.0057.0001 at 0015 [7.3.19].

125 Transcript, Jennifer Wild, Hearing Block 12, 21 March 2024, p 97-9807 [16–18].
126 Transcript, Angus Campbell, Hearing Block 12, 28 March 2024, p 101-10353 [31–33].
127 Transcript, Robert Chipman, Hearing Block 12, 13 March 2024, p 91-9112 [4–11].
128 Exhibit 68-02.001, Hearing Block 10, Department of Defence, Response to Notice to Give, NTG-DEF-124, DEF.9999.0096.0001 at 0004 [1].
129 Exhibit 48-02.002, Hearing Block 6, Department of Defence, Response to Notice to Give, NTG-DEF-065, DEF.9999.0032.0057 at 0058 [3–6], 0059 [9].
130 K Jones and others, *Defence Force and Veteran Suicides: Literature Review*, Phoenix Australia, July 2020, pp 41, 45 (Exhibit 08-06.017, Hearing Block 1, EXP.0001.0015.0004).
131 N Kerr and others, 'The "Transition" to Civilian Life From the Perspective of Former Serving Australian Defence Force Members', *Journal of Veterans Studies*, vol 9, 1, 2023, pp 132–134 (Exhibit L-01.105, DVS.2222.0001.4848).
132 Transcript, Angela Maguire, Hearing Block 4, 12 April 2022, pp 29-2674 [44]–29-2675 [10].
133 Name withheld, Submission, ANON-Z1E7-Q1X2-K, p [2].
134 Name withheld, Submission, ANON-Z1E7-QZ4P-P, p [2].
135 Name withheld, Submission, ANON-Z1E7-QZ4P-P, p [2].
136 Exhibit 68-02.001, Hearing Block 10, Department of Defence, Response to Notice to Give, NTG-DEF-124, DEF.9999.0096.0001 at 0025 [102].
137 Exhibit 68-02.004, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-220-02, Military Personnel Policy Manual, DEF.1220.0002.0001 at 0444 [1.6]; Exhibit 68-02.005, Hearing Block 10, Department of Defence, Response to Notice to Produce, NTP-DEF-164-03, ADF Philosophical Doctrine – Personnel, DEF.1164.0006.0013 at 0073 [4.38]; Exhibit 68-02.001, Department of Defence, Response to Notice to Give, NTG-DEF-124, DEF.9999.0096.0001 at 0029 [114], 0031 [120] and 0033 [129–139].
138 Name withheld, Submission, ANON-Z1E7-QZ4P-P, p [2].
139 Name withheld, Submission, ANON-Z1E7-QW92-T, p [2].
140 Name withheld, Submission, ANON-Z1E7-QZ55-V, p [2] of supplementary material.
141 Name withheld, Submission, ANON-Z1E7-Q1UJ-8, p [2].
142 J Hughes and others, Australian Institute of Family Studies, *Strengthening Defence and veteran couple relationships through relationship education*, Final report, September 2023, pp 1–2 (Exhibit L-01.007, DVS.2222.0001.0414).
143 Transcript, Andrea Phelps, Hearing Block 1, 8 December 2021, p 8-769 [25–28]; Exhibit 87-02.040, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-289, Analysis of IGADF Inquiry Report regarding ADF member suicides (June 2016 - June 2022): Supplementary analysis of relationship breakdowns as a contributing factor, DEF.1289.0001.0001 at 0003.
144 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2020*, 2022, p vi (Exhibit 69-03.022, Hearing Block 10, DEF.1167.0004.0136).
145 Mark Direen, Submission, ANON-Z1E7-QQ4P-D, p [6].
146 Exhibit 72-02.003, Hearing Block 10, Department of Defence, Response to Notice to Give, NTG-DEF-154B, DEF.9999.0102.0001 at 0012 [24].
147 Relationships Australia, Submission, ANON-Z1E7-QXMP-D, p [2].
148 Name withheld, Submission, ANON-Z1E7-QM7A-W, p [6] of supplementary material; Name withheld, Submission, ANON-Z1E7-QM64-F, p [2]; Name withheld, Submission, ANON-Z1E7-QMEZ-4, pp [1–2] of supplementary material; Name withheld, Submission, ANON-Z1E7-QM2D-U, p [2]; Name withheld, Submission, ANON-Z1E7-QMD1-T, pp [6–11] of supplementary material.
149 Name withheld, Submission, ANON-Z1E7-QM71-D, p [3]; Name withheld, Submission, ANON-Z1E7-QME8-2, p [11]; Paul Forrest, Submission, ANON-Z1E7-QZ9D-F, pp [1–6] of supplementary material; Name withheld, Submission, ANON-Z1E7-QEUD-P, pp [2–4]; Andira Kauer, Submission, ANON-Z1E7-QQ27-J, p [2].
150 Name withheld, Submission, ANON-Z1E7-QQ52-G, pp [15–27]; Jason Colquhoun, Submission, ANON-Z1E7-QWKW-H, p [2]; Name withheld, Submission, ANON-Z1E7-Q198-T, pp [2–3]; Name withheld, Submission, ANON-Z1E7-QM2D-U, p [2]; Name withheld, Submission, ANON-Z1E7-QZSE-A, pp [1-2] of supplementary material.

151 Name withheld, Submission, ANON-Z1E7-QMHJ-Q, p [45] of supplementary material; Name withheld, Submission, ANON-Z1E7-QZME-4, pp [24–25] of supplementary material; Name withheld, Submission, ANON-Z1E7-QMD1-T, p [3] of supplementary material; Transcript, Simon Marshall, Hearing Block 1, 8 December 2021, p 8-711 [1–3]; Helen King, Submission, ANON-Z1E7-QQ4U-J, p [20].
152 Rebecca Harris, Submission, ANON-Z1E7-Q1SS-F, p [2].
153 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 47 (Exhibit F-01.061, DVS.0011.0001.1192).
154 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 5 (Exhibit F-01.061, DVS.0011.0001.1192).
155 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, p 147 [5.5] (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584).
156 Exhibit 24-02.001, Hearing Block 4, Lara Gunn, Witness Statement, EXP.0004.0015.0023 at 0032 [13.1]; Exhibit 38-01.001, Hearing Block 5, Leonard Roberts-Smith, Response to Notice to Give, NTG-LRS-001, LRS.0001.0001.0001 at 0018–0020; G Rumble and others, *Report of the Review of allegations of sexual and other abuse in Defence: Facing the problems of the past*, General findings and recommendations, October 2011, vol 1, pp 122–125 (Exhibit 17-03.017, Hearing Block 3, EXP.0003.0010.0319); Defence Abuse Response Taskforce, *Report on Abuse in Defence*, Progress Report, November 2014, pp 351–352 (Exhibit 26-02.006, Hearing Block 4, EXP.0004.0010.0009); Inspector-General of the Australian Defence Force, *Own Initiative Inquiry: Implementation of Military Justice Arrangements for Dealing with Sexual Misconduct in the Australian Defence Force*, December 2021, pp 60–61 (Exhibit 24-01.040, Hearing Block 4, KJE.0000.0001.1390); Exhibit 101-03.128, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-270, DEF.9999.0182.0001 at 0006–0007.
157 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 67 (Exhibit F-01.061, DVS.0011.0001.1192).
158 Appendix L, Defence Survey Data.
159 Angela McKay, Submission, ANON-Z1E7-QME7-1, p [1] of supplementary material.
160 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p viii (Exhibit F-01.061, DVS.0011.0001.1192).
161 Department of Defence, *Women in the Australian Defence Force (ADF), 2021–2022, Ten Years in Review*, November 2022, p 64 (Exhibit 73-01.039, Hearing Block 10, DEF.1167.0006.0939).
162 Exhibit W-01.002, Department of Defence, Response to Notice to Give, NTG-DEF-213B, DEF.9999.0151.0059 at 0061.
163 Transcript, Matthew Yannopoulos, Hearing Block 12, 5 March 2024, pp 87-8565 [33]–87-8566 [6].
164 Exhibit 86-03.006A, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-213C-1, DEF.9999.0165.0001 at 0002 [2].
165 Name withheld, Submission, ANON-Z1E7-QWRT-N, p [2].
166 Name withheld, Submission, ANON-Z1E7-Q9JE-Z, p [2].
167 Name withheld, Submission, ANON-Z1E7-QWFS-8, p [3] of supplementary material; Name withheld, Submission, ANON-Z1E7-Q8JJ-4, p [2].
168 Name withheld, Submission, ANON-Z1E7-Q1YQ-K, p [2].
169 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p viii (Exhibit F-01.061, DVS.0011.0001.1192).
170 T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, pp 59–60 (Exhibit L-01.026, DVS.2222.0001.0531); Transcript, Megan MacKenzie, Hearing Block 3, 8 March 2022, pp 17-1501 [33]–17-1502 [10]; R Kimerling and others, 'Military Sexual Trauma and Suicide Mortality', *American Journal of Preventive Medicine*, vol 50, 6, 2016 (Exhibit 17-03.24, Hearing Block 3, EXP.0003.0010.0291).

171 K Carra and others, 'Service and demographic factors, health, trauma exposure, and participation are associated with adjustments for former Australian Defence Force members', *Military Psychology*, vol 5, 35, 2023, p 487 (Exhibit F-04.110, DVS.1111.0001.4385).
172 Name withheld, Submission, ANON-Z1E7-QWFS-8, pp [2–3] of supplementary material.
173 Name withheld, Submission, ANON-Z1E7-QWRT-N, p [2].
174 Exhibit 35-02.002, Hearing Block 5, Angus Campbell, Witness Statement, DEF.9999.0011.0344 at 0452 [415].
175 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0145–0146; *Defence Force Discipline Act 1982* (Cth) ss 15–62.
176 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0146–0147.
177 Exhibit 78-02.005, Hearing Block 11, Department of Defence, Response to Notice to Produce, NTP-DEF-024, Commanders' Guide to Discipline, September 2020, DEF.1024.0001.3876 at 3882.
178 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0146 [44]; Exhibit 78-02.005, Hearing Block 11, Department of Defence, Response to Notice to Produce, NTP-DEF-024, Commanders' Guide to Discipline, September 2020, DEF.1024.0001.3876 at 3882.
179 M Clemente and D Padilla-Racero, 'The effects of the justice system on mental health,' *Psychiatry, Psychology and Law*, vol 27, 5, 2020, p 879 (Exhibit F-03.008, DVS.1111.0001.4812).
180 M Clemente and D Padilla-Racero, 'The effects of the justice system on mental health,' *Psychiatry, Psychology and Law,* 2020, vol 27, 5, 2020, p 879 (Exhibit F-03.008, DVS.1111.0001.4812).
181 Exhibit 86-03.014, Hearing Block 12, Inspector-General of the ADF, Response to Notice to Produce, NTP-IGD-037, Minutes of meeting 04/2022 of the Military Justice Steering Group, November 2022, IGD.0032.0001.0001 at 0004.
182 Exhibit 86-03.014, Hearing Block 12, Inspector-General of the ADF, Response to Notice to Produce, NTP-IGD-037, Minutes of meeting 04/2022 of the Military Justice Steering Group, November 2022, IGD.0032.0001.0001 at 0004.
183 Exhibit 101-01.028, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-316, Chiefs of Service Committee, Agendum 2021/558 – Military Justice System Update, September 2022, DEF.1316.0001.0032 at 0035 [20].
184 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 48 (Exhibit F-01.061, DVS.0011.0001.1192).
185 G Rumble and others, *Report of the Review of allegations of sexual and other abuse in Defence: Facing the problems of the past*, October 2011, vol 1, pp xxxi, 106 (Exhibit 17-03.017, Hearing Block 3, EXP.0003.0010.0319).
186 Exhibit F-03.002, Department of Defence, Response to Notice to Produce, NTP-DEF-021, Good decision-making in Defence: A guide for decision-makers and those who brief them, DEF.1005.0001.2294 at 2320; Exhibit 35-02.027, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0181 at 0211, 0221–0222.
187 GAP Veteran and Legal Services, Submission, ANON-Z1E7-Q8YA-A, pp [11, 18–19] of supplementary material.
188 Exhibit 82-02.009, Hearing Block 11, Department of Defence, Response to Notice to Produce, NTP-IGD-010, Issues identified in IGADF Inquiries concerning the conduct of Inquiries: 2020–2022, IGD.0007.0012.0008 at 0008.
189 Exhibit 01-03.091, IDI Hearing, Department of Defence, Response to Notice to Produce, NTP-DEF-052-02, Administrative Inquiries Manual, Edition 3, July 2022, DEF.1052.0003.0592 at 0649.
190 Inspector-General of the Australian Defence Force, *Inspector-General of the Australian Defence Force Annual Report, 1 July 2019–30 June 2020*, 2020, p 18 (Exhibit 79-02.059, Hearing Block 11, EXP.0011.0001.0037); Inspector-General of the Australian Defence Force, *Inspector-General of the Australian Defence Force Annual Report, 1 July 2020–30 June 2021*, 2021, p 17 (Exhibit 79-02.061, Hearing Block 11, EXP.0011.0001.0077); Inspector-General of the Australian Defence Force, *Inspector-General of the Australian Defence Force, Annual Report, 1 July 2021–30 June 2022*, 2022, p 18 (Exhibit 79-02.062, Hearing Block 11,

EXP.0011.0001.0001); Inspector-General of the Australian Defence Force, *Inspector-General of the Australian Defence Force, Annual Report, 01 July 2022–30 June 2023*, 2023, p 21 (Exhibit P-01.057, DVS.0000.0001.9977).

191 Transcript, Nikki Coleman, Hearing Block 11, 29 August 2023, p 77-7448 [17–19].

192 Inspector-General of the Australian Defence Force, *Own Initiative Inquiry: Implementation of Military Justice Arrangements for Dealing with Sexual Misconduct in the Australian Defence Force*, December 2021, p v [34].

193 PFLR-18.2 (Military Justice, Commonwealth Response), PFL.0007.0002.0245 at 0263.

194 Exhibit 86-03.019, Hearing Block 12, Response to Notice to Produce, NTP-DJO-001-02, VCDF to CPERS Handover Takeover Pack Military Justice Accountable Officer, DJO.1001.0002.0001 at 0008 [55].

195 Transcript, David Johnston, Hearing Block 12, 4 March 2024, pp 86-8511 [44]–86-8512 [2].

196 Exhibit H-01.003, Department of Defence, Response to Notice to Produce, NTP-DEF-234-01, Department of Defence, Military Justice Steering Group 2/23 paper – Workstream 1: Assurance, DEF.1234.0001.0085 at 0087.

197 Exhibit 78-02.005, Hearing Block 11, *Commanders' Guide to Discipline,* 2nd Edition, September 2020, DEF.1024.0001.3876 at 3882.

198 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p x (Exhibit F-01.061, DVS.0011.0001.1192).

199 B Wadham and others, *Research into Defence Abuse 2018-2022*, Flinders University, ORAMA Institute, Open Door, October 2021, pp 2–3 (Exhibit 01-02.006, Hearing Block 1, EXP.0001.0012.0041).

200 Phoenix Australia, *Wellness Action through Checking Health*, WATCH Project Report, 2022, p 4 (Exhibit F-03.006, DEF.1155.0003.0542); *Defence Force Discipline Act 1982* (Cth).

201 Exhibit 86-03.005, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-183, DEF.9999.0158.0051 at 0052 [2].

202 Exhibit QQ-01.003, Joshua Clifford, Witness Statement, DEF.9999.0194.0001 at 0044 [121–122].

203 Kathleen Moore, Submission, ANON-Z1E7-QZ4C-9, p [7] of supplementary material; Allan Warren, Submission, ANON-Z1E7-QZR2-P, pp [4–6] of supplementary material.

204 Transcript, Patrick Keane, Hearing Block 11, 7 September 2023, pp 84-8243 [10]–84-8244 [7].

205 Transcript, Kahlil Fegan, Hearing Block 5, 20 June 2022, p 32-3053 [6–9].

206 Name withheld, Submission, ANON-Z1E7-QZVM-N, pp [2–4].

207 Exhibit 86-03.006, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-237, DEF.9999.0173.0001 at 0040 [148].

208 *Defence Regulation 2016* (Cth) s 24(c).

209 Exhibit 78-02.001, Hearing Block 11, Department of Defence, Response to Notice to Give, NTG-DEF-016, DEF.9999.0103.0123 at 0145.

210 Exhibit 78-02.001, Hearing Block 11, Department of Defence, Response to Notice to Give, NTG-DEF-016, DEF.9999.0103.0123 at 0145–0146.

211 Transcript, Douglas Humphreys, Hearing Block 11, 29 August 2023, p 77-7424 [1–2].

212 Transcript, Douglas Humphreys, Hearing Block 11, 29 August 2023, p 77-7427 [39].

213 Appendix K, Comparative suicide rates and select causes of death; Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-008, AHW.9999.0005.0001, Table 3.

214 Appendix K, Comparative suicide rates and select causes of death.

215 Pauline Collins, Submission, ANON-Z1E7-QWCC-N, p [4].

216 Exhibit 78-02.001, Hearing Block 11, Department of Defence, Response to Notice to Give, NTG-DEF-016, DEF.9999.0103.0123 at 0139.

217 Pauline Collins, Submission, ANON-Z1E7-QWCC-N, p [5].

218 Name withheld, Submission, ANON-Z1E7-QZ8C-D, p [3].

219 Exhibit 86-03.019, Hearing Block 12, Response to Notice to Produce, NTP-DJO-001-02, VCDF to CPERS Handover Takeover Pack Military Justice Accountable Officer, DJO.1001.0002.0001 at 0220 [12(c)].

220 Australian Commission on Safety and Quality in Healthcare, *Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative analysis of coronial and Defence documents*, November 2021, p 100 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552).

221 B Litz and others, 'Moral injury and moral repair in war veterans: A preliminary model and intervention strategy', *Clinical Psychology Review*, vol 29, 2009, pp 697, 700 (Exhibit 04-02.005, Hearing Block 1, EXP.0001.0022.0263).
222 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 52 (Exhibit F-01.061, DVS.0011.0001.1192).
223 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 52 (Exhibit F-01.061, DVS.0011.0001.1192).
224 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 50 (Exhibit F-01.061, DVS.0011.0001.1192).
225 As cited in Patrick Lindsay, Submission, ANON-Z1E7-QEX7-C, p [15] of supplementary material.
226 Transcript, Nikki Jamieson, Hearing Block 1, 2 December 2021, p 4-358 [12–24].
227 Caroline Hofman, Submission, ANON-Z1E7-QXDN-2, p [5].
228 Transcript, Jacqueline Drew, Hearing Block 10, 19 July 2023, p 70-6757 [14–17].
229 Transcript, Jacqueline Drew, Hearing Block 10, 19 July 2023, p 70-6757 [21–22].
230 Transcript, Jacqueline Drew, Hearing Block 10, 19 July 2023, p 70-6757 [27–32].
231 Exhibit G-01.001, Chrystina Stanford, Witness Statement, DVS.2222.0001.0314 at 0324.
232 Exhibit G-01.001, Chrystina Stanford, Witness Statement, DVS.2222.0001.0314 at 0323.
233 L Monteith and others, 'Perceptions of institutional betrayal predict suicidal self-directed violence among veterans exposed to military sexual trauma', *Journal of Clinical Psychology*, vol 72, 7, 2016, pp 8–11 (Exhibit 01-05.008, Hearing Block 1, EXP.0001.0020.0160).
234 Transcript, Nikki Jamieson, Hearing Block 1, 2 December 2021, p 4-351 [2–5].
235 Transcript, Nikki Jamieson, Hearing Block 1, 2 December 2021, pp 4-356 [47]–4-357 [1].
236 Transcript, Nikki Jamieson, Hearing Block 1, 29 November 2021, pp 1-52 [39–47], 1-54 [38–43].
237 Name withheld, Submission, ANON-Z1E7-QZ22-P, p [2].
238 Name withheld, Submission, ANON-Z1E7-QQZ8-U, p [2].
239 Name withheld, Submission, ANON-Z1E7-QQ65-M, p [2].
240 Name withheld, Submission, ANON-Z1E7-Q1V9-R, p [2].
241 Madonna Paul, Submission, ANON-Z1E7-QMSE-W, p [1] of supplementary material.
242 Name withheld, Submission, ANON-Z1E7-Q17Q-H, p [2].
243 Department of Defence, Department of Veterans' Affairs, *Impact of Combat Summary Report*, Transition and Wellbeing Research Programme Impact of Combat Study, 2019, p viii (Exhibit 20-03.053, Hearing Block 3, DEF.0001.0001.5892); J Belding and others, 'The Millennium Cohort Study: The first 20 years of research dedicated to understanding the long-term health of US Service Members and Veterans', *Annals of Epidemiology*, vol 67, 2022, pp 63–66 (Exhibit 75-02.043, Hearing Block 10,STU.0000.0002.7713).
244 J Belding and others, 'The Millennium Cohort Study: The first 20 years of research dedicated to understanding the long-term health of US Service Members and Veterans', *Annals of Epidemiology*, vol 67, 2022, p 63 (Exhibit 75-02.043, Hearing Block 10, STU.0000.0002.7713).
245 M Van Hooff and others, *Transition and Wellbeing Research Programme Key Findings Report*, Department of Defence and Department of Veterans' Affairs, 2019, p 46 (Exhibit 20-03.056, Hearing Block 3, DEF.1029.0002.0066).
246 T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, pp 30–31 (Exhibit L-01.026, DVS.2222.0001.0531); M Van Hooff and others, *Transition and Wellbeing Research Programme Key Findings Report*, Department of Defence and Department of Veterans' Affairs, 2019, p 46 (Exhibit 20-03.056, Hearing Block 3, DEF.1029.0002.0066); J Belding and others, 'The Millennium Cohort Study: The first 20 years of research dedicated to understanding the long-term health of US Service Members and Veterans', *Annals of Epidemiology*, vol 67, 2022, pp 63–67 (Exhibit 75-02.043, Hearing Block 10, STU.0000.0002.7713).
247 Mark Direen, Submission, ANON-Z1E7-QQ4P-D, p [6].
248 Melanie Pike, Submission, ANON-Z1E7-QQN2-9, p [3].
249 Exhibit 87-01.001, Hearing Block 12, Matthew Yannopoulos, Witness Statement, DEF.9999.0151.0202 at 0212 [42]; Exhibit 49-01.016, Department of Defence, Response to

Notice to Produce, NTP-DEF-061-02, Recruiting and Retention Tiger Team, Final Report, September 2022 DEF.1061.0003.0027 at 0027; Transcript, Duncan Hayward, Hearing Block 7, 19 October 2022, pp 49-4739 [35]–49-4740 [18].

250 Exhibit 87-01.001, Hearing Block 12, Matt Yannopoulos, Witness Statement, DEF.9999.0151.0202 at 0212 [42].

251 Exhibit 90-06.035, Hearing Block 12, Mark Hammond, Witness Statement, MHM.0001.0001.0001 at 0065 [295]; Exhibit 98-02.001, Hearing Block 12, Simon Stuart, Witness Statement, SST.1001.0001.0001 at 0042 [201]; Exhibit 91-02.002, Hearing Block 12, Robert Chipman, Witness Statement, ROC.0001.0001.0001 at 0024 [128–129].

252 Transcript, Duncan Hayward, Hearing Block 7, 19 October 2022, p 49-4740 [4–5].

253 D Oh and others, 'Examining the links between burnout and suicidal ideation in diverse occupations', *Frontiers in Public Health*, vol 11, 2023, p 3 (Exhibit 90-03.024, Hearing Block 12, DVS.0012.0001.1479); Transcript, Gordon Parker, Hearing Block 10, 20 July 2023, p 71-6911 [1–25].

254 Exhibit 90-03.026, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-344-02, Preliminary Insights – Review of the Defence Workforce Fatigue Management Approach, IGADF Afghanistan Inquiry Reform Program, DEF.1344.0003.0080 at 0084 [6].

255 Exhibit 90-03.026, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-344-02, Preliminary Insights – Review of the Defence Workforce Fatigue Management Approach, IGADF Afghanistan Inquiry Reform Program, DEF.1344.0003.0080 at 0084 [7].

256 Name withheld, Submission, ANON-Z1E7-Q8XK-K, p [2].

257 Name withheld, Submission, ANON-Z1E7-QM48-H, p [4].

258 Name withheld, Submission, ANON-Z1E7-QWRK-C, pp [2–3].

259 Exhibit 39-02.049, Hearing Block 5, Department of Defence, Response to Notice to Produce, Defence Health Manual, Volume 2, Part 6, Military Employment Classification System, DEF.1413.0001.0093 at 0093 [2.2].

260 Exhibit L-01.018, Department of Defence, Response to Notice to Produce, NTP-DEF-233A-02, Military Personnel Policy Manual, Part 3, Chapter 2, Australian Defence Force Military Employment Classification System, DEF.1233.0003.0130 at 0324 [2.21–2.22].

261 Exhibit 39-02.049, Hearing Block 5, Department of Defence, Response to Notice to Produce, Defence Health Manual, Volume 2, Part 6, Military Employment Classification System, DEF.1413.0001.0093 at 0093 [2.2].

262 Appendix K, Comparative suicide rates and select causes of death.

263 Appendix K, Comparative suicide rates and select causes of death.

264 Department of Defence, Department of Veterans Affairs, *Transition and Wellbeing Research Programme Mental Health*, Wellbeing Transition Study, 2018, p vii (Exhibit 20-03.043, Hearing Block 3, DEF.0001.0001.0145); Exhibit V-01.004, Department of Veterans' Affairs, Response to Notice to Produce, NTP-DVA-001, Australian Housing and Urban Research Institute – Homelessness amongst Australian veterans: Summary of project findings, May 2019, DVA.0001.0001.1623 at 1666; Department of Defence, Department of Veterans' Affairs, *Mental Health and Wellbeing Transition Study Physical Health Statu*s, Transition and Wellbeing Research Programme, 2018, p 165 (Exhibit 20-03.044, Hearing Block 3, DEF.0001.0001.4178); N Kerr and others, 'The "Transition" to Civilian Life from the Perspective of Former Serving Australian Defence Force Members', *Journal of Veterans Studies*, vol 9, 1, 2023, p 134 (Exhibit L-01.105, DVS.2222.0001.4848); Australian Commission of Safety and Quality in Health Care, *Final Report: Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative analysis of coronial and Defence documents*, November 2021 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552).

265 Exhibit 96-01.013, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-255, DEF.9999.0164.0034 at Tables 12.5, 12.6, 12.7.

266 Transcript, Rodney Pope, Hearing Block 10, 18 July 2023, p 69-6685 [5–6].

267 Exhibit 55-01.005, Hearing Block 8, Glenn Ryan, Witness Statement, DEF.9999.0022.0001 at 0112.

268 Department of Defence, *Department of Defence Annual Report 2018–19*, 2019, p 113(Exhibit P-01.051, DVS.0000.0002.0021); Department of Defence, *Department of Defence Annual Report 2019–20*, 2020, p 139 (Exhibit P-01.052, DVS.0000.0002.0306); Department of Defence, *Department of Defence Annual Report 2020–21*, 2021, p 136 (Exhibit P-01.053,

ACA.1001.0005.0662); Department of Defence, *Defence Annual Report 2021–22*, 2022, p 138 (Exhibit 69-03.017, Hearing Block 10, DEF.1151.0005.0032); Department of Defence, *Defence Annual Report 2022–23*, 2023, p 109 (Exhibit I-01.004, DVS.2222.0001.5087).

269 Name withheld, Submission, ANON-Z1E7-QZ2Q-N, pp [13–15].

270 Siu Ping Wong, Submission, ANON-Z1E7-QZ2M-H, p [16] of supplementary material.

271 Australian Government, *National Defence: Defence Strategic Review*, 2023, p 7 (Exhibit 63-02.002, Hearing Block 9, SSH.1001.0002.0186).

272 Exhibit 40-05.010, Hearing Block 5, Angus Campbell, Witness Statement, DEF.9999.0011.0344_R at 0432 [313].

273 Exhibit F-01.017, Department of Defence, Response to Notice to Produce, NTP-DEF-048, ADFRI 032 Pre-Entry Fitness Assessment, May 2022, DEF.1048.0005.1081 at 1085.

274 Exhibit 90-03.010, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-207, DEF.9999.0158.0001 at 0018–0019; Exhibit 40-05.010, Hearing Block 5, Angus Campbell, Witness Statement, DEF.9999.0011.0344_R at 0433 [320]; Exhibit UU-01.010, Department of Defence, Response to Notice to Give, NTG-DEF-184, DEF.9999.0197.0001 at 0016–17.

275 Transcript, Duncan Hayward, Hearing Block 6, 10 August 2022, p 47-4606 [16–18].

276 Transcript, Rodney Pope, Hearing Block 10, 18 July 2023, p 69-6668 [28–31].

277 Transcript, Rodney Pope, Hearing Block 10, 18 July 2023, p 69-6668 [35–39].

278 Exhibit 101-01.022, Hearing Block 12, Department of Defence, Response to Notice to Produce, NTP-DEF-269, 1st Recruit Training Battalion presentation titled 'Explain the Requirements for Soldierly Conduct', DEF.1269.0004.0094 at 0121.

279 T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, p 54 (Exhibit L-01.026, DVS.2222.0001.0531).

280 Brendan Stent, Submission, ANON-Z1E7-QZ95-Z, p [2] of supplementary material.

281 Transcript, Nikki Jamieson, Hearing Block 1, 29 November 2021, p 1-53 [13–15].

282 *Defence Force Discipline Act 1982* (Cth) s 38.

283 Transcript, Alexandra Bailey, Hearing Block 1, 1 December 2021, p 3-226 [33–45].

284 Name withheld, Submission, ANON-Z1E7-QWVT-S, p [10].

285 Indiana Conrad Harding, Submission, ANON-Z1E7-QZ2T-R, p [4].

286 Rowan King on behalf of Scheryn Aspinall-Clarke, Submission, ANON-Z1E7-Q8FE-U, p [3].

287 Rowan King on behalf of Scheryn Aspinall-Clarke, Submission, ANON-Z1E7-Q8FE-U, p [3]

288 Name withheld, Submission, ANON-Z1E7-QWYU-W, p [3].

289 Kathleen Moore, Submission, ANON-Z1E7-QZ4C-9, pp [2, 5–6] of supplementary material.

290 Transcript, Mary Frost, Hearing Block 7, 25 October 2022, p 52-5095 [4–28]; Transcript, Michael Malley, Hearing Block 10, 20 July 2023, p 71-6822 [31–39]; Transcript, Christian Lind, Hearing Block 1, 29 November 2021, p 1-114 [26–32]; Transcript, Nikki Jamieson, Hearing Block 1, 29 November 2021, p 1-56 [30–38].

291 Name withheld, Submission, ANON-Z1E7-QWAJ-T, p [2].

292 Name withheld, Submission, ANON-Z1E7-QX48-V, p [3].

293 Transcript, Louise O'Sullivan, Hearing Block 12, 12 March 2024, p 90-8946 [32–42].

294 Transcript, Stephan Rudzki, Hearing Block 10, 18 July 2023, pp 69-6663 [31–42], 69-6696 [7–27]; Transcript, Robin Orr, Hearing Block 10, 18 July 2023, pp 69-6696 [41]– 69-6697 [11]; Indiana Conrad Harding, Submission, ANON-Z1E7-QZ2T-R, p [4]; Ryan Tiralongo, ANON-Z1E7-Q865-U, p [1] of supplementary material; Transcript, David Ready, Hearing Block 7, 20 October 2022, p 50-4917 [3–10]; Name withheld, Submission, ANON-Z1E7-QQNM-4, p [2]; Hayden Jenzen, Submission, ANON-Z1E7-QZTQ-Q, pp [3–4]; Transcript, Kahlil Fegan, Hearing Block 5, 20 June 2022, p 32-3030 [39–46]; Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-185, DEF.9999.0121.0001 at 0003–0007 [Tables 2.1–2.3]; Exhibit 55-04.003, Hearing Block 8, Robert Worswick, Witness Statement, RWO.0000.0001.0006_R at 0011–0012 [48–53]; Name withheld, Submission, ANON-Z1E7-QZVM-N, p [2]; Transcript, Martin Parker, Hearing Block 7, 27 October 2022, p 54-5332 [18–22]; Name withheld, Submission, ANON-Z1E7-Q1XK-C, pp [3–5].

295 Name withheld, Submission, ANON-Z1E7-QW42-N, p [2].

296 Exhibit S-01.060, Department of Defence, Response to Notice to Produce, NTP-DEF-413, Defence Health Manual, Volume 2, Part 6, Military Employment Classification System, DEF.1413.0001.0093 at 0093 [2.1].

297 Exhibit S-01.060, Department of Defence, Response to Notice to Produce, NTP-DEF-413, Defence Health Manual, Volume 2, Part 6, Military Employment Classification System, DEF.1413.0001.0093 at 0093 [2.1].
298 Exhibit 39-02.049, Hearing Block 5, Department of Defence, Response to Notice to Produce, Defence Health Manual, Volume 2, Part 6, Military Employment Classification System, DEF.1413.0001.0093 at 0095 [2.14]; Transcript, Darrell Duncan, Hearing Block 5, 29 June 2022, p 39-3804 [1–6].
299 Transcript, Darrell Duncan, Hearing Block 5, 29 June 2022, pp 39-3809 [35–37], 39-3810 [9–15].
300 Transcript, Samantha Juckel, Hearing Block 5, 29 June 2022, p 39-3822 [18–24].
301 *Kioa v West* (1985) 159 CLR 550 at 629; *Johns v Release on Licence Board* (1987) 9 NSWLR 103 at 116; *Re Macquarie University; ex parte Ong* (1989) 17 NSWLR 113 at 135–137; *Claro v Minister for Immigration, Local Government and Ethnic Affairs* (1993) 119 ALR 342 at 353–354; *Roderick v Australian and Overseas Telecommunications Corp. Ltd* (1992) 39 FCR 134 at 143–144; *Youssef v Minister for Immigration and Ethnic Affairs* (1987) 14 ALD 550; *Minister for Immigration and Ethnic Affairs v Taveli* (1990) 23 FCR 162 at 183–184; *Roderick v Australian and Overseas Telecommunications Corp. Ltd* (1992) 39 FCR 134 at 143–144; *NIB Health Funds Ltd v Private Health Insurance Administration Council* (2001) 115 FCR 561 at 585; *Beckner v Minister for Immigration, Local Government and Ethnic Affairs* (1991) 30 FCR 49; *R v Hull Prison Board of Visitors; ex parte St Germain (No. 2)* [1979] 1 WLR 1401; *Moore v Guardianship and Administration Board* [1990] VR 902 at 914; *Mayes v. Mayes* [1971] 1 WLR 679; *R v Medical Practitioners Professional Conduct Tribunal; ex parte Medical Board* (1985) 40 SASR 84; *Escobar v Spindaleri* (1986) 7 NSWLR 51; *Annetts v McCain* (1990) 170 CLR 596; *R v Windridge; ex parte Pacific Coal Pty Ltd* [1992] 2 Qd R 180; *Thai v Deputy Commissioner of Taxation* (1994) 53 FCR 525 at 272.
302 Exhibit 78-02.001, Hearing Block 11, Department of Defence, Response to Notice to Give, NTG-DEF-016, DEF.9999.0103.0123 at 0138 [25].
303 Name withheld, Submission, ANON-Z1E7-Q8ZJ-M, p [2].
304 Transcript, Darrell Duncan, Hearing Block 5, 29 June 2022, p 39-3824 [6–11].
305 Exhibit 39-02.009, Hearing Block 5, Samantha Juckel, Witness Statement, DEF.9999.0018.0001 at 0028.
306 Transcript, Scott Foster, Hearing Block 5, 29 June 2022, pp 39-3842 [41]–39-3843 [6]; Exhibit 01-01.051, In Depth Inquiry, Deputy Director Separations and Military Employment Classification Review Board, Witness Statement, DVS.0000.0001.6969 at 6973.
307 Name withheld, Submission, ANON-Z1E7-QZT3-S, p [3].
308 Exhibit 30-03.009, Hearing Block 4, Royal Commission into Defence and Veteran Suicide Introductory Defence Briefing, August 2021, STU.0001.0001.5446 at 5456.
309 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 4 (Exhibit F-01.061, DVS.0011.0001.1192).
310 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-008, Attachment A, AHW.9999.0005.0001 at Table 2.
311 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-185, DEF.9999.0121.0001 at 0043–0046; Transcript, Stephan Rudzki, Hearing Block 10, 18 July 2023, p 69-6696 [10–14]; Exhibit 96-01.013, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-255, Tranche 1 Annexure A, DEF.9999.0164.0034 at Table 12.5, Table 12.6 and Table 12.7.
312 Name withheld, Submission, ANON-Z1E7-QM48-H, p [2] of supplementary material.
313 Transcript, Jonathan Lane, Hearing Block 6, 4 August 2022, p 43-4248 [37–41].
314 A Cameron and others, 'Towards a Better Understanding of Hypervigilance in Combat Veterans, Military Behavioural Health', *Military Behavioural Health*, vol 7, 2, 2019, p 206 (Exhibit 75-02.049A, Hearing Block 10, STU.0010.0001.0436).
315 Name withheld, Submission, ANON-Z1E7-Q94Q-P, p [18] of supplementary material.
316 Glendon Leigh James, Submission, ANON-Z1E7-QXKJ-5, p [3] of supplementary material.
317 Name withheld, Submission, ANON-Z1E7-QZHD-X, p [30] of supplementary material.
318 Transcript, David Forbes, Hearing Block 6, 9 August 2022, p 46-4547 [35–36].
319 Name withheld, Submission, ANON-Z1E7-QW5S-Q, p [3].
320 Owen Bartrop, Submission, ANON-Z1E7-Q18K-C, p [1] of supplementary material.
321 Stephen Windahl, Submission, ANON-Z1E7-QQ4Z-Q, p [1] of supplementary material.

322 Glendon Leigh James, Submission, ANON-Z1E7-QXKJ-5, p [2] of supplementary material.
323 Name withheld, Submission, ANON-Z1E7-QM48-H, pp [23–24] of supplementary material.
324 Australian Institute of Health and Welfare, *Final report to the Independent Review of Past Defence and Veteran Suicides*, 2021, p 19 (Exhibit F-03.007, SUB.0000.0002.0059).
325 J Thompson and others, 'Group Identity, difficult adjustment to civilian life, and suicidal ideation in Canadian Armed Forces Veterans: Life After Service Studies', *Journal of Military, Veteran and Family Health*, vol 5, 2, 2019 (Exhibit L-01.106, DVS.2222.0001.4862).
326 K Carra and others, 'Service and demographic factors, health, trauma exposure, and participation are associated with adjustment for former Australian Defense Force members', *Military Psychology*, vol 35, 5, 2023, p 488 (Exhibit F-04.110, DVS.1111.0001.4385) (Citations removed).
327 Department of Defence, Department of Veterans' Affairs, Family Wellbeing Study, Part 1 and Part 2, Transition and Wellbeing Research Programme, 2018, p 334 (Exhibit 20-03.046, Hearing Block 3, DEF.0001.0001.5958); Productivity Commission, A Better Way to Support Veterans, No. 93, June 2019, vol 1 (Exhibit 01-01.010, Hearing Block 1, INQ.0000.0001.2299); Exhibit A-01.011, Department of Defence, Response to Notice to Produce, NTP-DEF-001, Career Transition Assistance Scheme Review, August 2018, DEF.0001.0001.0015; University of Newcastle, Mental Health and Wellbeing Service Delivery, Horizon Scan: 2022, Report for the Department of Veterans' Affairs, 2022, p 9 (Exhibit F.05.017, DVA.5045.0001.0710); Department of Veterans' Affairs, Evidence Compass, What are the family protective factors for members transitioning from Defence Services? Summary of the Rapid Evidence Assessment, 2015, p 4 (Exhibit R-01.006, AIF.0001.0001.7666); Australian Institute of Family Studies, Submission, BHLF-Z1E7-QFYH-Y, p [8].
328 Department of Defence, Department of Veterans Affairs, *Family Wellbeing Study, Part 1 and Part 2*, Transition and Wellbeing Research Programme, 2018, p 334 (Exhibit 20-03.046, DEF.0001.0001.5958); M Fossey and others, 'The transition of military veterans from active service to civilian life: impact of transition on families and the role of the family, support and recognition', in C Castro and S Dursun (eds), *Military Veteran Reintegration*, Elsevier, 2019, pp 203–204 (Exhibit L-01.086, DVS.2222.0001.4379).
329 Department of Veterans Affairs, Department of Defence, *Transition Taskforce Improving the transition experience*, 2018, p 47 (Exhibit 21-01.001, Hearing Block 3, AWW.0000.0001.0697).
330 Department of Veterans Affairs, Department of Defence, *Transition Taskforce Improving the transition experience*, 2018, p 6 (Exhibit 21-01.001, Hearing Block 3, AWW.0000.0001.0697).
331 Department of Defence, *Australian Defence Force Families research 2019 – Findings from the ADF Families Survey 2019*, February 2020, p 11 (Exhibit F-08.048, DEF.1010.0001.8302); Australian Institute of Family Studies, Department of Veterans' Affairs, *Family Wellbeing Study*, Transition and Wellbeing Research Programme, 2018 (Exhibit R-01.008, AIF.0001.0001.1337); Australian Institute of Family Studies, *The Transition and Wellbeing Research Programme, Family and Wellbeing Study*, Qualitative component, Department of Defence and Department of Veterans' Affairs, p 19 (Exhibit L-01.074, AIF.0001.0001.1762); Australian Institute of Family Studies, Submission, BHLF-Z1E7-QFYH-Y, p [2] of supplementary material.
332 University of Newcastle, *Mental Health and Wellbeing Service Delivery, Horizon Scan: 2022*, Report for the Department of Veterans' Affairs, 2022, p 19 (Exhibit F-05.017, DVA.5045.0001.0710).
333 Australian Institute of Family Studies, Submission, BHLF-Z1E7-QFYH-Y, p [6] of supplementary material.
334 Australian Institute of Family Studies, *The Transition and Wellbeing Research Programme, Family and Wellbeing Study*, Qualitative component, Department of Defence and Department of Veterans' Affairs, pp 170–171, 188 (Exhibit L-01.074, AIF.0001.0001.1762).
335 Department of Defence, *Australian Defence Force Families research 2019 – Findings from the ADF Families Survey 2019*, February 2020, p 12 (Exhibit F-08.048, DEF.1010.0001.8302); Exhibit 79-01.015, Hearing Block 11, Sandi Laaksonen-Sherrin, Witness Statement, SLS.0000.0001.0009 at 0086; K Jones and others, *Defence Force and Veteran Suicides: Literature review*, Phoenix Australia, July 2020, pp 36, 41, 45, 48 (Exhibit 01-05.002, Hearing Block 1, EXP.0001.0020.0174); Australian Institute of Family Studies, Submission, BHLF-Z1E7-QFYH-Y, p [6] of supplementary material.
336 As cited in RSL Victoria, Submission, ANON-Z1E7-QWYD-C, p [55] of supplementary material.
337 Exhibit 73-01.001, Hearing Block 10, Justine Greig, Witness Statement, DEF.9999.0105.0001 at 0107 [306].

338 Productivity Commission, *A Better Way to Support Veterans*, No. 93, June 2019, vol. 1, p 319 (Exhibit 01-01.10, Hearing Block 1, INQ.0000.0001.2299).
339 Exhibit L-01.033, Suicide Prevention Australia and Mental Health Australia, Submission, SUB.0000.0020.0011 at 0036; Exhibit 30-01, Hearing Block 4, Ben Hofmann, Witness Statement, BHO.0000.0001.0001_R at 0015; Transcript, Jonathon Morgan, Hearing Block 11, 28 August 2023, p 76-7364 [4–11]; Transcript, Jeffery Sengelman, Hearing Block 12, 7 March 2024, pp 89-8859 [43]–89-8860 [9]; Exhibit 57-01.001, Hearing Block 8, Kylie Reynolds, Witness Statement, KRE.0000.0001.0014_R at 0041–0042 [164–165].
340 Exhibit 08-03, Hearing Block 1, Name withheld, Witness Statement, SMA.0000.0001.0001 at 0014 [59–60], 0015 [66], 0016 [68–70] and 0017 [71–73]; Exhibit 30-01, Hearing Block 4, Ben Hofmann, Witness Statement, BHO.0000.0001.0001_R at 0013 [82–83], 0015 [96]; Exhibit 43-02.002, Hearing Block 6, Gavin Tunstall, Witness Statement, GTU.0000.0001.0001_R at 0013 [94]; Exhibit 12-03.001, Hearing Block 2, Danny Liversidge, Witness Statement, DLI.0000.0001.0007_R at 0013 [50–51] and 0014 [52–57]; Exhibit 53-01.001, Hearing Block 7, Paul Walker, Witness Statement, PAW.0000.0001.0001_R at 0010 [61]; Exhibit 49-03.001, Hearing Block 7, Justin Huggett, Witness Statement, JHG.0000.0001.0001_R at 0013 [56] and 0022 [104]; Exhibit 55-02.001, Hearing Block 8, James Geercke, Witness Statement, JGE.0000.0001.0001_R at 0019–0020; Exhibit 69-01.002, Hearing Block 10, William Kearney, Witness Statement, WIK.0000.00001.0001_R at 0006 [27–33].
341 Transcript, Natasha Fox, Hearing Block 3, 15 March 2022, p 21-1903 [37–39].
342 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021,* supplementary tables, table S9:3 (Exhibit K-01.123, DVS.2222.0001.3284).
343 Exhibit UU-01.006, Department of Veterans' Affairs, DVA Projections – Executive Summary of DVA Beneficiaries in Receipt of Pension(s), Allowance(s) or Health Care, DVS.6666.0001.5510 at 5510.
344 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985 suicide monitoring 1997 to 2021*, catalogue number PHE 327, 2022, p 39 (Exhibit K-01.123, Hearing Block 8, DVS.2222.0001.3284).
345 D Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009, pp 173–174 (Exhibit 75-01.015, Hearing Block 10, DVA.5002.0002.1862).
346 Australian Public Service Commission, *Capability Review Department of Veterans' Affairs*, November 2013, p 5 (Exhibit 74-02.035, Hearing Block 10, DVS.0010.0001.1779).
347 National Mental Health Commission, *Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families,* Final report: Findings and Recommendations, March 2017, pp 35–36 (Exhibit 01-01.008, Hearing Block 1, INQ.0000.0001.1488).
348 A Collie, *The Mental Health Impacts of Compensation Claim Assessment Processes*, Monash University, March 2019, p 44 (Exhibit 11-01.001, Hearing Block 2, STU.0002.0001.0001).
349 A Collie, *The Mental Health Impacts of Compensation Claim Assessment Processes*, Monash University, March 2019, p 25 (Exhibit 11-01.001, Hearing Block 2, STU.0002.0001.0001).
350 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, pp 19 [36], 66 [1.74] (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584).
351 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, p 24 [57] (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584).
352 Name withheld, Submission, ANON-Z1E7-Q18U-P, p [2].
353 Name withheld, Submission, ANON-Z1E7-QQEC-H, p [2].
354 Name withheld, Submission, ANON-Z1E7-QZVA-9, p [2].
355 Name withheld, Submission, ANON-Z1E7-QZVZ-2, p [3].
356 Name withheld, Submission, ANON-Z1E7-Q1W5-N, p [13] of supplementary material.
357 Name withheld, Submission, ANON-Z1E7-Q1NN-5, p [2].
358 Mark Direen, Submission, ANON-Z1E7-QQ4P-D, p [5].
359 Name withheld, Submission, ANON-Z1E7-QZHD-X, p [33] of supplementary material.
360 Arthur Ventham, Submission, ANON-Z1E7-Q8VW-W, p [3].
361 Name withheld, Submission, ANON-Z1E7-QM6F-1, p [3].
362 Name withheld, Submission, ANON-Z1E7-QZHD-X, p [12] of supplementary material.
363 John-Davide Greilinger, Submission, ANON-Z1E7-QWB6-7, p [16].

364 Name withheld, Submission, ANON-Z1E7-QQ9Z-V, p [14].
365 Name withheld, Submission, ANON-Z1E7-QQEC-H, p [2].
366 Ricky Ryan, Submission, ANON-Z1E7-Q8S6-S, p [2]; Name withheld, Submission, ANON-Z1E7-QQEC-H, p [2].
367 Annabelle Elizabeth Wilson, Submission, ANON-Z1E7-QWF7-C, p [15].
368 Annabelle Elizabeth Wilson, Submission, ANON-Z1E7-QWF7-C, pp [17–23].
369 Royal Commission into Defence and Veteran Suicide, *Interim Report*, August 2022, pp 169–255.
370 PFLR-36.4 (Special Report, Commonwealth response), PFL.0003.0002.0019 at 0024–0026; Exhibit 75-01.003, Hearing Block 10, Response to Notice to Give, NTG-DVA-072, DVA.9999.0070.0032 at 0035–0036; Department of Veterans' Affairs, Voluntary Submission, 22 December 2023, pp 6 [2.6], 22 [6.6] (Exhibit 93-02.001, DVS.0012.0001.1895); Transcript, Laura Sham, Hearing Block 10, 25 July 2023, pp 74-7154 [45]–74-7155 [20].
371 PFLR-36.4 (Special Report, Commonwealth response), PFL.0003.0002.0019 at 0022; The Hon Richard Marles, Deputy Prime Minister and Minister for Defence, the Hon Matt Keogh, Minister for Veterans' Affairs and Defence Personnel, *Supporting Australia's veterans and their families*, media release, 14 May 2024 (Exhibit UU-01.008, DVS.6666.0001.5531).
372 Department of Veterans' Affairs, Voluntary submission to the Royal Commission – June 2024, p 12 [2.7] (Exhibit ZZ-01.005, DVS.7777.0001.0012).
373 Department of Veterans' Affairs, Voluntary submission to the Royal Commission – June 2024, pp 8 [1.16], 12 [2.6] (Exhibit ZZ-01.005, DVS.7777.0001.0012).
374 Exhibit 93-02.001, Hearing Block 12, Department of Veterans' Affairs, Submission, DVS.0012.0001.1895 at 1902 [3.4].
375 Exhibit 93-02.001, Hearing Block 12, Department of Veterans' Affairs, Submission, DVS.0012.0001.1895 at 1902 [3.4].
376 Exhibit UU-01.006, Department of Veterans' Affairs, DVA Projections – Executive Summary of DVA Beneficiaries in Receipt of Pension(s), Allowance(s) or Health Care, DVS.6666.0001.5510 at 5510.
377 Exhibit 93-02.001, Hearing Block 12, Department of Veterans' Affairs, Submission, DVS.0012.0001.1895 at 1900 [2.5].
378 PFLR-36.4 (Special Report, Commonwealth response), PFL.0003.0002.0019 at 0023.
379 PFLR-36.4 (Special Report, Commonwealth response), PFL.0003.0002.0019 at 0023; PFLR-66.1 (DVA Culture supplementary PFN, Commonwealth response), PFL.0027.0002.0029 at 0040.
380 Australian Public Service Commission, *Trust in Australian Public Services 2023*, Annual Report, 2023, p 7 (Exhibit AA-01.026, DVS.0000.0002.0832).
381 Australian Public Service Commission, *Trust in Australian Public Services 2023,* Annual Report, 2023, p 31 (Exhibit AA-01.026, DVS.0000.0002.0832).
382 PFLR-36.4 (Special Report, Commonwealth response), PFL.0003.0002.0019 at 0023; Flinders University, *A cycle of impacts: Department of Veterans' Affairs Culture of claims services to veterans survey development and results analysis*, March 2024, p 5 (Exhibit 93-02.023 DVA.0057.0001.0001).
383 Flinders University, *A cycle of impacts: Department of Veterans' Affairs Culture of claims services to veterans survey development and results analysis*, March 2024, p 57 (Exhibit 93-02.023, DVA.0057.0001.0001).
384 Flinders University, *A cycle of impacts: Department of Veterans' Affairs Culture of claims services to veterans survey development and results analysis*, March 2024, p 9 (Exhibit 93-02.023, DVA.0057.0001.0001).
385 Flinders University, *A cycle of impacts: Department of Veterans' Affairs Culture of claims services to veterans survey development and results analysis*, March 2024, p 57 (Exhibit 93-02.023, DVA.0057.0001.0001).
386 Stephen Windahl, Submission, ANON-Z1E7-QQ4Z-Q, p [17] of supplementary material; Joseph Van Haren, Submission, ANON-Z1E7-Q9HX-H, p [2]; Robert Wooten, Submission, ANON-Z1E7-QXT6-T, p [2]; Amber Elise Warke, Submission, ANON-Z1E7-QEGB-6, pp [2–3].
387 Department of Veterans' Affairs, Voluntary submission to the Royal Commission – June 2024, p 6 [1.3] (Exhibit ZZ-01.005, DVS.7777.0001.0012).
388 Exhibit 31-01.002, Hearing Block 4, Department of Veterans' Affairs, Background paper for the Royal Commission, EXP.0004.0020.0233 at 0234.

389 Department of Veterans Affairs, *Annual Report 2017–18*, 2018, p 2 (Exhibit 22-05.016, Hearing Block 3, DVS.0000.0001.5699).
390 Department of Veterans Affairs, *Veterans Mental Health and Wellbeing Strategy and National Action Plan 2020–2023,* 2020, p 6 (Exhibit 20-03.089, Hearing Block 3, DVA.5007.0001.0011).
391 Exhibit 74-02.002, Hearing Block 10, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-084, DVA.9999.0070.0001 at 0001.
392 Transcript, Elizabeth Cosson, Hearing Block 4, 14 April 2022, p 31-2960 [12–20].
393 Exhibit K-01.047, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-100, DVA.9999.0109.0001 at 0008 [4.7].
394 Department of Veterans' Affairs, Voluntary submission to the Royal Commission – June 2024, p 28 [5.30] (Exhibit ZZ-01.005, DVS.7777.0001.0012).
395 Department of Veterans' Affairs, 'Non-liability mental health care', webpage, last updated 14 February 2023, https://www.dva.gov.au/get-support/providers/programs-services/mental-health-providers/non-liability-mental-health-care, viewed 18 June 2024.
396 Australian Physiotherapy Association, *Veterans deserve better access to healthcare: DVA must act now*, media release, 19 July 2023 (Exhibit CC-01.091, DVS.6666.0001.2655).
397 National Mental Health Commission, *Review into the Suicide and Self-Harm Prevention Services available to Current and Former Serving ADF Members and Their Families Final Report: Findings and Recommendations*, 28 March 2017, pp 7, 28 (Exhibit 47-03.088, Hearing Block 6, DEF.1029.0001.0432); Phoenix Australia, *Mental Health Impacts of Compensation Claim Assessment Processes on Claimants and Their Families*, September 2018, p 12 (Exhibit F-04.012, DVA.5042.0001.0463), citing D Forbes and others, *The Transition and Wellbeing Research Programme: Mental Health and Wellbeing Transition Study*, Report 2: Pathways to Care, 2018 (Exhibit 20-03.042, Hearing Block 3, DEF.0001.0001.3715); M Van Hooff and others, *Transition and Wellbeing Research Programme Key Findings Report*, Department of Defence and Department of Veterans' Affairs, 2019 (Exhibit 20-03.056, Hearing Block 3, DEF.1029.0002.0066); University of Newcastle, *Mental Health and Wellbeing Service Delivery, Horizon Scan: 2022*, Report for the Department of Veterans' Affairs, 2022, p 51 (Exhibit F.05.017, DVA.5045.0001.0710).
398 University of Newcastle, *Mental Health and Wellbeing Service Delivery, Horizon Scan: 2022*, Report for the Department of Veterans' Affairs, 2022, p 51 (Exhibit F.05.017, DVA.5045.0001.0710).
399 Exhibit AA-01.022, Department of Veterans' Affairs, Response to Notice to Produce, NTP-DVA-120, 'Mental Health and Wellbeing Services Division Service Review and Transformation Program, Service Review: Final Report', June 2023, DVA.5081.0002.0266 at 0280.
400 Exhibit AA-01.022, Department of Veterans' Affairs, Response to Notice to Produce, NTP-DVA-120, 'Mental Health and Wellbeing Services Division Service Review and Transformation Program, Service Review: Final Report', June 2023, DVA.5081.0002.0266 at 0279.
401 Exhibit AA-01.022, Department of Veterans' Affairs, Response to Notice to Produce, NTP-DVA-120, 'Mental Health and Wellbeing Services Division Service Review and Transformation Program, Service Review: Final Report', June 2023, DVA.5081.0002.0266 at 0279.
402 Exhibit AA-01.022, Department of Veterans' Affairs, Response to Notice to Produce, NTP-DVA-120, 'Mental Health and Wellbeing Services Division Service Review and Transformation Program, Service Review: Final Report', June 2023, DVA.5081.0002.0266 at 0287.
403 Transcript, Alison Frame, Hearing Block 10, 26 July 2023, p 75-7232 [20–30].
404 Transcript, Elizabeth Cosson, Hearing Block 4, 14 April 2022, p 31-2959 [45–47].
405 Exhibit 93-02.001, Hearing Block 12, Department of Veterans' Affairs, Submission, DVS.0012.0001.1895 at 1923.
406 Transcript, Robert Chipman, Hearing Block 12, 13 March 2024, p 91-9177 [4–9].
407 Transcript, Mark Hammond, Hearing Block 12, 14 March 2024, p 92-9273 [26–29].
408 Transcript, Mark Hammond, Hearing Block 12, 14 March 2024, p 92-9270 [20–24].
409 Transcript, Mark Hammond, Hearing Block 12, 14 March 2024, p 92-9270 [40–45].
410 Transcript, Simon Stuart, Hearing Block 12, 22 March 2024, p 98-9993 [18–46].
411 Transcript, Angus Campbell, Hearing Block 12, 28 March 2024, pp 101-10256 [46]–101-10257 [4].
412 The Hon Scott Morrison MP, Prime Minister, and The Hon Peter Dutton MP, *Defence workforce to grow above 100,000*, media release, 10 March 2022 (Exhibit 31-01.033, Hearing Block 4, EXP.0004.0020.0161).
413 Exhibit 90-03.012, Hearing Block 12, Defence 2000, Our Future Defence Force, DVS.0012.0001.1293 at 1375.

414 Transcript, Louise O'Sullivan, Hearing Block 12, 12 March 2024, p 90-8947 [20–21].
415 Mark Direen, Submission, ANON-Z1E7-QQ4P-D, pp [8–9].
416 Exhibit 89-01.001, Hearing Block 12, Jeffery Sengelman, Witness Statement, JSL.0000.0001.0001 at 0006 [18].
417 Exhibit 89-01.001, Hearing Block 12, Jeffery Sengelman, Witness Statement, JSL.0000.0001.0001 at 0006 [18].
418 Name withheld, Submission, ANON-Z1E7-QZ55-V, p [3].
419 Peter Luffman, Ken McGowan and Heather Wuillemin, Submission, ANON-Z1E7-QMAR-R, p [4] of supplementary material.
420 Name withheld, Submission, ANON-Z1E7-Q1UJ-8, p [2].
421 Transcript, Richard Marles, Hearing Block 12, 7 March 2024, p 89-8932 [11–16].
422 Transcript, Angus Campbell, Hearing Block 12, 28 March 2024, p 101-10257 [30–39].
423 Ian Norton, Submission, ANON-Z1E7-QM2G-X, p [2].
424 Transcript, Richard Marles, Hearing Block 12, 7 March 2024, p 89-8892 [4–20]; Department of Defence, *National Defence Strategy*, 2024, p 33 (Exhibit R-01.026, DVS.4444.0001.0108); The Hon Richard Marles MP, Deputy Prime Minister, Minister for Defence, The Hon Matt Keogh MP, Minister for Defence Personnel, Minister for Veterans' Affairs, The Hon Matt Thistlethwaite MP, Assistant Minister for Defence, Assistant Minister for Veterans' Affairs, Assistant Minister for the Republic, *Albanese Government invests in our future Defence Force*, media release, 2 May 2023 (Exhibit 90-03.022, Hearing Block 12, DEF.1233.0003.0126).

Recommendations

Recommendation 1: Improve the capacity of future royal commissions to undertake their inquiries

To enable the efficient operation of future royal commissions:

(a) the Australian Government should amend the *Royal Commissions Act 1902* (Cth) so there are meaningful consequences for non-compliance with a compulsory notice

(b) the Australian Government should undertake measures to ensure that royal commissions benefit from more independent representation in government, either by:

  (i) setting up protocols that limit the engagement of the Royal Commissions Branch of the Attorney-General's Department with the Australian Government Solicitor (AGS), or

  (ii) moving the Royal Commissions Branch to a separate agency, for example to the Department of Prime Minister and Cabinet, or:

  (iii) setting up a liaison person or team in the Attorney-General's Department, whose role is to deal with royal commissions only

(c) the Australian Government should apply consistent and transparent arrangements to allow royal commissions timely access to material covered by public interest immunity, and consider legislative amendment to facilitate royal commissions' access to this material

(d) The Attorney-General's Department should provide settled advice and options on the operation of public interest immunity, Parliamentary privilege and procedural fairness in the operation of royal commissions.

(Volume 1: About the Royal Commission)

Recommendation 2: Improve outcomes and access to support for recruits in *ab initio* training

Defence should improve support for all recruits in *ab initio* training to build resilience and embed help-seeking behaviours. Developed in partnership with people with lived experience of service, the model of support should:

(a) utilise mental health screening conducted during *ab initio* training (Recommendation 65) to identify and provide support to proactively meet recruits' needs

(b) reduce barriers to accessing timely and appropriate care, including physical health, mental health, spiritual health, pastoral care and peer supports

(c) ensure that changes to 'recruitment risk appetite' do not jeopardise members' mental and physical health, including for those who enter under reduced physical fitness standards, as waiver recipients or with higher psychological risk, including by:

  (i) longitudinal tracking of health, wellbeing and safety outcomes for members from initial training and throughout their Australian Defence Force career

  (ii) with members' consent, sharing insights about recruits' support needs obtained through recruitment processes to enable *ab initio* training institutions to offer relevant supports proactively

(d) prioritise and promote postings at *ab initio* training institutions and ensure that instructors have the resourcing, capabilities and personal attributes necessary to lead and educate young people, including vulnerable individuals.

(Chapter 3: Recruitment and initial training)

Recommendation 3: Build the capability of career managers

Defence should build the capability of career managers to engage with and respond to member needs and preferences when making posting decisions, including by:

(a) improving the ratio of career managers to members

(b) upskilling career managers to engage with vulnerable individuals through training in trauma-informed approaches

(c) providing the training, resourcing, data and guidance for career managers to identify and mitigate cumulative stressors experienced by members, including psychosocial risk such as exposure to unacceptable behaviour, when making posting decisions.

(Chapter 4: Postings and deployments)

Recommendation 4: Mitigate the adverse impacts of the posting cycle

Defence should take steps to mitigate the adverse impacts of the posting cycle on members and their families, including:

(a) measures to reduce the frequency of relocation

(b) improved supports for members and their families moving to a new location that target known stressors, such as housing, childcare and children's education, partner/spouse employment and community ties

(c) measures to implement greater mobility across the Australian Defence Force and flexible working options

(d) working with state and territory governments to ensure that children of Defence personnel can enrol in educational institutions without having a fixed address as a result of Defence-required relocations of the family.

(Chapter 4: Postings and deployments)

Recommendation 5: Support all serving members to decompress, rest and reintegrate, especially after high-risk experiences

Defence should:

(a) implement a clear and consistent framework for post-deployment supports for members and their families that addresses the psychosocial aspects of reintegration. This should include:

  (i) an evidence-based approach to decompression and reintegration that allows for individual needs, informed by experience in comparable industries such as emergency services

  (ii) training that addresses common issues that arise on entering and exiting operational activities, which may include grief, hypervigilance, sleep issues, excess alcohol use and aggression

  (iii) with members' consent, a handover from their commanding officer on deployment to their commanding officer at home that identifies stressors experienced by the member on deployment

(b) implement a structured and comprehensive approach to respite across the Australian Defence Force (ADF) that is not limited to 'arduous deployments' and that addresses fatigue across the workforce

(c) analyse data collected on high-risk experiences, including deployments, to derive lessons for improved risk and fatigue management across the organisation and build a better understanding of the future physical and mental health needs of ADF members and veterans.

(Chapter 4: Postings and deployments)

Recommendation 6 : Improve the procedural fairness of the military employment classification system

Defence should ensure members are treated fairly when making decisions about their fitness to be employed or deployed by the Australian Defence Force. To achieve this, Defence should:

(a) publish a guidance direction for decision-makers in the military employment classification system on the requirements of procedural fairness

(b) ensure members may review all relevant documents before a decision is made about their military employment classification and have an opportunity to make direct representations to the decision-maker, including at Military Employment Classification Review Board meetings.

(Chapter 5: The military employment classification system and medical separation)

Recommendation 7: Increase employment opportunities within the Australian Defence Force for members who cannot be deployed

Defence should implement measures to increase employment opportunities within the Australian Defence Force (ADF) for members who are no longer able to be deployed due to illness or injury. Measures should include:

(a) systematic identification, within Defence workforce planning and other policies, of roles that may be suitable and should be considered for members who cannot deploy

(b) a commitment to maximising opportunities for continuing employment of ADF members who are no longer able to be deployed due to illness or injury, including by minimising reliance on external service providers and contractors

(c) processes to measure and monitor the number of members who can and cannot be deployed, and how changes in this ratio impact on, and are illustrative of, the wellbeing of members.

(Chapter 5: The military employment classification system and medical separation)

Recommendation 8: Maximise workforce retention by addressing factors that contribute to voluntary separation

In the next iteration of the Defence Strategic Workforce Plan (or its equivalent), Defence should specifically focus on outcomes-based retention initiatives. The plan should:

(a) draw on service-specific workforce experience data, monthly workforce reporting and analysis of factors driving voluntary separation

(b) address contributors to voluntary separation, including burnout, fatigue and psychosocial stress

(c) establish targets, with accompanying performance measures, to enable evaluation of the effectiveness of retention initiatives.

The plan should inform the evolution of Defence's Employee Value Proposition and be implemented in alignment with the Defence Work Health and Safety Strategy.

(Chapter 6: Retention issues and voluntary separation)

Recommendation 9: Improve organisational culture and leadership accountability to increase member wellbeing and safety

The Chief of the Defence Force, Australian Defence Force (ADF) service chiefs and the Chief of Personnel should agree on a suite of ADF culture targets, supported by data-driven metrics. Targets should be outcomes-based and time-bound. At a minimum, targets should be developed for the following cultural priorities:

(a) safety, health and wellbeing, with a focus on psychosocial safety

(b) unacceptable behaviour and sexual misconduct, with a focus on removing barriers to reporting and improving complaints management

(c) senior leadership accountability.

The annual culture report should be publicly available and report on each service's progress against culture targets, as well as ADF-wide results.

(Chapter 7: Culture and leadership)

Recommendation 10: Develop service-specific action plans to implement the Defence Respect@Work Framework

The Australian Human Rights Commission should undertake an independent assessment of the extent to which underlying drivers, risk and protective factors in the Defence Respect@Work Framework are present in each service, and recommend actions to address gaps and known risks.

Following these recommendations, Navy, Army and Air Force should develop service-specific action plans for the Defence Respect@Work Framework, including implementation timeframes, to be approved by the Minister for Defence and the Minister for Defence Personnel.

(Chapter 7: Culture and leadership)

Recommendation 11: Assess Australian Defence Force leaders based on upward feedback and performance against culture, health and wellbeing targets

Defence should amend the annual performance appraisals of Australian Defence Force (ADF) leaders (from the rank of Colonel to the rank of General, and equivalents) to include upward feedback from their direct reports, and assessment against outcomes-based targets related to culture, health and wellbeing.

At a minimum, Defence should develop outcomes-based targets for leaders for the following domains and metrics:

(a) safety, health and wellbeing

  (i) psychological safety climate, based on the new Values and Behaviours Survey metrics related to managers and commanders

(b) gender equality

  (i) difference in cultural reporting between men and women (KPI 11 metrics, *Women in the ADF Report*)

  (ii) women feel equally included (KPI 13 Metrics, *Women in the ADF Report*)

(c) reporting and management of unacceptable behaviour

  (i) level of under-reporting of unacceptable behaviour and sexual misconduct (reported separately and disaggregated by gender)

  (ii) satisfaction with management of unacceptable behaviour and sexual misconduct (reported separately and disaggregated by gender).

(Chapter 7: Culture and leadership)

Recommendation 12: Consider emotional intelligence and performance against wellbeing targets in selecting leaders to promote

The Australian Defence Force should strengthen its leadership selection and promotion process by:

(a) assessing a candidate's performance against culture, health and wellbeing targets (see Recommendation 11) as part of the 'fit and proper person' check for leadership and command selection and promotion

(b) including psychometric testing, particularly emotional intelligence measurement, as part of the command selection framework, based on command-assessment programs in the United Kingdom and the United States.

(Chapter 7: Culture and leadership)

Recommendation 13: Co-design a new doctrine recognising that operational readiness depends on a healthy workforce

Defence should convene a select panel to co-design a new doctrine on 'people, capability and service' with Australian Defence Force (ADF) members.

The doctrine should make it clear that Australia's military capability and operational readiness depend on having a physically and mentally healthy workforce, where prevention, early intervention and recovery are not in opposition to values of service and sacrifice, but are essential for these values to be expressed in a sustainable way that serves our nation's interest.

The select panel should:

(a) consist of ex-serving members and represent experience at both the commissioned and non-commissioned officer ranks, across Navy, Army and Air Force

(b) undertake a co-design process including representation from a broad range of age groups, ranks, bases and services, and maximise involvement of members who have experienced physical and mental health issues

(c) present the new doctrine on 'people, capability and service' to the Chief of Personnel and the Chief of the Defence Force for endorsement by no later than December 2026

(d) identify any other single-service or ADF cultural norms, symbols, systems, policies or processes identified by members or commanding officers as barriers to the prioritisation of member health and wellbeing, and suggest changes in a report to the Minister for Defence and the Minister for Defence Personnel.

(Chapter 7: Culture and leadership)

Recommendation 14: Understand the prevalence and effects of military sexual trauma and improve responses to support victims

The Australian Government should commission independent research on the prevalence of military sexual trauma among serving and ex-serving Australian Defence Force (ADF) members. This research should examine:

(a) the link between sexual misconduct and suicide and suicidality, other impacts experienced during service, and specific needs of victims at the time of transition, and benchmark the ADF response with best practice approaches to inform recommendations for improvements

(b) the terminology 'sexual misconduct' used by the ADF, compared to 'military sexual trauma and violence', and the impact of terminology on victims.

(Chapter 8: Military sexual violence)

Recommendation 15: Clarify definitions and processes related to sexual offences

Defence should amend its Complaints and Resolutions Manual to:

(a) include definitions of sexual offences aligned with the *Crimes Act 1900* (ACT) sexual offence provisions, that clearly describe the types of behaviours and actions that constitute each offence

(b) provide clear and explicit instructions that managers and commanders who receive a report of sexual misconduct should consult with the Joint Military Police Unit to determine whether the conduct constitutes an offence, before taking any further action.

(Chapter 8: Military sexual violence)

Recommendation 16: Evaluate training on managing sexual misconduct and make it mandatory for all leaders

Defence should commission an independent evaluation of the Sexual Misconduct Incident Management Workshop as a matter of priority. Following any required improvements identified by this evaluation, sexual misconduct incident management training should be mandatory for all commanders and managers.

(Chapter 8: Military sexual violence)

Recommendation 17: Prioritise the prevention of sexual misconduct in the Australian Defence Force

The Australian Defence Force should develop a comprehensive sexual misconduct prevention strategy that includes primary prevention and early intervention, as well as targeted behaviour change programs for perpetrators of sexual misconduct.

The strategy should be:

(a) developed in partnership with the Australian Human Rights Commission and Our Watch, include specific actions for implementation, including timeframes, and be tailored to the ADF context

(b) submitted to the Minister for Defence and the Minister for Defence Personnel for endorsement, and published on the Defence website.

(Chapter 8: Military sexual violence)

Recommendation 18: Strengthen workplace protections during sexual misconduct investigations

The Australian Defence Force should develop a dedicated policy that applies when sexual misconduct incident investigations are underway in the administrative, disciplinary or civilian justice systems.

The policy should:

(a) provide that the commanding officer must immediately apply one of the following interim actions to the alleged perpetrator, neither of which imply any finding of guilt or wrongdoing:

  (i) amend their work arrangements to ensure no contact between the victim and the alleged perpetrator (depending on the nature of the work, this may require re-assignment to a different location), noting that the arrangement must not restrict the victim from accessing any common areas

  (ii) allow suspension with pay

(b) ensure that the commanding officer's decision must be informed by a comprehensive risk assessment of the safety, health and wellbeing of the victim, the alleged perpetrator and the broader workplace, with the reasons for the decision being recorded

(c) ensure that interim actions are reviewed on a regular basis until the matter has been resolved through both the disciplinary (or criminal) and administrative systems.

The policy should not preclude the commanding officer from:

(d) suspending an alleged perpetrator without pay (either in full or part), in accordance with the *Defence Force Discipline Act 1982* (Cth) and the Defence Force Regulation 2016

(e) taking any additional interim actions as necessary.

(Chapter 8: Military sexual violence)

Recommendation 19: Protect victims of sexual misconduct from disadvantage over the course of their careers

To ensure there are no inadvertent career consequences for victims of sexual misconduct and to support the safety of victims over the course of their careers, Defence should:

(a) develop a neutral label to signify where a change in working hours, or a short-notice or out-of-cycle posting, has occurred to protect a member's health and wellbeing, in a way that protects individual privacy and clearly signals that no career penalty should apply. Similar amendments should be made to the military employment classification system and in guidance to promotions boards

(b) report to the Minister for Defence Personnel by no later than 30 June 2025 on whether career management, human resources and Defence housing systems have been updated to ensure victims of sexual misconduct are not posted with their perpetrator/s over the course of their career.

(Chapter 8: Military sexual violence)

Recommendation 20: Amend the legislation related to sentencing perpetrators of military sexual offences

The Australian Government should amend Section 70 of the *Defence Force Discipline Act 1982* (Cth) to:

(a) expressly require service tribunals to consider the impact of a sexual offence on the victim as a factor during sentencing, including a victim impact statement if one has been made, and allow the victim to read their statement aloud if they choose to do so, in a closed or open court

(b) make it clear that if an offender is of higher rank than a victim, this should be considered an aggravating factor for the purpose of sentencing.

The Australian Defence Force Chief Judge Advocate should amend Practice Note 6 – Part IV Sentencing to require the prosecution counsel to invite victims to make a victim impact statement for consideration by the service tribunal during sentencing.

(Chapter 8: Military sexual violence)

Recommendation 21: Implement a 'presumption' of discharge for Australian Defence Force members found to have engaged in certain forms of sexual misconduct

The Chief of the Defence Force should issue a directive providing for a presumption that anyone in the Australian Defence Force (ADF) who is found to have engaged in certain forms of sexual misconduct will be discharged.

(a) The directive should apply to specified forms of sexual misconduct including, but not limited to, sexual harassment, sexual offences, related offences including intimate image abuse, stalking, and any other offence involving conduct of a sexual nature against an ADF member including prejudicial conduct, assault and obscene conduct.

(b) The standard of proof is the balance of probabilities. For the directive to apply, there needs to be a finding, either by a criminal/disciplinary tribunal or administratively by command, substantiating that sexual misconduct has occurred. Where a sexual offence allegation has been made but has not proceeded to prosecution, or has been prosecuted but has not resulted in a conviction, the behaviour must be assessed on the balance of probabilities to determine whether the directive applies.

(c) Procedural fairness should be afforded to the member before a decision on whether to retain or discharge them is made. The directive should provide guidance on factors to be taken into account by the decision-maker. The decision must be approved by the relevant service chief.

(d) Discharge statistics related to decisions made under the directive should be provided annually to the Minister for Defence and the Minister for Defence Personnel. Statistics should be disaggregated by service and be accompanied by an analysis of common themes, lessons learnt, and actions taken in response.

(Chapter 8: Military sexual violence)

Recommendation 22: Adopt a policy of mandatory discharge for Australian Defence Force members convicted of sexual and related offences

Defence should adopt a policy of mandatory discharge for Australian Defence Force members convicted of sexual and related offences (including stalking and intimate image abuse) in the military and civilian criminal justice systems, subject to further legal advice on the legislative barriers, if any.

(Chapter 8: Military sexual violence)

Recommendation 23: Record convictions of sexual offences in Australian Defence Force records and civilian criminal records

As a matter of urgency, the Australian Government should:

(a) ensure the Australian Defence Force has a complete and reliable record of all serving members who have been convicted of sexual offences and related offences (including stalking and intimate image abuse) in civilian courts

(b) work with state and territory governments to ensure that civilian criminal records include convictions of sexual offences and related offences (including stalking and intimate image abuse) made under the *Defence Force Discipline Act 1982* (Cth).

(Chapter 8: Military sexual violence)

Recommendation 24: Annually publish anonymised data on outcomes of all incidents of sexual misconduct

Defence should publish data on administrative and disciplinary outcomes for all forms of sexual misconduct incidents. At a minimum, this data should:

(a) be published on an annual basis, disaggregated by service

(b) identify the nature and type of all sexual misconduct incidents, including:

  (i) the nature and type of sexual offences and related offences, including intimate image abuse, stalking and relevant service offences that include sexual misconduct as an element

  (ii) other forms of sexual misconduct, including sexual harassment and sex discrimination

(c) include demographic information of victims and perpetrators, including age, rank and gender.

(Chapter 8: Military sexual violence)

Recommendation 25: Conduct a formal inquiry into military sexual violence in the Australian Defence Force

The Australian Government should commission an external, independent, expert inquiry into military sexual violence in the Australian Defence Force (ADF), with a report that includes recommendations provided to the Minister for Defence, the Minister for Defence Personnel and the Attorney General, and made public.

The terms of reference for this inquiry should be developed in consultation with victims of sexual violence in the ADF (serving and ex-serving), and at a minimum should include:

(a) the effectiveness of the military justice system compared to the civilian justice system in receiving, investigating and adjudicating on sexual and related offences. This should include an examination of the Joint Military Police Unit's investigative powers and capability to conduct sexual offence investigations; the referral of matters to civilian police; any barriers faced by civilian police investigating sexual offences on ADF bases; sentencing outcomes; recidivism rates; decisions not to prosecute and conviction rates

(b) the underlying reasons for the reduction in actions (including making a report, and agreeing to reported matters being investigated) taken by victims of sexual violence, including the role of alcohol and other barriers, and the adequacy of ADF policies in addressing these

(c) the effectiveness of anonymous reporting options including awareness, uptake and impact compared to alternative approaches (including but not limited to the approach taken in the United States).

The inquiry should have regard to all lived-experience testimony, statements, exhibits and published submissions made to this Royal Commission that are related to sexual violence in the ADF.

(Chapter 8: Military sexual violence)

Recommendation 26: Foster a strong culture of reporting unacceptable behaviour

Defence should foster a strong reporting culture to:

(a) proactively identify at-risk locations, cohorts, ranks or roles where toxic subcultures are flourishing

(b) implement risk mitigation strategies to address unacceptable behaviour directly in the locations, cohorts, ranks or roles identified

(c) report publicly on identified hot spots of unacceptable behaviour and what actions have been taken to address unacceptable behaviour.

(Chapter 9: Unacceptable behaviour and complaints management)

Recommendation 27: Evaluate outcomes to ensure that Defence has addressed the intent behind recommendations

Defence should evaluate the outcomes of actions taken to implement the recommendations made by the Commonwealth Ombudsman in its review *Does Defence handle unacceptable behaviour complaints effectively? Defending Fairness*, to ensure that the intent of the recommendations is achieved.

(Chapter 9: Unacceptable behaviour and complaints management)

Recommendation 28: Coordinate governance, assurance and policy functions of the military justice system

Defence should establish a home for military justice governance, assurance and policy and provide sufficient resourcing to achieve the following functions:

(a) monitor qualitative and quantitative data and analyse trends across the range of military justice processes and outcomes

(b) prioritising strategies to improve military justice record-keeping and data input issues to remediate data quality and facilitate analysis

(c) monitoring the effectiveness of implementation of recommendations from various military justice reviews (including Inspector-General of the Australian Defence Force), including activity and impact evaluation

(d) continue to define military justice metrics and align them with health and wellbeing metrics, and in so doing, to:

  (i) identify and monitor risks of misuse and abuse of military justice processes

  (ii) track complaints and trends related to termination, offence type and investigation outcomes

  (iii) identify members who are repeatedly subject to military justice processes

  (iv) identify officers who apply disproportionately high numbers of administrative sanctions

(e) establish and implement effectiveness measures for military justice reforms / key actions on the Military Justice Steering Group action plan

(f) review current-status reporting on initiatives in line with good-practice governance principles.

(Chapter 10: The ADF military justice system)

Recommendation 29: Establish a new role to improve training and communication on conducting inquiries

Defence should establish the Joint Workforce Capability Employment Manager as a priority, whose scope of work should include:

(a) reviewing the effectiveness of training in how to conduct 'fact finds' and inquiries and ensuring that trauma-informed principles are embedded throughout the training

(b) reviewing the effectiveness of policies and communication material related to 'fact finds' and inquiries.

(Chapter 10: The ADF military justice system)

Recommendation 30: Prioritise the Inspector-General's inquiry into the weaponisation of the administrative system

The Inspector-General of the Australian Defence Force should initiate an own-initiative inquiry into the weaponisation of the military justice administrative system by the end of 2024.

The inquiry should consider how to improve accountability of commanders who are found to misuse and abuse military justice processes. Measures to identify misuse and abuse may include monitoring trends in administrative sanctions and locations, cohorts, roles or ranks found to be associated with disproportionately high rates of sanctions.

(Chapter 10: The ADF military justice system)

Recommendation 31: Consider how mental health may contribute to poor conduct before recommending administrative termination

That it be mandatory for Defence, when recommending administrative termination of a member under Section 24 (1) (c) of the Defence Regulation 2016 (Cth) 'retention-not-in-service-interest', to consider the member's current mental health and/or the role that mental health may have played in the behaviour that attracted administrative action.

(Chapter 10: The ADF military justice system)

Recommendation 32: When requested, conduct a merits review when a member's service is terminated for the reason 'retention-not-in-service-interest'

Defence should implement a merits-review process for involuntary separation under Section 24 (1) (c) of the Defence Regulation 2016 (Cth) 'retention-not-in-service-interest' through consultation and collaboration with the Inspector-General of the Australian Defence Force (ADF) and the Administrative Appeals Tribunal/ Administrative Review Tribunal.

(a) Defence should introduce an enhanced merits-review process in the Redress of Grievance Directorate of the Inspector-General of the ADF.

(b) The Australian Government should consider giving jurisdiction to a specialist division of the Administrative Appeals Tribunal/Administrative Review Tribunal to manage a fast-track method for conducting external merits reviews. It is proposed that an external merits review would only be considered after the independent merits review process of the Inspector-General of the ADF had been completed.

(Chapter 10: The ADF military justice system)

Recommendation 33: Seek to understand whether/how involvement in military justice processes contributes to adverse outcomes

Defence should undertake further research to better understand the stressors that are both associated with, and lead to, involvement in administrative and disciplinary processes, including:

(a) identifying prevalence rates of suicide and suicidality for serving and ex-serving members who have been exposed to military justice administrative and disciplinary processes

(b) exploring the connection between members' use of alcohol and other drugs as a numbing strategy to help them cope with trauma and service-related stressors, and involvement in administrative or disciplinary processes

(c) identifying opportunities to intervene when members are engaging in maladaptive coping strategies before their behaviour leads to administrative or disciplinary action.

Based on the outcomes of this research, Defence should implement policies to support members involved with military justice processes and minimise the risk of adverse outcomes, including suicide and suicidality.

(Chapter 10: The ADF military justice system)

Recommendation 34: Prioritise the review into the regulations governing court martial panels

Defence should prioritise the review of current provisions relating to court martial panels not being required to provide reasons for punishments being imposed.

Defence should document this in the 2024/25 Military Justice Steering Group workplan.

(Chapter 10: The ADF military justice system)

Recommendation 35: Determine whether support mechanisms for members involved with military justice processes are effective

Defence should evaluate the effectiveness of the key support mechanisms for those involved in military justice proceedings, including but not limited to:

(a) support officers

(b) individual welfare boards.

In its evaluation, Defence should consider members' experiences of the supports provided.

(Chapter 10: The ADF military justice system)

Recommendation 36: Trial a model outside the chain of command for supporting members involved in military justice processes

The Australian Defence Force (ADF) should fund and pilot a model for automatic, opt-out referral to both legal and welfare support services for members engaged in certain military justice processes that is separate from the chain of command (for example, the Workplace Behaviour Adviser Network, the Sexual Misconduct Prevention and Response Office, and the Employee Assistance Program).

In developing the pilot, the ADF should:

(a) consider the role of individual welfare boards in the process

(b) make it clear that once the referral is received, the relevant service would be responsible for initiating contact

(c) consider thresholds for referral, and focus on increasing support for members exposed to factors known to contribute to higher risk of psychosocial harm, suicide and suicidality for example:

  (i) those involved (both as victims and accused) in unacceptable behaviour complaints, sexual misconduct incidents, and disciplinary proceedings for offences under the *Defence Force Discipline Act 1982* (Cth)

  (ii) those who are being considered for administrative termination.

The ADF should evaluate the pilot at its conclusion to assess the demand impacts and benefits in order to inform the decision for a broader roll-out.

(Chapter 10: The ADF military justice system)

Recommendation 37: Develop a charter of minimum standards for all members involved in military justice processes

The Australian Defence Force (ADF) should develop a charter of minimum standards for all members involved with or subject to disciplinary processes, or involved in matters handled by the Inspector-General of the ADF. It should include commitments to:

(a) treating members with courtesy, compassion, dignity and respect, and consideration of their welfare needs

(b) providing members with information that is clear and understandable about:

  (i) the relevant military justice processes

  (ii) the legal, welfare and victim-support services available to them

(c) referring members to relevant support services

(d) providing updates at key stages of the process, including explaining the outcomes at its conclusion

(e) giving victims of unacceptable behaviour the opportunity to provide a victim impact statement to inform sentencing, where the accused has been found guilty.

The charter should also contain defined roles and responsibilities for meeting the minimum standards.

The charter should be publicly available and members may refer to these minimum standards via the existing appeals and complaints processes where they feel these standards have not been upheld.

(Chapter 10: The ADF military justice system)

Recommendation 38: Improve governance processes related to accountability and continuous improvement

To improve accountability and continuous improvement regarding mental health and wellbeing outcomes, Defence should:

(a) continue to work towards including health, wellbeing and safety measures in its Budget Paper performance measure, and ensure these measures cascade into future corporate plans

(b) prioritise the development of the Monitoring and Evaluation Framework in partnership with the Department of Veterans' Affairs, for the joint Mental Health and Wellbeing Strategy 2024–2028, and set out what success would look like for that strategy in terms of outcomes in the short, medium and long term, against the wellbeing domains

(c) continue to develop a clear performance logic, including the translation of performance measures from budget papers, the corporate plan, and the joint strategy into clear accountability measures for senior leaders in Defence

(d) once the Enterprise Reform Program has been implemented, assess how improvements in the collection, sharing and use of data may better support performance measurement, in line with the Defence performance logic model.

Acknowledging the challenges in improving performance measurement, and the risk of unintended consequences, the Australian Government should assist Defence to build performance management experience and expertise at the unit, service and enterprise level by:

(e) prioritising Defence in the broader Australian Public Service performance management capability uplift

(f) prioritising Defence in the Australian Public Service Commission Capability Review program

(g) supporting a coaching and mentoring program in areas (identified by Defence) that have responsibility for developing and implementing reforms in performance measurement.

(Chapter 11: Governance and accountability in Defence)

Recommendation 39: Address risk factors for suicide and suicidality and report on progress as part of enterprise-level risk management

Defence should address in-service risk factors for suicide and suicidality as part of the reporting processes related to enterprise risk management and the development of mental health and wellbeing strategy by:

(a) identifying in-service risk factors to be reported (including, but not limited to, the risk factors for suicide and suicidality related to Australian Defence Force service identified in Chapter 1, Understanding suicide)

(b) developing outcomes-based measures against these risk factors

(c) developing risk controls and measures of control effectiveness.

Enterprise risk management must be informed by a contemporary assessment of hazards related to the health and wellbeing of Defence personnel and should inform delivery of the joint Mental Health and Wellbeing Strategy 2024–2028.

(Chapter 11: Governance and accountability in Defence)

Recommendation 40: Improve governance mechanisms from the unit level to the enterprise level

In order to identify and address barriers to effective governance from the unit level to the enterprise level, Defence should:

(a) review all internal and external governance reporting mechanisms

(b) identify root causes of non-compliance with required reporting

(c) identify duplicative reporting information and processes

(d) draw on process-improvement methodologies (for example, Lean Thinking) to reduce the administrative burden of reporting and governance compliance across Defence

(e) improve governance, performance-reporting and data literacy at the unit, service and enterprise level via training and/or embedding coaching.

(Chapter 11: Governance and accountability in Defence)

Recommendation 41: Build project-management capability so that reform initiatives are successful

To build sustained capability to implement lasting policy changes, Defence should:

(a) engage independent expertise to undertake a project management maturity assessment of the areas in Defence that will be responsible for implementing the recommendations of this Royal Commission

(b) upon completion of the maturity assessment, develop a blueprint and implementation plan to deliver the improvements to those areas of project management capability that require an uplift

(c) monitor the implementation of the capability uplift through to completion via a Tier 1 Committee.

(Chapter 11: Governance and accountability in Defence)

Recommendation 42: Ensure that future Inspectors-General of the Australian Defence Force will not have served in the ADF

The Australian Government should amend Part VIIIB Division 2, sections 110E to 110P of the *Defence Act 1903* so that:

(a) a person appointed as the Inspector-General of the ADF must not have served in the ADF

(b) the Inspector-General should be supported by two Deputy Inspectors-General with appropriate skills and experience, for example, having served in the ADF or having experience and understanding of the justice system, including military justice

(c) the Deputy Inspector-General positions are to be statutory appointments.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 43: Allow the Inspector-General of the Australian Defence Force to make recruitment decisions for the staffing of their office

The Inspector-General of the Australian Defence Force (ADF) should have the responsibility and authority for the selection of staff in their office, including as to whether staff are drawn from the ADF, the Australian Public Service, or from other sources.

The Inspector-General should have the power to select and recruit freely from the ADF without being constrained by whom the Chief of the Defence Force, the service chiefs or the Director of Military Legal Capability select or recommend.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 44: Ensure that staff of the office of the Inspector-General of the Australian Defence Force have the necessary skills, expertise and qualifications

The Inspector-General of the Australian Defence Force (ADF) should develop a workforce plan that includes:

(a) a review of the skills, expertise and professional qualifications required to discharge effectively the Inspector-General's complete functions

(b) an assessment of the current workforce in the office of the Inspector-General in which any competency gaps are identified

(c) a strategic plan to attract and deliver the required capability profile to the office of the Inspector-General.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 45: Improve transparency and accountability of the Inspector-General of the Australian Defence Force by increasing their reporting requirements

The Inspector-General of the Australian Defence Force (ADF) should improve the transparency and accountability of their office by:

(a) updating and publishing comprehensive guidance or other standard operating procedures on its website, including quality-assurance measures, related to the discharge of the Inspector-General's functions in each directorate of the office of the Inspector-General

(b) establishing and including in this guidance specific performance measures related to timeliness in the completion of assessments and inquiries and the consideration of redress of grievance complaints, and reporting annually on performance against these measures.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 46: Ensure staff of the Inspector-General of the Australian Defence Force are trained in trauma-informed practice

The Inspector-General of the Australian Defence Force should ensure that all staff in the office of the Inspector-General (including consultants) who engage with members' next of kin and family members; are communicating with complainants, respondents or witnesses for the purpose of an inquiry; or who are charged with considering a redress-of-grievance complaint have completed the Compassionate Foundations course or equivalent training in trauma-informed practice before doing so, and complete refresher training every two years.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 47: The Inspector-General to inquire into all deaths of serving members unless suicide can be excluded as the cause of death

The Inspector-General of the Australian Defence Force (ADF) should ensure that where suicide cannot be categorically excluded as the cause of death of an ADF member, a formal inquiry under written directions is conducted.

When undertaking such an inquiry, the Inspector-General should obtain input from a qualified mental health expert, such as a psychologist, when determining:

(a) whether suicide may have been the cause of death

(b) where suicide cannot be excluded, what the contributing factors may have been and whether there was a 'service nexus'

(c) what recommendations should be made.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 48: When a member dies by suicide, appoint a legal officer to represent the interests of the deceased and support the next of kin

When a serving member dies by suicide, or is suspected to have died by suicide, the Inspector-General of the Australian Defence Force should ensure that a legal officer from Defence Counsel Services has been appointed to represent the interests of the deceased upon written directions for a formal inquiry being issued.

The Inspector-General should ensure that interviews with the member's next of kin are conducted after the legal officer has been appointed and made contact with them.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 49: Minimise disclosure restrictions of Inspector-General inquiry reports and ensure they are fair and understood by the next of kin

In relation to non-disclosure directions made pursuant to section 21 of the *Inspector General of the Australian Defence Force Regulations 2016:*

(a) staff from the office of the Inspector-General must explain the scope of the directions to next of kin and family members before they are made

(b) the directions should not apply to information that next of kin themselves provide to an inquiry, and which next of kin may know independently of anything contained in a draft, unredacted or redacted report

(c) next of kin should be consulted directly about the persons that are to be included in the carve-outs to the directions permitting disclosure, and persons nominated by the next of kin should be included unless there is a good reason not to include them

(d) restrictions on disclosure in respect of unredacted and redacted final reports should only extend to those parts of the reports that need to have disclosure restricted in the interests of the defence of the Commonwealth, or for reasons of fairness to a person who the Inspector-General considers may be affected by the inquiry

(e) the Inspector-General should establish a mechanism by which next of kin may have the directions that are made reviewed by a legal officer of the office of the Inspector-General who was not involved in the relevant inquiry or in the decision to make the directions. The Inspector-General must have regard to the issues or concerns raised by the legal officer

(f) there should be comprehensive guidance in relation to the making and terms of Section 21 directions included in the updated comprehensive guidance on the Inspector-General's website.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 50: Amend the scope of the Inspector-General's role to inquire into suicide deaths of former Australian Defence Force members

The Inspector-General should be required and empowered to inquire into the death of a former Australian Defence Force (ADF) member where the death may have been by suicide, and where:

(a) the death occurs:

  (i) after 30 September 2024; and

  (ii) within two years of the former member ceasing to be an ADF member; and

(b) the Inspector-General is notified or otherwise learns of the death within three months of the date of death.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 51: The Inspector-General to regularly review inquiries into suicide deaths to determine common themes

The Inspector-General of the Australian Defence Force should conduct a review of all inquiries and reports into suicide or suspected suicide every three years to determine whether there are any common themes and contributing factors, and report the findings to the Chief of the Defence Force, the Minister for Defence and the Minister for Defence Personnel.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 52: Conduct a merits review when a member's service is involuntarily terminated and they submit a redress of grievance complaint

When a member makes a redress of grievance complaint concerning a decision to terminate their service, the Inspector-General of the Australian Defence Force should:

(a) (in addition to Recommendation 32) conduct a review in the nature of a merits review and determine, in their view, the correct or preferable decision

(b) conclude their consideration of the complaint within 60 days of referral

(c) give the member the opportunity to provide any further information or submissions prior to concluding their consideration of the complaint, in person, if practicable to do so, when the proposed outcome will not be favourable to the member.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 53: Give members 21 days to make a complaint after being notified of a decision to terminate their service

Defence should amend Section 41(2) of the *Defence Regulations 2016* to allow a member to make a complaint up to 21 days after they are notified of a decision to terminate their service.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 54: Improve the frequency of military justice-related audits conducted by the Inspector-General of the Australian Defence Force

The Inspector-General of the Australian Defence Force (ADF) should:

(a) conduct a routine military justice performance audit of every major ADF unit every three years, and of every *ab initio* training establishment every two years

(b) conduct a longitudinal study of all audit reports every two years to determine trends, themes and issues of concern, and provide the outcomes of this analysis to the Chief of the Defence Force, the Minister for Defence and the Minister for Defence Personnel

(c) audit at least three non-major units each year that are not part of the Directorate of Military Justice Performance Audit routine audit cycle.

(Chapter 12: Role and functions of the Inspector-General of the ADF)

Recommendation 55: Conduct an audit into Defence workplace health and safety risk management

The Defence Audit and Risk Committee should commission an audit into Defence workplace health and safety (WHS) risk management within the next 12 months. The audit should include, but not be limited to:

(a) reviewing WHS hazard trends with a focus on psychosocial health and compliance with requirements of the *Work Health and Safety Act 2011* (Cth)

(b) reviewing the accuracy of existing WHS enterprise risk reporting, including the WHS dashboard

(c) assessing WHS risk-assessment methodology, and the accuracy of categorisations of 'likelihood' and 'impact' of hazards within the 'WHS' enterprise risk category

(d) assessing the suitability and effectiveness of WHS hazard controls, including their ability to be measured for impact.

The findings of the audit must be reflected in the delivery of the Defence WHS Strategy and WHS risk reporting going forward.

(Chapter 13: Oversight of Defence workplace health and safety)

Recommendation 56: Improve guidance and understanding of Defence's 'if in doubt, notify' policy

Comcare and Defence should work together to improve guidance and understanding of the 'if in doubt, notify' policy in relation to determinations about when to report notifiable incidents to Comcare.

(Chapter 13: Oversight of Defence workplace health and safety)

Recommendation 57: Comcare to regularly review Australian Defence Force determinations of 'service nexus' for suicide attempts and suspected deaths by suicide

Comcare should improve its quality assurance of Australian Defence Force (ADF) 'service nexus' determinations made by the ADF by:

(a) undertaking a periodic review of service nexus determinations made by the ADF for incidents of suicide, suspected suicide, attempted suicide, and non-fatal self-harm by ADF members, where the ADF has concluded that the incident did not arise out of the conduct of the ADF's business or undertaking, under section 38(1) of the *Work Health and Safety Act 2011* (Cth)

(b) evaluating the results of these periodic reviews after three years to determine whether there is a continued need for them. The timeframe of three years will enable Comcare to test a sufficient sample size to inform a decision about whether to continue periodic reviews.

Defence should fund any additional resourcing required by Comcare to undertake these periodic reviews over the three-year period and conduct its evaluation at the end of that period.

(Chapter 13: Oversight of Defence workplace health and safety)

Recommendation 58: Give Comcare access to the National Veterans' Data Asset

Comcare should have access to the National Veterans' Data Asset (Recommendation 107), to inform Comcare's regulatory approach to preventing psychosocial harm including latent harm.

(Chapter 13: Oversight of Defence workplace health and safety)

Recommendation 59: Defence to participate in Comcare's Psychosocial Proactive Inspection Program

Defence should participate in Comcare's Psychosocial Proactive Inspection Program, once the evaluation has established that it is effective.

Either:

(a) Defence should fund its participation in that program, or

(b) a Commonwealth appropriation should be made to Comcare for the purpose of Defence's participation in the program.

(Chapter 13: Oversight of Defence workplace health and safety)

Recommendation 60: Improve strategies for harm prevention and early intervention by sharing quality data with Comcare

To improve Comcare's ability to inform prevention and early intervention strategies for suicide and latent harm arising from Australian Defence Force service, Defence should:

(a) share with Comcare on a quarterly basis through the Suicide and Self-Harm Working Group meeting:

  (i) data on psychosocial harm (including data related to notifiable and non-notifiable incidents)

  (ii) Defence's analysis of this data to identify systemic issues related to psychosocial harm

(b) share with Comcare through the Defence-Liaison Forum meeting what actions it has taken to document and implement controls to address systemic hazards, risks and issues relating to psychosocial harm.

(Chapter 13: Oversight of Defence workplace health and safety)

Recommendation 61: Establish a brain injury program

Defence and the Department of Veterans' Affairs should establish a brain injury program that covers, at a minimum, relevant Army corps, special forces, Navy clearance divers, Air Force combat controllers, and serving and ex-serving members exposed to mefloquine and/or tafenoquine. The program should:

(a) aim to better understand, and mitigate, the impact of repetitive low-level blast exposure on brain processes

(b) assess and treat neurocognitive issues affecting serving and ex-serving members, whatever their cause.

To do this, it should:

(c) monitor and assess environmental exposure to blast overpressure

(d) record members' exposure to traumatic brain injury and minor traumatic brain injury, including in medical records

(e) establish a neurocognitive program suitable for serving and ex-serving members experiencing a range of neurocognitive issues, whatever their cause. This could be adapted from the former Mending Military Minds program

(f) provide referral pathways for further medical assessment, when required.

(Chapter 14: Introduction to health care for members and veterans)

Recommendation 62: Establish a research translation centre for defence and veteran health care

The Australian Government should support the development of a research translation centre for Defence and veteran health care, or a similar body with an explicit research translation focus.

(a) Defence and the Department of Veterans' Affairs (DVA) should work with relevant stakeholders, including researchers and health providers with expertise and experience in defence and veteran health care, to develop a model for the establishment of the research translation centre and priority initiatives for funding.

(b) The model should be informed by the National Health and Medical Research Council criteria for accreditation of a research translation centre, and include the following aims:

  (i) promoting and increasing research on Defence and veteran health care in Australia

  (ii) translating research into improvements to the health system and better outcomes for patients

  (iii) facilitating collaboration among and between researchers and clinicians

  (iv) supporting research-infused education and training.

(c) Defence and DVA should jointly develop a business case for the research translation centre for consideration by the Australian Government.

(Chapter 14: Introduction to health care for members and veterans)

Recommendation 63: Reduce stigma and remove structural and cultural barriers to help seeking

The Australian Defence Force (ADF) should identify and remove cultural and structural barriers to help seeking and make a greater concerted effort to reduce stigma. This should include:

(a) the Australian Government should remove reference to the word 'malingering' at Section 38 of the *Defence Force Discipline Act 1982* (Cth)

(b) Defence should review all its policies and procedures and amend or remove those that are stigmatising

(c) the ADF should develop a dedicated training program and a communications campaign to reduce stigma and promote help seeking.

(Chapter 15: Promoting health and wellbeing among ADF members)

Recommendation 64: Establish an enterprise-wide program to monitor and prevent physical and psychological injury

The Australian Defence Force should establish a comprehensive, enterprise-wide injury surveillance and prevention program. The program should encompass physical and psychosocial risks and hazards, and:

(a) be adequately resourced, including by engaging staff with appropriate expertise in injury prevention, including physical and psychosocial injury and illness

(b) identify the most common injury risks and hazards and implement strategies for preventing or minimising them

(c) include functionality within the reporting system to identify root causes or contributing factors including location, time, and activity being undertaken at the time of injury

(d) actively monitor where injuries and psychological risks and hazards occur and generate quarterly reports on injury rates and clusters with actionable recommendations for commanding officers.

(Chapter 15: Promoting health and wellbeing among ADF members)

Recommendation 65: Improve access to, timeliness and quality of mental health screening and use the data effectively

The Australian Defence Force should ensure that its mental health screening continuum effectively identifies members who require additional support and/or who are at heightened risk of suicide, and that these individuals receive support, by:

(a) ensuring that members have access to screening and are offered referrals for further support at all known points of vulnerability, including: during *ab initio* training, when their military employment classification is downgraded, and accessing rehabilitation

(b) ensuring that a sufficient and appropriately trained workforce is available to administer the mental health screening continuum and conduct the required follow-ups, including:

  (i) ensuring screening is done in such a way that encourages disclosure, including face-to-face screening wherever possible

  (ii) ensuring members receive timely and appropriate referrals following screenings where required

  (iii) monitoring the uptake of referrals and following up with members who do not action these referrals

  (iv) monitoring members who are overdue for screenings and following up with them

(c) introducing tools that screen for known risk factors for suicide and suicidality that are not currently screened for, including problematic anger, sleeping difficulties and military sexual trauma

(d) using the data collected during screenings for longitudinal surveillance.

(Chapter 15: Promoting health and wellbeing among ADF members)

Recommendation 66: Where possible, support injured members to be rehabilitated at work, within their home unit

The Australian Defence Force (ADF) should support and resource rehabilitation services within the ADF to adopt a tailored approach, from members rehabilitating within their home unit, either with or without the support of a specialist rehabilitation service working in conjunction with the chain of command when required, to coordination of rehabilitation and recovery through a specialist rehabilitation unit only in exceptional circumstances and when necessary to optimise functioning and return to work.

Consistent with this approach:

(a) Defence policies and procedures related to rehabilitation should adopt the principle of recovering at work, where safe to do so. This principle should be embedded in the Defence Health Manual, Military Personnel Manual, ADF Rehabilitation Program Procedures Manual, and other relevant policies and guidelines.

(b) rehabilitation at home or in a designated rehabilitation unit should be reserved for exceptional circumstances, and even in these instances, home units must maintain connection with the member undergoing rehabilitation, whether that be at home or assigned to a designated rehabilitation unit

(c) rehabilitation outcomes should be publicly reported on a regular basis.

(Chapter 16: ADF healthcare services)

Recommendation 67: Align Defence's clinical governance framework with the national model framework

Defence should work with relevant bodies, including the Australian Commission on Safety and Quality in Health Care and the Royal Australian College of General Practitioners, and in consultation with Bupa, the Department of Veterans' Affairs (DVA) and relevant civilian health services to review its clinical governance framework, with a view to aligning it with the National Model Clinical Governance Framework.

Defence should give particular attention to:

(a) strengthening its quality improvement systems to actively manage and improve the safety and quality of its health care

(b) ensuring that performance monitoring systems are in place to monitor clinical effectiveness

(c) establishing partnerships across DVA, civilian healthcare services and specialist facilities for serving and ex-serving members, and leveraging these partnerships to respond optimally to the unique needs of each patient

(d) ensuring that serving members are a partner in the design, delivery and evaluation of Australian Defence Force healthcare services.

(Chapter 16: ADF healthcare services)

Recommendation 68: Strike the right balance between upholding confidentiality and disclosing information when a member is in distress

Defence should ensure that members and commanding officers understand how the *Privacy Act 1988* (Cth) operates and the importance of members' consenting to their health information being shared with those able to facilitate appropriate care and support, in the event members are distressed or experiencing mental health challenges.

To this end, Defence should:

(a) continue its proactive approach to consent and provide regular training on the Privacy Act

(b) regularly evaluate members' understanding of the importance of consent and how Defence will use their personal information

(c) by the end of 2025 and regularly thereafter (no less frequently than every three years), review its privacy policy and amend it as appropriate to ensure that it is clear, particularly with respect to:

  (i) what it means to provide consent, and why consent is important, particularly for ensuring that family members are equipped with relevant information to support a members' mental health and wellbeing

  (ii) how members' health information is reasonably necessary for, or directly related to, the functions and activities of the Australian Defence Force (ADF), including what 'suitability for service from a health perspective' means

  (iii) when a 'general permitted situation' (as defined in section 16A of the *Privacy Act 1988* (Cth)) exists in the context of the ADF, particularly when a member is experiencing distress or mental health challenges that puts them at risk of suicidality

  (iv) when members' mental health information will be disclosed to their commander or manager to facilitate their wellbeing; when, in the context of the ADF, disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual or to public health or safety, and to whom the information can be disclosed.

If barriers remain following review and amendment of the Defence privacy policy, then consideration could be given to subsequent legislative change, as part of the process set out in Recommendation 74.

(Chapter 16: ADF healthcare services)

Recommendation 69: Improve suicide-prevention training so it is practical, tailored, informed by lived experience and delivered in person

The Australian Defence Force should revise and improve its suicide-prevention training so it:

(a) focuses on practical rather than theory-based learning, and ensures members are familiar with what support is available

(b) is scaled, to emphasise different levels of responsibility, from junior ranks to commanders. Specific training should be offered to senior leaders, which sets out how they can support those under their command

(c) is informed by, and involves, members with lived experience of suicide, suicidality or mental health

(d) delivers all suicide prevention training in-person by no later than 31 December 2025.

(Chapter 17: ADF and DVA suicide prevention programs and initiatives)

Recommendation 70: Revise protocols for responding to suicidal crisis to be in line with clinical best practice

By no later than 31 December 2025, Defence should revise its protocols for responding to suicidal crisis so they are applied consistently, in line with clinical best practice.

(a) The protocols should, among other things, specify:

  (i) the availability of, and arrangements for accessing, culturally appropriate crisis care facilities

  (ii) a minimum standard for aftercare

  (iii) how monitoring and follow-up support should occur following a suicide-related incident

  (iv) approaches to reintegration following a suicidal crisis.

(b) The revised protocols should be developed in partnership with an external body with expertise in managing suicidal crisis and aftercare.

(c) The revised protocols and their application across the three services should be subject to independent evaluation after five years.

(Chapter 17: ADF and DVA suicide prevention programs and initiatives)

Recommendation 71: Increase the Department of Veterans' Affairs fee schedule so it is aligned with that of the National Disability Insurance Scheme

The Australian Government should amend the Department of Veterans' Affairs (DVA) fee schedule to mitigate the challenges faced by veterans in accessing health care, ensuring that:

(a) at a minimum, the revised fee schedule aligns with that of the National Disability Insurance Scheme

(b) efforts to mitigate supply constraints are prioritised, such as non-fee-for-service components, additional loading, and/or incentive payments, including in areas with few health services for the populations being served.

DVA should reduce the time taken to pay healthcare providers, and track and publicly report on the time taken to provide these payments.

(Chapter 18: Health care for ex-serving members)

Recommendation 72: Expand and strengthen healthcare services for veterans

The Australian Government and state and territory governments should prioritise networks of care in the National Funding Agreement on Veterans' Wellbeing (Recommendation 88).

To enable this, the Department of Veterans' Affairs (DVA) should develop a plan to expand and strengthen specialised health care for veterans. It should set out how to bring together the different components of the health system to meet the health needs of veterans. DVA should complete the plan by September 2026 and submit it to the Veterans' Ministerial Council for endorsement as part of the funding agreement.

The plan must set out measures to improve the coverage of specialised veterans' care, including by:

(a) providing support for primary and allied care providers whose services focus on veterans' health needs

(b) expanding veteran-specific secondary and tertiary health services

(c) developing additional partnership agreements between DVA and primary health networks.

It must also support the integration of veterans' health services at a local and national level, including by:

(d) better informing veterans about available services

(e) using existing health infrastructure, such as primary health networks

(f) developing local exchanges to tighten relationships between medical and allied health care practitioners.

The plan should be guided by current and future needs and informed by data on Australia's veteran population showing the size of veteran communities in different areas, where specialised services currently exist or are lacking, and how and where veterans access health services.

(Chapter 18: Health care for ex-serving members)

Recommendation 73: Improve military cultural competency in health professions working with veterans

The Department of Veterans' Affairs (DVA) should complement the work outlined in Recommendation 72 by expanding its efforts to build cultural competency relating to veterans among health workers who operate in mainstream health settings. DVA should expand its training modules and enable health professionals working with veterans to complete them. It should promote this work, including through partnerships with professional bodies.

(Chapter 18: Health care for ex-serving members)

Recommendation 74: Clarify the application of the Privacy Act to veterans to determine whether amendments are necessary

The Department of Veterans' Affairs (DVA) should seek legal advice clarifying the application of the *Privacy Act 1988* (Cth) (and any other relevant legislation) to veterans and their families in the context of sharing data and information related to health, wellbeing and safety.

DVA should use this advice to inform consideration of whether legislative amendments are required to optimise the management of the health and wellbeing of veterans. Consideration may be given to extending the scope of any changes to encompass serving members, if this is needed following the review of the Defence privacy policy proposed at Recommendation 68.

(Chapter 18: Health care for ex-serving members)

Recommendation 75: Conduct an independent review of Open Arms and publish the report

The Australian Government should commission an independent review of Open Arms, to commence in 2027, following the implementation of the new Model of Care and led by a qualified entity outside of the Defence portfolio.

The scope of the review should be wide-ranging and it should examine:

(a) how Open Arms is discharging its functions, including its compliance with clinical standards and its management of at-risk clients

(b) issues that could affect Open Arms' ability to discharge its functions, including workforce, culture and funding

(c) what functions Open Arms should perform within the wider network of services accessible to serving and ex-serving members

(d) the appropriateness of Open Arms' delivery model, and whether another model is preferable.

The Australian Government should make the review's report public.

(Chapter 19: Open Arms)

Recommendation 76: Develop a postvention framework with experts and those with lived experience of suicide bereavement

The Australian Defence Force should develop a postvention framework that must be implemented following a serving member's death by suicide (or suspected suicide) for the purposes of supporting the member's family members and colleagues, as well as first responders. It should involve:

(a) collaborating with and seeking input from peak postvention organisations and those with lived experience of suicide bereavement

(b) developing communication materials and training modules for commanders and key decision-makers about trauma-informed postvention support for Defence personnel

(c) the use of a systematic process for identifying and referring those at highest risk following a suicide death

(d) consideration of the unique circumstances of each posting or cultural circumstances of the bereaved

(e) greater surveillance and evaluation of the broader impact of suicide on personnel and their functioning for the purposes of improving interventions.

(Chapter 20: Postvention)

Recommendation 77: Develop a suite of postvention resources in collaboration with stakeholders

Defence and the Department of Veterans' Affairs should fund and facilitate the development of a postvention network of suicide-bereavement resources in collaboration with ex-service organisations, states and territories, lived experience peers, and civilian support organisations to augment current postvention offerings, which can be inclusively accessed by and are tailored for the military community and all those affected by veteran suicide.

(Chapter 20: Postvention)

Recommendation 78: Prevent, minimise and treat moral injury

Defence and the Department of Veterans' Affairs should work collaboratively to develop an agreed approach to minimising the negative impacts of moral injury, including the risk of suicide and suicidality for serving and ex-serving members. The approach should evolve in line with emerging research and best practice, and at a minimum include:

(a) implementing education, training and support programs with the explicit objectives of preventing, minimising and treating moral injury

(b) considering using the Moral Injury Outcome Scale or other tools, as the evidence base evolves, to support the early identification and treatment of moral injury

(c) conducting or commissioning further research to better understand moral injury in the Australian military population.

(Chapter 21: Moral injury)

Recommendation 79: Ensure that respect for and recognition of service are embedded throughout Defence and the Department of Veterans' Affairs

Respect and recognition should be a key element of separation and transition processes; they must also be the foundation for all interactions with members and former members of the Australian Defence Force during service and civilian life.

Defence and the Department of Veterans' Affairs should:

(a) examine their processes to identify ways in which respect in interactions with serving and ex-serving members can be increased

(b) create a survey to benchmark the levels of respect shown to current and ex-serving members prior to 30 June 2025

(c) conduct this survey every two years to identify areas for improvement, and introduce improvements no later than the following year

(d) support the Joint Transition Authority to review its policy on recognition and farewells on a regular basis (at least every three years) to identify areas for improvement, and introduce these improvements by the following year.

(Chapter 23: Transition from military to civilian life)

Recommendation 80: The Department of Veterans' Affairs to take responsibility for supporting members to transition out of the Australian Defence Force

Defence should continue to be responsible for supporting members to prepare for and complete separation from the Australian Defence Force (ADF). The new executive agency to be established in the Department of Veterans' Affairs (DVA) (Recommendation 87) should take responsibility for supporting members to transition into civilian life.

Through the new agency, DVA should:

(a) establish a meaningful relationship with serving members as soon as they begin a pathway towards transition

(b) conduct a transition readiness review prior to separation, which includes the member, their commanding officer and DVA support person

(c) lead transition screening and expand it to assess members' psychosocial readiness for transition, including purpose and connection, help-seeking, beliefs about civilians, and regimentation and adaptability

(d) with the consent of the member, share transition screening results (wholly or partially) with the member's commanding officer and key transition support people within Defence and DVA (with Defence and DVA implementing a proactive process to obtain members' consent to share this information)

(e) proactively reach out to ex-serving members in the 12 months after they leave the ADF to understand their experience of transition, how they are adjusting to civilian life, and connect them with supports delivered by Australian Government agencies, states and territories, and ex-service organisations.

(Chapter 23: Transition from military to civilian life)

Recommendation 81: The Department of Veterans' Affairs to fund a program to support members' wellbeing during transition to civilian life

The Department of Veterans' Affairs (DVA) should fund and commission a cultural transition program to support members to build and maintain wellbeing during the transition from military to civilian life. The purpose of the program should be to empower members to develop the skills to adjust and integrate into civilian culture successfully and sustain social connections.

The program should:

(a) be designed by an expert panel independent from DVA, including people with lived experience of service and transition (both serving and ex-serving Australian Defence Force members) and expertise in cultural adjustment and trauma-informed approaches

(b) be delivered in two parts, the first prior to separation and the second within six months of separation

(c) be evaluated three years after the commencement of the program to assess its outcomes and effectiveness, with adjustments made accordingly.

(Chapter 23: Transition from military to civilian life)

Recommendation 82: Establish a consistent, locally responsive policy on ex-serving members' access to bases

Defence should establish a consistent policy on access to military bases that includes the objective of supporting ex-serving members and their families to maintain social connections following separation from the Australian Defence Force. The policy should allow for local decision-making that balances the benefits of maintaining social connection with former colleagues in the 12 months following separation, with the need to maintain base security.

(Chapter 23: Transition from military to civilian life)

Recommendation 83: Increase opportunities for members to gain civilian qualifications from Defence training and education

Defence should expand the objective of its education and training policies and programs from a sole focus on Defence capability requirements to include member lifetime wellbeing. Specifically, Defence should:

(a) commencing 1 July 2025, issue all civilian accreditations for Defence training at the point of completion of the requisite training, rather than at the point of transition from service

(b) remove arbitrary limits on the number of civilian qualifications that may be awarded to a member in recognition of Defence training they have completed

(c) 'fill the gap' between Defence and civilian training (where an equivalent civilian qualification exists), either by expanding the content of the Defence training course or by funding bridging training for members prior to separation.

(Chapter 23: Transition from military to civilian life)

Recommendation 84: Issue separating members with a reference that states their skills, experience and capabilities

To support ex-serving members to promote their skills and experience in the civilian job market, the Australian Defence Force should issue a reference to each member at separation. The reference should reflect the individual skills and experience of the member and include a personalised statement on the capabilities they demonstrated in their most recent role/s. Contact details of the member's commanding officer approximate to, or at, the point of transition should be provided wherever possible.

(Chapter 23: Transition from military to civilian life)

Recommendation 85: Develop employment pathways for ex-serving members in public sector agencies

The Australian Public Service Commission and its state and territory equivalents should work with public sector agencies to develop and prioritise employment pathways for ex-serving members. They should prioritise agencies in portfolios where military capabilities and lived experience of service are especially relevant, including health, justice, corrections, police, veterans' affairs and defence.

(Chapter 23: Transition from military to civilian life)

Recommendation 86: Ongoing funding for Veterans' and Families' Hubs

The Australian Government should develop a recurrent funding model for Veterans' and Families' Hubs to support their financial sustainability and ongoing operations. In particular, the funding model should ensure that the operating costs of hubs can be met (that is, separate from the costs associated with the services delivered by various providers). The funding model should be developed in consultation with lead organisations of Veterans' and Families' Hubs, as bespoke arrangements are likely to be needed.

Funding agreements should include standardised, de-identified data collection and reporting requirements to inform ongoing service delivery improvements and help to identify service gaps. Data should be shared with state and territory governments.

(Chapter 24: Empowering veterans to thrive)

Recommendation 87: Establish a new agency to focus on veteran wellbeing

The Australian Government should establish a new executive agency focused on veteran wellbeing. The new agency should have distinctive branding, but be administratively nested within the Department of Veterans' Affairs (DVA) to ensure seamless information sharing and referrals.

The new veteran wellbeing agency should have the following functions:

(a) Transition – to play a key role in supporting veterans to transition from military to civilian life (Recommendation 80), build relationships and encourage veterans to access early interventions and supports

(b) System navigation and connection to wellbeing supports at the individual level – to help veterans to navigate the wellbeing ecosystem by providing clear information online about available services, and by working in partnership with Veterans' and Families' Hubs and expanding engagement with veterans through state and territory shopfronts

(c) Improve referral pathways and service integration at the systems level by:

  (i) managing relationships between Veterans' and Families' Hubs, ex-service organisations (ESOs), DVA, Australian and state and territory government agencies and non-government service providers

  (ii) ensuring referral pathways are in place and services are integrated to the greatest extent possible

  (iii) advising DVA and state and territory governments on service gaps

(d) Co-designing wellbeing supports – to work with veterans and ESOs to co-design new prevention and early intervention wellbeing programs and services at the local level, supported by a dedicated funding stream under the redesigned grants program for ESOs.

The new veteran wellbeing agency should have an ongoing operating budget, and the following capabilities and features:

(e) staff who have lived experience of military service

(f) offices established in area/s where large numbers of veterans live

(g) customer service expertise, including in digital-led solutions

(h) a trauma-informed communications and service-delivery approach

(i) led by a CEO who reports to the Secretary of DVA

(j) adhering to a service charter and associated key performance indicators, supported by regular and transparent reporting requirements.

(Chapter 24: Empowering veterans to thrive)

Recommendation 88: Develop a national funding agreement on veterans' wellbeing

A national funding agreement on veterans' wellbeing should be developed, with immediate focus on the following priorities:

(a) improving outcomes for veterans who are experiencing homelessness, including a long-term investment framework that supports capital and operational expenditure for veteran-specific housing and the provision of wraparound services

(b) supporting veterans who are incarcerated, both during and after their incarceration

(c) facilitating school enrolments for children of serving members, without requiring a confirmed address

(d) developing networks of health care for veterans (see Recommendation 72)

(e) obtaining individual consent from veterans who separate involuntarily for medical or other reasons (and other cohorts at higher risk of suicide and suicidality) to provide their personal data to state and territory governments to ensure they can receive tailored support and referrals to veteran-specific services, including Veterans' and Families' Hubs.

(Chapter 24: Empowering veterans to thrive)

Recommendation 89: Establish a national peak body for ex-service organisations

The Australian Government, in consultation with ex-service organisations (ESOs), should establish a national peak body for ESOs following a co-design process.

The role, functions, membership, governance and funding model of the peak body should be informed by the outcomes of the business case, and agreed between the Department of Veterans' Affairs and the ESO sector. The funding model should not exclude participation of any eligible ESOs, particularly those who operate on a not-for-profit basis.

(Chapter 24: Empowering veterans to thrive)

Recommendation 90: Remove the service differential for permanent impairment compensation and expand mental health support to all reserve personnel

The Australian Government should:

(a) remove the service differential as it relates to permanent impairment compensation

(b) extend non-liability health care for mental health conditions to all reserve personnel.

(Chapter 25: Entitlements and claims processing)

Recommendation 91: Implement combined benefits processing for all initial liability and permanent impairment claims

The Department of Veterans' Affairs (DVA) should implement combined benefits processing for all initial liability and permanent impairment claims under the *Military Rehabilitation and Compensation Act 2004* (Cth) (the new single Act) for veterans' entitlements, noting that some limited exceptions will apply.

The Australian Government should ensure that DVA has sufficient additional funding to implement this new approach to claims processing.

(Chapter 25: Entitlements and claims processing)

Recommendation 92: Review claims to the Department of Veterans' Affairs associated with physical and sexual abuse

The Department of Veterans' Affairs (DVA) should commission an independent review of claims made between 2015 and 2024 that are associated with physical and sexual abuse during service. The review should:

(a) determine if there is any material difference in the acceptance or correctness rates for these claims compared to other claim types and, if so, identify why and any required changes to veterans' entitlements legislation, DVA policy, and/or training and support provided to delegates

(b) recommend any necessary improvements that will ensure delegates deliver services in a trauma-informed way and understand the dynamics of military sexual violence and other forms of abuse during service

(c) examine the supports in place for victims who have submitted a claim of this kind and recommend any necessary improvements to align with best practice.

(Chapter 25: Entitlements and claims processing)

Recommendation 93: Fund the Transition Medical Assessment Pilot Program on an ongoing and national basis

The Australian Government should provide funding to the Department of Veterans' Affairs and Defence to support:

(a) expanding the Transition Medical Assessment Pilot Program to North Queensland in 2025–26

(b) rolling out the program nationally to serve all Australian Defence Force members who are medically separating with complex needs from 2026–27 onwards.

(Chapter 25: Entitlements and claims processing)

Recommendation 94: Improve timeliness and reporting on information-sharing between Defence and the Department of Veterans' Affairs for claims processing

To ensure timely information-sharing between the Department of Veterans' Affairs (DVA) and Defence for the purpose of claims processing:

(a) DVA and Defence should establish a key performance indicator for the timeliness of information provided by Defence through the Single Access Mechanism, and report on performance in annual reports

(b) Defence should report annually on the progress of records digitisation until all records are fully digitised.

(Chapter 25: Entitlements and claims processing)

Recommendation 95: Support the expanded application of 'presumptive liability'

The Department of Veterans' Affairs (DVA) should:

(a) establish a dedicated ongoing workstream to support the expanded use of presumptive liability as part of its research and evaluation model, informed by the views of the expert committee on veteran health research (Recommendation 117)

(b) follow developments in civilian workers' compensation schemes, and consider where they are relevant to Australian Defence Force (ADF) contexts. As an immediate priority, DVA should consider whether a presumption related to liability for post-traumatic stress disorder should apply to certain roles within the ADF.

(Chapter 25: Entitlements and claims processing

Recommendation 96: Ongoing funding for Provisional Access to Medical Treatment

The Australian Government should fund Provisional Access to Medical Treatment beyond June 2026 on an ongoing basis.

(Chapter 25: Entitlements and claims processing)

Recommendation 97: Consider giving the Veteran Payment to more veterans with physical health conditions

The Department of Veterans' Affairs (DVA), in conjunction with the Repatriation Commission, should examine whether there are specific cohorts of veterans with physical health conditions who are at higher risk of suicide and may therefore benefit from receiving the Veteran Payment.

If such cohorts are identified, DVA should seek the appropriate authority from the Australian Government to extend the Veteran Payment to those cohorts.

(Chapter 25: Entitlements and claims processing)

Recommendation 98: Strengthen Department of Veterans' Affairs performance targets for claims processing timeframes, and improve transparency

Department of Veterans' Affairs (DVA) performance targets for the timeliness of liability and permanent impairment claims under the *Military Rehabilitation and Compensation Act 2004* (Cth) (the new single Act) should be reset so that:

(a) by 1 July 2026, at least 65% of claims are determined within 90 days

(b) by 1 July 2028, at least 80% of claims are determined within 90 days.

Starting in 2024–25, DVA should include in its annual reports:

(c) data-driven measures of DVA's compliance with its customer service standards

(d) the percentage of claims for which DVA requested an independent medical examination

(e) the number of additional conditions and sequelae covered by presumptive liability compared with the previous year, as well as the number and percentage of initial liability determinations that were made pursuant to presumptive liability provisions.

(Chapter 25: Entitlements and claims processing)

Recommendation 99: Improve compensation advocacy by funding professional, paid advocates

The Australian Government should replace the Building Excellence in Support and Training (BEST) grant program with an ongoing, demand-driven funding program for professional, paid veteran compensation advocates. At a minimum, the amount of funding should be increased to provide compensation advocacy for:

(a) all veterans who need support to submit a liability and/or compensation claim with the Department of Veterans' Affairs

(b) all veterans seeking an internal or external review of a claims decision.

Funding allocations should be for a minimum of three years to provide employment stability. They should be designed to ensure equitable geographic service coverage and meet the diverse demographic needs of the veteran population, including female veterans and LGBTIQ+ veterans.

(Chapter 26: Supporting DVA claimants and clients)

Recommendation 100: Improve the transparency, accountability and effectiveness of the Department of Veterans' Affairs rehabilitation program

The Department of Veterans' Affairs (DVA) should improve the transparency of the DVA Rehabilitation Program and how its effectiveness is measured. At a minimum, this should include:

(a) reinstating the program performance indicator that measures the percentage of clients for whom rehabilitation goals were met or exceeded, with a target of 75%, and including this measure in annual public reporting

(b) expanding key performance indicators for rehabilitation program providers to measure the percentage of clients who meet or exceed their rehabilitation goals, disaggregated by goal type (for example, medical management, vocational and psychosocial). This information should be shared with DVA rehabilitation clients so they can make an informed choice of provider (as related to Recommendation 101 on choice and autonomy).

(Chapter 26: Supporting DVA claimants and clients)

Recommendation 101: Give Department of Veterans' Affairs clients more choice and autonomy

Veterans supported by the Department of Veterans' Affairs should be afforded similar levels of choice and autonomy to National Disability Insurance Scheme (NDIS) participants, to the greatest extent possible. At a minimum, this should include:

(a) enabling veterans to:

(i) choose their rehabilitation provider, supported by clear information about provider quality and service characteristics (including information specified in Recommendation 100)

(ii) self-manage their budget for approved household assistance on an opt-in basis, to align with the autonomy and payment conditions afforded to NDIS clients and providers

(b) reimbursing veterans for travel costs to see their preferred healthcare providers (noting that some constraints will apply), supported by legislative reform developed in consultation with veterans.

(Chapter 26: Supporting DVA claimants and clients)

Recommendation 102: Implement and improve upon the Defence Strategy for Preventing and Responding to Family and Domestic Violence

In addition to, and as part of the implementation of the Defence Strategy for Preventing and Responding to Family and Domestic Violence 2023–2028, Defence should:

(a) recognise the nexus between family violence and suicide, including the inclusion of family violence indicators within approaches to suicide prevention, and consideration of suicide risk within responses to family violence

(b) implement all recommendations made by Defence Families of Australia (DFA) in its issues paper on Australian Defence Force families and domestic violence and work collaboratively in an enduring fashion with the DFA to deliver ongoing reforms to prevent family and domestic violence and support victims of family and domestic violence

(c) establish and communicate a set of minimum standards to guide its approach to family and domestic violence that are publicly available and:

  (i) clearly articulate victim safety (including that of children) as the primary consideration in decision-making

  (ii) define how Defence will ensure that any protection orders that may be in place can be upheld in the workplace, including how it will ensure that postings and workplace arrangements prioritise the safety of the victim

  (iii) include clear expectations regarding disclosure by Defence members who are the respondent on a protection order relating to family violence

(d) take steps to ensure that Defence property, equipment and resources are not used to perpetrate family and domestic violence, including that Defence housing stability is not used as a means to exercise coercive control or to create barriers to safe separation

(e) ensure that there are no impediments to Defence personnel accessing emergency services responses while on base, in relation to family and domestic violence. All materials regarding family and domestic violence should include emergency services response information and be regularly reviewed for currency.

(Chapter 27: Importance of families)

Recommendation 103: Improve the support, communication and services provided to Defence families

In recognition of the critical role that Defence families play in Defence capability, and the stressors that service life places on the member and their family unit, Defence should:

(a) increase and enhance the suite of family support programs and initiatives available to Defence families, informed by co-design with members, families and Advocates. This should include:

  (i) systematically analysing data from the Defence Member and Family Helpline to better understand issues and trends, and create opportunities to better assist members and their families

  (ii) removing barriers to families directly accessing information and services provided by Defence Member and Family Support (DMFS)

  (iii) providing an evidence-based suite of information and resources to support families, especially at times of peak stress including postings, return from deployment and member transition

  (iv) facilitating greater access to or provision of family therapy, and services that support partners and children of Defence members

  (v) an enhanced DMFS communications strategy

(b) ensure that systems are in place to communicate directly with families on an 'opt out' basis to provide information on available services and supports, assisted by a refreshed DMFS communications strategy and greater efforts to publicise the supports available

(c) develop and implement a framework to evaluate outcomes, including the efficiency and effectiveness of all current and future DMFS initiatives, with this material to be made public to demonstrate transparency and accountability for the performance of DMFS

(d) work with the Australian, state and territory governments to investigate and improve arrangements for facilitating employment opportunities for partners of Defence members as well as opportunities for remote working, or preferential employment of this cohort in appropriate roles

(e) work with the Australian Government, following the completion of the Defence Childcare Review and the Productivity Commission Review into Early Childhood Education and Care, to identify and realise opportunities to improve the provision of child care services to Defence members.

(Chapter 27: Importance of families)

Recommendation 104: Improve the profile, resourcing and impact of the Defence Family Advocate

To achieve the best possible representation of serving and ex-serving members and their families, the Australian Government should:

(a) improve the profile, resourcing and impact of the Defence Family Advocate, by:

  (i) providing the Defence Family Advocate with appropriate staffing, budget and remuneration, with a salary and employment conditions at an equivalent rate to comparable executive positions, supported by full-time staff with the same employment conditions as their counterparts in Defence and the public service

  (ii) formalising the relationship between the Defence Family Advocate and the Veteran Family Advocate Commissioner

  (iii) working with the new Defence Family Advocate to implement the recommendations made in the 'Our Community' and the PricewaterhouseCoopers reviews to refine and improve the governance and outcomes of the Defence Family Advocate

(b) appropriately staff and resource the Veteran Family Advocate Commissioner and their office to improve outcomes and ensure that veteran families are represented in policy design, decision-making and advocacy

(c) investigate whether shared administrative support for both office holders may further assist collaboration and support the efficiency of their operations.

(Chapter 27: Importance of families)

Recommendation 105: Improve coordination with coroners and the National Coronial Information System

The Australian Government Attorney-General's Department should work with its state and territory counterparts to establish mechanisms that improve coordination between coroners, the Department of Veterans' Affairs (DVA), the Australian Bureau of Statistics and the National Coronial Information System and work towards:

(a) aligning coronial practices related to making determinations of intentional self-harm to improve the consistency and timeliness of national suicide reporting

(b) implementing communication strategies between Defence, the Inspector-General of the Australian Defence Force, DVA and coroners to support the streamlined provision of information and reduce the risk of stress on families

(c) sharing good-practice support regarding trauma-informed care.

(Chapter 28: Coroners)

Recommendation 106: Establish a suicide database of serving and ex-serving members

Defence should design and develop a new suicide database that is appropriate for the purpose of suicide monitoring and reporting of all relevant data of permanent, reserve and ex-serving members. The design and development of the database should:

(a) leverage data collected throughout the service journey from recruitment to discharge and beyond

(b) capture a broader range of risk and protective factors, including but not limited to recording incidents of unacceptable behaviour and injuries, which is necessary to improve understanding of suicide, suicidality and self-harm

(c) be informed by best-practice approaches from other countries, including the United States.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 107: Establish the National Veterans' Data Asset

To improve understanding of deaths by suicide and provide better support to veterans and their families, the Australian Government should:

(a) provide appropriation funding to the Australian Institute of Health and Welfare and the National Suicide Prevention Office (or any subsequent body assuming its functions) to establish and maintain a National Veterans' Data Asset that brings together data from Defence, the Department of Veterans' Affairs, and states and territories, to enable timely monitoring and surveillance of suicide and suicidality of serving and ex-serving Australian Defence Force (ADF) members

(b) provide appropriation funding to the Australian Institute of Health and Welfare and the National Suicide Prevention Office to:

  (i) use the National Veterans' Data Asset to produce discrete annual public reports and other research to monitor and improve understanding of suicidality and deaths by suicide, and the associated risk factors for serving and ex-serving ADF members and their families

  (ii) commission an independent program of evaluation of the implementation and functioning of the National Veterans' Data Asset, including an interim evaluation and a post-implementation evaluation.

The Australian Government and state and territory governments, through their relevant agencies, should use the National Veterans' Data Asset for the purposes of:

(c) furthering their understanding of suicide, suicidality, and health and wellbeing among serving and ex-serving members and their families; and

(d) preventing deaths by suicide and improving postvention for serving and ex-serving members and their families.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 108: Ensure that all relevant jurisdictions and entities regularly provide data to the National Veterans' Data Asset

So that all jurisdictions provide data regularly to the National Veterans' Data Asset:

(a) the Australian Government, and state and territory governments, through their relevant agencies, should provide relevant data at quarterly intervals to the National Veterans' Data Asset (Recommendation 107)

(b) Defence and the Department of Veterans' Affairs should prioritise data governance arrangements in order to provide data for the National Veterans' Data Asset to support its development and ongoing use.

(Chapter 29: Use of data and research by Defence and DVA

Recommendation 109: Defence to report annually on its progress towards data maturity

Defence should report on its progress to improve data maturity, each year, to the Minister for Defence, using the 2021 Defence Enterprise Data Maturity Assessment as a baseline. Reports should be supported by surveys of Defence staff every three years in addition to the data capability maturity assessment tool.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 110: Review Defence's data assets and address issues with their quality, management, integration and use

The Defence Chief Data Integration Officer (CDIO) and Defence Data and Analytics Board should establish a program of review of Defence's data assets. As part of this program:

(a) the reviews should be conducted by Defence's Data Division and focus on the quality, awareness, management, access, integration and use of the dataset

(b) the CDIO should designate actions required of data custodians to address any issues identified by each review and be provided with follow-up reports from Enterprise Data Custodians on the progress of actions following completion of Data Division reviews.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 111: Achieve a ‘gold standard’ rating for Defence datasets related to suicidality and suicide

The Defence Chief Data Integration Officer should direct data custodians to improve the data quality of datasets related to suicide, self-harm and suicidality so they achieve a ‘gold standard’ rating. This will ensure the data is reliable and supports accurate decision-making. The remediation should focus on addressing issues of duplicated, missing, incomplete and non-standardised data, and ensuring datasets can be integrated.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 112: Include data on suicide and suicidality in the enterprise-wide Defence data catalogue

Defence should prioritise the inclusion of datasets related to suicide and suicidality in its enterprise-wide data catalogue. Defence should also make its data catalogue publicly available and include the quality rating of each dataset.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 113: Ensure commanding officers access and use quality data for continuous improvement of wellbeing metrics

To better support Defence commanders and personnel, Defence should:

(a) use data from the following sources to provide Australian Defence Force commanders with data for their units and teams, as well as relevant comparison points:

  (i) the new Defence suicide database (Recommendation 106)

  (ii) the National Veterans' Data Asset (Recommendation 107)

  (iii) internal surveys

  (iv) unacceptable behaviour reporting and injury reporting.

(b) ensure the data is provided in a timely manner, in an accessible format and with necessary context, and provide training that supports commanders to use the data to inform decision-making.

Commanders should use this data for continuous improvement and to better understand the wellbeing of the members under their command.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 114: Defence and the Department of Veterans' Affairs to prioritise research into veteran health and wellbeing, and publish their workplans

Defence and the Department of Veterans' Affairs should publish research workplans showing research priorities on issues affecting the health and wellbeing of current and ex-serving members. These workplans should be updated annually and include information on planned research and the progress of research that is underway.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 115: Defence and the Department of Veterans' Affairs to publish their research into veteran health and wellbeing

Defence and the Department of Veterans' Affairs should conduct and, as a matter of course, publish research that includes information on the health and wellbeing of serving and ex-serving members.

Prior to publication, research outputs should be subject to review from independent researchers, including from the new expert committee on veteran health research (see Recommendation 117).

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 116: Improve the quality, evaluation, translation and sharing of research findings

Defence and the Department of Veterans' Affairs (DVA) should create evaluation and research teams in a central area of their respective departments to improve the quality and coordination of research and evaluation practices. These central research and evaluation teams should be given the following responsibilities:

(a) take the lead on improving the research and evaluation culture

(b) manage the evaluation of programs and policies within their respective departments, and ensure evaluations are appropriate and effective

(c) develop and maintain the evaluation schedule of all mental health and suicide prevention programs

(d) develop and maintain a central library of program evaluations and relevant research, ensuring that evaluation findings are used and incorporated into future programs and policies

(e) monitor the integration of research outputs into policy, programs and practices, thus ensuring that research outputs are translated effectively

(f) use data and research to provide timely, targeted and effective advice to improve suicide prevention, intervention and postvention support

(g) implement the continuing joint Defence and DVA research agenda

(h) in the case of the Defence evaluation and research team, develop a revised survey research program with surveys that:

  (i) collect information that can be used to evaluate Defence programs and policies effectively

  (ii) capture data on the health and wellbeing of Australian Defence Force members

  (iii) capture data not otherwise included in Defence administrative datasets and the National Veterans' Data Asset.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 117: Establish an expert committee on veteran research

Defence and the Department of Veterans' Affairs (DVA) should establish an expert committee on veteran research, comprising experts from government, academia and the private sector who have skills and experience in military and veterans' affairs, health care, rehabilitation and family support.

The committee should:

(a) be informed by international examples of success from Five Eyes partners and other nations

(b) include representatives with lived experience of service life, suicidality and mental health

(c) fulfil the functions described in Chapter 29, Use of data and research by Defence and DVA, and provide advice to Defence and DVA on research and evaluation matters relevant to improving the wellbeing of serving and ex-serving members.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 118: Use the Census to collect information on ex-serving members as a population

To ensure there is ongoing collection of reliable statistics and information on ex-serving Australian Defence Force (ADF) members in the Australian community, the Australian Government should:

(a) direct the Australian Bureau of Statistics (ABS) to continue the existing Census question on ADF service in 2026 and in future censuses

(b) direct the ABS to include an additional question on year of separation for ex-serving members in the 2026 Census and in future censuses, with the ABS undertaking any testing required to include this question on the 2026 Census.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 119: Improve understanding of veteran health by adding questions to Australian Bureau of Statistics surveys

The Australian Government should fund the Australian Bureau of Statistics to:

(a) include additional questions on Australian Defence Force (ADF) service in any future iterations of the National Health Study, the National Study of Mental Health and Wellbeing, the General Social Survey and the Personal Safety Survey, prompting respondents to state whether they are a current or ex-serving ADF member and if so, whether they served in the permanent forces or solely in the reserve forces

(b) increase the sample of serving and ex-serving members in any future iterations of these surveys to allow for robust reporting on serving and ex-serving members.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 120: Increase funding for research into veteran health and wellbeing

The Australian Government should provide increased funding for research into the health and wellbeing of serving and ex-serving Australian Defence Force members by:

(a) providing $10 million through the National Health and Medical Research Council to support a Special Initiative research grant program focused on veteran health and wellbeing

(b) considering opportunities to fund veteran health and wellbeing research through the Medical Research Future Fund and Million Minds Mental Health Research Mission.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 121: Enable research into the health and wellbeing of Defence families

The Australian Government should enable research on the health and wellbeing of families of current and ex-serving members through:

(a) expanded National Health and Medical Research Council funding for veteran health and wellbeing research

(b) Defence and the Department of Veterans' Affairs leading research in conjunction with lived experience individuals (see Recommendation 117)

(c) the Australian Institute of Health and Welfare, the Australian Bureau of Statistics and the Australian Institute of Family Studies being funded to collaborate and leverage existing datasets and the National Veterans' Data Asset (see Recommendation 107), to develop a better understanding of veteran families through research on wellbeing and risk and protective factors.

(Chapter 29: Use of data and research by Defence and DVA)

Recommendation 122: Establish a new statutory entity to oversee system reform across the whole Defence ecosystem

The Australian Government should establish a new statutory entity with the purpose of providing independent oversight and evidence-based advice in order to drive system reform to improve suicide prevention and wellbeing outcomes for serving and ex-serving Australian Defence Force members.

(Chapter 30: Beyond the Royal Commission)

About the Royal Commission

Establishment of the Royal Commission

1. The Royal Commission into Defence and Veteran Suicide was announced on 19 April 2021.[1] It was formally established as an independent public inquiry by Letters Patent issued by the then Governor-General, His Excellency General the Hon David Hurley AC CVO DSC (Retd), on 8 July 2021.[2] The Commonwealth Letters Patent were followed by Letters Patent issued by each of Australia's states, which included similar terms and supported the Royal Commission.[3]

2. Our terms of reference were wide-ranging and broad in scope. We were directed to focus on cultural, structural and systemic issues; be informed by an understanding of individual experiences; and make findings and recommendations to address the persistently high rates of suicide and suicidality among serving and ex-serving members of the Australian Defence Force (ADF). Our terms of reference are set out in full in Appendix A, Letters Patent.

Extensions to our inquiry

3. It was initially expected that the Royal Commission would deliver its findings and recommendations to the Governor-General by 15 June 2023. However, it soon became apparent that the original 2-year timeframe for completion would not afford us sufficient time to undertake the depth of inquiry required and develop achievable, long-lasting solutions.

4. The complexity of our task increased in late 2021, when the Australian Institute of Health and Welfare released updated figures on suicide in the defence and veteran community that altered the scale of our inquiry. Consequently, we requested and were granted a 12-month extension from the former Australian Government.

5. Following the granting of this extension, we faced numerous additional challenges to our work program. This related to claims of public interest immunity and parliamentary privilege, and the need to gather evidence sensitively without affecting issues of national security. Our inquiry was also affected by delays in the provision of vital data from the Department of Defence and the Department of Veterans' Affairs (DVA).

6. We also became aware that some witnesses and others engaging with us might be experiencing acute or chronic suicidality and mental health challenges. We therefore needed to take the time to implement a trauma-informed approach when working with those who had experienced past harm and injury.

7. On 11 May 2023, we wrote to the Prime Minister, the Hon Anthony Albanese MP, to request a further 12-month extension. The Prime Minister declined our request, noting the importance of our recommendations being delivered as soon as practicable to enable the Australian Government to progress measures that will improve the lives of serving and ex-serving ADF members and their families.

8. We understood and appreciated the rationale behind the Prime Minister's response to our request. From the commencement of our inquiry, we have been determined to develop actionable solutions to the cultural and systemic issues that are failing serving and ex-serving ADF members and their families, and to bring about long-lasting and meaningful improvements to their lives and livelihoods.

9. However, recognising that existing timeframes continued to impact the quality and extent of our work program, we requested and were granted a further 3-month extension, which resulted in the delivery date of this final report being moved to 9 September 2024.

10. Additional Letters Patent were issued following these two extensions.[4]

Commissioners

11. Three Commissioners were selected to lead this inquiry by the former Governor-General, in the name of Her Majesty Queen Elizabeth II and, following her death, thereafter in the name of His Majesty King Charles III.

12. We are Royal Commission Chair Naguib (Nick) Kaldas APM, the Hon James Douglas KC and Dr Peggy Brown AO. We were appointed based on our professional expertise and previous experience in inquiries, the law and related matters. We were entrusted with conducting this inquiry, reporting on our findings and delivering recommendations.

Naguib (Nick) Kaldas APM

13. The Royal Commission Chair Kaldas's experience spans work in the NSW Police Force, the United Nations (UN) and numerous government committees.

14. Commissioner Kaldas served in the NSW Police for 35 years, as Deputy Commissioner from 2006 to 2016 and, before that, as Assistant Commissioner (Counter Terrorism and Special Tactics). During his time in the police force, Commissioner Kaldas worked primarily in major and organised crime investigations and counter-terrorism, spending more than a decade in homicide investigations. In 2004, he was deployed to serve as Deputy Chief Police Adviser with the Coalition Forces in Iraq, tasked with rebuilding the Iraqi National Police.

15. Commissioner Kaldas has held senior roles in the UN and other international agencies. This included leading UN investigations into the assassination of Lebanese Prime Minister Rafic Hariri and a number of related assassinations, from 2009 to 2010. He also led the joint UN/Organisation for the Prevention of Chemical Weapons investigation into the use of chemical weapons in the Syrian conflict in 2016. From 2016 to 2018, he served as Director of Internal Oversight in the UN Relief and Works Agency for Palestine Refugees in the Near East. In this role, he oversaw four departments – Investigations, Audit, Evaluation and an Ethics Division – working across Lebanon, Syria, Jordan, Gaza and the West Bank.

16. Commissioner Kaldas is a graduate of the Federal Bureau of Investigation (FBI) Hostage Negotiation Program and its Leadership in Counter Terrorism Program. He is a graduate of the FBI National Executive Institute, the peak program for law enforcement executives. For eight years, he was a member of the Australian National Counter-Terrorism Committee, the peak policy body dealing with counter-terrorism in Australia.

17. Commissioner Kaldas is Chair of the Advisory Board of Multicultural NSW and a member of the Board of the Commission for International Justice and Accountability. He is also a member of the Independent Steering Committee, Operation Kenova (Scotland Yard re-investigation of historic political murders committed during The Troubles in Northern Ireland).

18. Commissioner Kaldas has received numerous awards – including the Australian Police Medal, the National Medal and the Overseas Humanitarian Service Medal – and many commendations for outstanding performance of duty in Australia and overseas. He holds a master's degree in public policy and administration, and was awarded an Honorary Doctorate from Western Sydney University. He is also an industry professor at the University of Technology Sydney.

The Hon James Douglas KC

19. Commissioner the Hon James Douglas KC has had a longstanding career in the law.

20. In 1972, Commissioner Douglas served as associate to his father, the Hon Mr Justice James Douglas. From 1973 to 1974 he served as associate to the Right Hon Sir Harry Gibbs GCMG AC KBE, during his time as a justice of the High Court of Australia.

21. Commissioner Douglas was admitted as a barrister of the Supreme Court of Queensland in 1973, and commenced practice at the bar in 1977. He was appointed Queen's Counsel (now King's Counsel) in 1989. He served as President of the Bar Association of Queensland from 1999 to 2001. Commissioner Douglas was a justice of the Supreme Court of Queensland from 2003 to 2020, during which time he chaired the Rules Committee and the Streamlining Criminal Justice Committee.

22. He holds degrees in Arts and Law from the University of Queensland and a postgraduate Bachelor of Laws from Cambridge University. He is also a member of the Australian Academy of Law, the International Academy of Comparative Law and the American Law Institute.

23. Commissioner Douglas is a member of the Senate of the Australian Catholic University and President of the Order of Malta Australia. He was previously Chair of the Queensland Theatre Company, Chair of the Queensland Symphony Orchestra Advisory Board and President of the *Alliance Française de Brisbane*.

Dr Peggy Brown AO

24. Commissioner Dr Peggy Brown AO is a qualified medical practitioner and has held senior leadership roles across clinical and governance functions in the health sector.

25. Commissioner Brown is a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and a member of its Military, Veterans' and Emergency Services Personnel Mental Health Network, its Section of Leadership and Management, and its ADHD Network.

26. Commissioner Brown has held the positions of Clinical Advisor (Digital Mental Health) at the Australian Commission on Safety and Quality in Health Care (ACSQHC); Chief Executive Officer of the National Mental Health Commission; Director-General of the ACT Health Directorate; Chief Psychiatrist of the Australian Capital Territory; Chief Psychiatrist of the Northern Territory; Director of Mental Health, Queensland; and Chair of the Australian Health Ministers' Advisory Council. She has served as a member of the Agency Management Committee of the Australian Health Practitioner Regulation Agency, the Pharmaceutical Benefits Advisory Committee, the National e-Health Transition Authority and the Board of Health Workforce Australia. She was also formerly the Patron of the Australian BPD Foundation, and co-Chair of the Council of Clinical Leads for the International Initiative for Mental Health Leadership.

27. She has previously been contracted by DVA to conduct reviews of its Trauma Recovery Program and Wellbeing and Support Program. Commissioner Brown also served as a member of the DVA Chief Health Officer's Mental Health Expert Advisory Group before her appointment to this Royal Commission.

28. Commissioner Brown was engaged by the ACSQHC to provide strategic support and advice, and to chair the Expert Advisory Group for the Independent Qualitative Review of Past Defence and Veteran Suicides. She was also Chief Executive Officer of the National Mental Health Commission when it conducted the Review of Suicide and Self-Harm Services for Current and Former Members of the Australian Defence Force and their Families from 2016 to 2017.

29. Commissioner Brown's husband served as a member of the Australian Army from 1976 to 1985 and a reservist from 1986 to 1987.

Assistant Commissioners

30. In January 2024, two Assistant Commissioners were appointed in a specific capacity to hold private sessions, based on their previous experience and expertise.

Robert (Bob) Atkinson AO PSM

31. Assistant Commissioner Robert (Bob) Atkinson AO PSM has extensive experience in the Queensland Police Service and in previous appointments to the role of commissioner.

32. Assistant Commissioner Atkinson served in the Queensland Police Service for 44 years, including 12 years as Commissioner. During his time in the police service, he oversaw reforms instituted after the Fitzgerald Inquiry of 1990, as well as the implementation of recommendations of the Public Sector Management Commission Review Report of the Queensland Police Service from 1993.

33. Assistant Commissioner Atkinson served as one of six commissioners of the Royal Commission into Institutional Responses to Child Sexual Abuse from 2013 to 2017. He was then appointed Chair of the Queensland Government's Truth, Healing and Reconciliation Taskforce, formed in response to the child abuse royal commission.

34. In 2018, Assistant Commissioner Atkinson was appointed Special Advisor to the Queensland Minister for Child Safety, Youth and Women, the Hon Di Farmer MP. In this capacity, he delivered two reports relating to matters of youth justice.

35. Assistant Commissioner Atkinson has served as co-Chair of the Queensland Government's Domestic and Family Violence Prevention Council since 2019.

Dr Susan Young

36. Assistant Commissioner Dr Susan Young has a background as a registered nurse and midwife, with experience in clinical, academic and governance functions across the health and education sectors.

37. During the late 1970s and early 1980s, Assistant Commissioner Young worked as a nurse in repatriation hospitals. There, she cared for active and returned service personnel and personally witnessed the impacts of service on their physical and mental health.

38. Assistant Commissioner Young was later appointed to serve on the Board of the Australian Health Practitioner Regulation Agency (Ahpra), and has chaired the Regulatory Performance Committee of the Ahpra Board and was a member of the Ahpra Accreditation Advisory Committee. She was appointed Chair of the Queensland Board of the Medical Board of Australia for two terms, before continuing as a member for a further term, and was also a member of the National Injury Insurance Agency, Queensland.

39. Assistant Commissioner Young's academic background includes professorial positions within the tertiary education sector. She has served as a Director of Teaching and Learning and a Program Director in the School of Nursing and Midwifery at the University of Queensland.

The conduct of our inquiry

40. We conducted our inquiry in accordance with the *Royal Commissions Act 1902* (Cth). We gathered information relevant to our terms of reference through personal accounts (private sessions and submissions), community outreach activities, public hearings and research.

41. We heard directly from serving and ex-serving ADF members and their families; advocates and representatives of ex-service organisations (ESOs); clinicians; researchers and subject-matter experts; as well as senior public servants and leadership figures in the ADF.

42. The following sections provide an overview of how we conducted our inquiry and built our understanding of the complex issues related to suicide and suicidality among military personnel. Further detail and data on these aspects of our inquiry can be found in our appendices.

A trauma-informed approach

43. Trauma can occur when a person is exposed to one or more events and experiences that overwhelm their ability to cope. In a military context, trauma can involve physical injury, psychological injury and moral injury. Trauma can occur following experiences of violence, abuse and bullying at the hands of other service personnel and/or those in positions of authority. It can also result from systemic and institutional abuse, where the systems of power and practices in an organisation cause harm. These experiences can have a long-lasting effect on an individual's physical and mental health, affecting their personal relationships and employment prospects. These experiences can also alter an individual's perception of the meaning of life. Suicide is a possible outcome associated with cumulative trauma.

44. As a Royal Commission concerned with suicide and suicidality, it was critical to have a framework that prioritised the safety and wellbeing of those who engaged with us.

45. We established a dedicated and specialised team to champion the delivery of a trauma-informed approach across the Royal Commission. The Counselling and Enquiry Support team led our engagement with people with lived experience, and provided professional consultation and advice to all staff on implementing consistent and coordinated trauma-informed practice. CES staff members had backgrounds in social work, counselling and psychology, as well as expertise in the implementation of trauma-informed practice in organisational settings.

46. Our trauma-informed approach was based on the following principles:

- safety – focusing on what would make it 'safe enough' (physically and psychologically) for a person to share their experiences
- empowerment and choice – providing options for participants to be heard and enabling choice around the level of engagement that worked best for them, including the choice to remain anonymous
- collaboration – working in partnership with participants to identify and deliver a personalised engagement experience, recognising and valuing their input and resilience, and enabling ongoing support
- trust – building trust through respectful and timely engagement, being transparent about our processes and activities, sharing information in multiple formats to enable greater accessibility and being clear about how we would maintain confidentiality
- cultural responsivity – recognising the importance of culture in shaping identity, being alert to the impacts of structural inequality and experiences of racism and discrimination that may exacerbate trauma, and consulting with communities to develop culturally appropriate engagement strategies.

47. We recognised and acknowledged that many people who engaged with us had prior negative experiences in navigating administrative processes in government and/or non-government sectors. This could manifest as a lack of trust in institutions and, for some, a cynicism towards the prospects of this Royal Commission to effect meaningful change.

48. We endeavoured to ensure that the dynamics of abuse, trauma and neglect experienced by serving and ex-serving ADF members, their families and supporters were not replicated in their interactions with this Royal Commission.

49. Royal Commission staff members were alert to recognising the individual experiences of trauma, the way in which this presents in a service-based setting, and the importance of adopting a stepped care, person-centred model to respond to the unique needs of each individual. Our staff worked hard to proactively address barriers to engagement and to build trust through prompt, consistent and transparent practice.

50. In all circumstances, our staff members aimed to avoid duplicating or disrupting participants' existing support arrangements. Where required, we sought participant consent to liaise with their existing support teams to ensure continuity of care. We also worked collaboratively with participants to facilitate warm referrals and connections with community-based services where participants identified unmet needs or had needs that fell outside the scope of the Royal Commission's work.

Private sessions

51. A private session is a confidential meeting between a person with lived experience and one or two Commissioners, or an Assistant Commissioner. It is not a hearing of the Royal Commission, and a person who appears at a private session is not considered to be giving evidence.[5] Participants in private sessions were not required to take an oath or affirmation, and they were not subject to cross-examination. However, they were expected to tell the truth.

52. The private sessions provided a unique opportunity for serving and ex-serving ADF members and their family members to share their experiences of suicide and suicidality in a safe and supportive environment. These sessions provided a safe space where these stories and perspectives could be heard, believed and validated by the Commissioners or Assistant Commissioners.

53. We held close to 900 private sessions between November 2021 and June 2024. Private sessions were held in every capital city, as well as Townsville. Most participants elected to meet face to face with Commissioners or Assistant Commissioners. Around 25% of participants met with Commissioners or Assistant Commissioners online or participated via telephone.

54. The majority of private session participants were ex-serving ADF members (69%), followed by current serving members (17%), and participants who identified as family members of serving or ex-serving members (14%).

How we conducted private sessions

55. We published practice guidelines and a fact sheet about private sessions. These documents described the legal framework of the private sessions and explained to potential participants and members of the public how these sessions would be conducted.[6]

56. For many participants, the private session represented the first opportunity they had to share their story at all, or share it outside the ADF environment. It was important to ensure each participant felt safe and respected, and had the fullest opportunity to be heard. We sought to remove barriers to participation, and adopted a flexible, participant-centred approach to scheduling and conducting private sessions, and communicating with participants.

57. We assigned each private session participant a session support officer as a consistent point of contact. These support officers helped manage all aspects of the participants' private session experiences. We encouraged the participants to contact the Defence and Veterans' Legal Service, which provided free and independent legal support for serving and ex-serving ADF members and their families about their legal rights and how to safely share their experiences with us.

58. Participants could choose what and how much information they wished to share about their lived experience, and could bring a support person to their private session. Their session support officer was present during and after the private session. This ensured participants could discuss how they were feeling, raise any concerns and be connected to ongoing support if required.

59. After their private session, each participant was sent a personalised card signed by the Commissioner/s or Assistant Commissioner who held their private session, thanking them for sharing their experiences.

How private sessions guided our work

60. Private sessions were conducted in complete confidence – the information shared by participants does not appear on the public record, and the participants were not identified in our reports. Information shared in private sessions remains confidential for 99 years, and it is not subject to freedom of information requests or subpoenas.[7]

61. The information disclosed in a private session was only shared within the Royal Commission in de-identified ways, or in specific and limited circumstances. These circumstances included opening up a new line of inquiry or enabling Royal Commission staff members to approach a participant to be a witness at one of our public hearings.

62. Private sessions helped Commissioners develop a deeper understanding of the systemic issues affecting serving and ex-serving ADF members and their families. De-identified summaries of each private session, including key points and any recommendations suggested by participants, were provided to the Royal Commission's policy, data and research staff to help inform our inquiry. Therefore, every private session informed the Royal Commission's work.

63. Collectively, the Commissioners and Assistant Commissioners applaud the courage of those who came forward during private sessions, and acknowledge the privilege of bearing witness to these personal testimonies. A summary of our personal reflections and those of the Assistant Commissioners is outlined below.

Commissioner Kaldas

64. Commissioner Kaldas described our work as a large jigsaw puzzle, with each private session participant offering a small piece to help complete the big picture. The participants were generous in their contributions. Many not only opened up about and relived traumatic personal experiences but also offered thoughtful perspectives on solutions and a way forward.

65. According to Commissioner Kaldas, private sessions had an immeasurable impact on the Royal Commission's deliberations and the direction of our inquiry. It is his hope that the process of engaging in private sessions has given participants a feeling of closure or resolution and the knowledge that their stories will help change things for the better. Speaking directly to participants, Commissioner Kaldas said: 'We hear you, we see you, and we thank you'.

Commissioner Douglas

66. For Commissioner Douglas, the very act of listening to participants during private sessions was significant. Commissioner Douglas said that by engaging with the private sessions, he learnt to surrender his natural instinct as a barrister and a judge to interrogate. He gained more from the process of listening than he had anticipated.

67. Commissioner Douglas was particularly struck by the depth of emotion and visceral reactions shared by some participants when recalling the mistreatment they experienced during their military careers. In many ways, the personal and unfiltered nature of these disclosures was only made possible due to the confidential and safe environment of the private sessions. They were therefore uniquely valuable to the work of the Royal Commission.

Commissioner Brown

68. Commissioner Brown said private sessions shone a light on a range of experiences – positive and negative – and revealed themes consistently raised by different participants.

69. For Commissioner Brown, it was apparent that sometimes words simply could not convey what participants had been through. At other times, words were not needed to understand when participants had experienced something deeply personal and traumatic. These experiences were pivotal in shaping the course of participants' lives in many different ways. They impacted their relationships, ongoing employment, physical and mental health, self-worth, quality of life, and dreams and aspirations.

70. According to Commissioner Brown, the private sessions offered Commissioners and Assistant Commissioners the chance to gain a deeper understanding of the effects of these experiences on participants and their loved ones. In speaking directly to participants, Commissioner Brown stated: 'Your contribution to the Royal Commission is more than you may ever realise'.

Assistant Commissioner Atkinson

71. For Assistant Commissioner Atkinson, it was the courage and character of the private session participants that stood out the most. He valued participants' willingness to put their trust in the Royal Commission as an institution that carries a significant degree of authority. This was despite the fact that in almost all cases, the participants had been failed by those in positions of authority in the ADF and, at times, failed again in their dealings with DVA.

72. It was clear that the private session participants were and are fine Australians who wished to serve their country. While each had their own individual stories, experiences, observations and recommendations, the common thread in coming forward was they did not want what had happened to them to reoccur in the future. In this way, the private sessions were a vitally important piece of work for our country.

73. Assistant Commissioner Atkinson sincerely hopes the acceptance of the Royal Commission's recommendations and their genuine implementation will be a lasting acknowledgment of each private session participant's personal contribution to this inquiry.

Assistant Commissioner Young

74. It was clear to Assistant Commissioner Young that most private session participants had enlisted in the ADF to be part of something bigger than themselves, to learn new skills and to have pride in a career protecting their country.

75. Some of the stories shared were uplifting, illustrating humanity and compassion. However, Assistant Commissioner Young was struck by the consistent themes across many of the negative stories shared. Despite differences in gender, service, setting and time period, participants commonly disclosed that their experiences in the ADF had impacted their self-worth and mental health, family relationships, employment prospects and ability to achieve their life objectives. Many participants felt unable to retrieve that which was of most importance to them – a personal sense of inner peace.

76. Participants wished to share their stories not just to benefit the Royal Commission's understanding of their experiences but also to effect change, with the hope that no future service personnel would suffer like they had. In speaking directly to participants, Assistant Commissioner Young stated: 'Thank you for standing up, thank you for your willingness to share your stories. You will make a difference'.

Submissions

77. We received 5,865 submissions to our inquiry. A submission was defined as a statement to this Royal Commission from a member of the public or an organisation that covered issues relevant to our terms of reference. Submissions took the form of written documents, audio, video and image files.

78. A person could make a submission on behalf of themselves, another person or an organisation. The vast majority of submissions were about the author's lived experience. All submissions were reviewed by our Counselling and Enquiry Support team, who contacted any authors they identified as needing support.

79. While lived experience accounts did not constitute formal evidence, they helped inform our inquiry. The information documented in submissions provided us with valuable insights into risk and protective factors, and the personal impact of systemic issues contributing to suicide and suicidality among serving and ex-serving ADF members. The topics most frequently raised in submissions included ADF culture; governance and accountability; mental illness; DVA claims and compensation; ADF mental health support and responses; and bullying and harassment.

80. Most authors requested that their submissions be made public, under their name or anonymously. These submissions were published on the Royal Commission website, except where they contained information that was graphic, distressing or defamatory, or where there were concerns about privacy and confidentiality. Information shared in confidential submissions is not subject to freedom of information requests or subpoenas[8] and will remain confidential for 99 years.[9]

81. This final report only contains extracts from submissions where the author has provided their consent for this material to be shared publicly.

Community engagement

82. Serving and ex-serving ADF members and their families were key stakeholders in our inquiry. However, through broader community engagement strategies, we were able to hear from and work alongside other individuals and organisations who had an interest or expertise in issues relevant to our terms of reference.

Reference and advisory groups

83. We established three reference and advisory groups as forums for regular communication and ongoing engagement. They consisted of individuals and organisational representatives of serving and ex-serving ADF members and their families, people with lived experience, and individuals with professional expertise relevant to our inquiry.

84. Membership and participation in our reference and advisory groups was voluntary. Each group was chaired by a different Commissioner and had its own terms of reference.

Stakeholder Reference Group

85. The Stakeholder Reference Group was chaired by Commissioner Kaldas. Members included representatives from ex-service organisations (ESOs) and other groups that actively support serving and ex-serving ADF members and their families across Australia.

86. This group helped us to better understand the ESO sector and provided critical feedback on elements of our work program and community engagement initiatives. It kept us informed on how their organisations were working to support the mental health and wellbeing of their members and the wider serving and ex-serving community.

Defence and Veteran Suicide Prevention Reference Group

87. The Defence and Veteran Suicide Prevention Reference Group was chaired by Commissioner Douglas, with membership comprising serving and ex-serving ADF members. This group helped us understand the complexities of the ADF military operating environment, and the multifaceted nature of life as a serving member.

Lived Experience and Research Advisory Group

88. The Lived Experience and Research Advisory Group was chaired by Commissioner Brown. Its members were people with lived experience of suicide or suicidality in the defence and veteran context, and researchers working in areas of suicidality, data science, or defence and veteran health. This group provided advice on our research program, including research evidence and methodology.

Base visits and transition seminars

89. In 2022 and 2023, we visited 26 ADF facilities across Australia. This enabled us to hear directly from serving members and their families, and to better understand contemporary life on a military base.

90. We also attended numerous ADF Member and Family Transition Seminars in 2023. These seminars provided us with a valuable opportunity to hear about both positive and negative aspects of transitioning back to civilian life following time in service. We heard about the challenges experienced by individuals and families in navigating these changes, and their experiences receiving support from government agencies and ESOs.

Roundtables

91. Through partnerships developed with some state and territory government departments, we were able to participate and present at ESO roundtables in Darwin, Perth, Adelaide, Melbourne and Sydney. These roundtables provided us with the opportunity to engage with 30 to 50 representatives from local ESOs.

92. We also independently hosted roundtables as forums for informal discussion on issues relevant to our terms of reference. These roundtables were attended by representatives from ESOs, clinicians, academics and researchers, senior public servants, and serving and ex-serving ADF members.

93. Topics discussed at the roundtables included systemic issues related to ADF culture and governance structures, and gaps in research and data. We also discussed risk factors relating to recruitment and deployment, transition, DVA claims processing and opportunities for greater coordination across the ESO sector.

Gathering evidence

Hearings

94. During our inquiry, we held 12 public hearings and heard from more than 340 witnesses over 101 hearing days. We also held ceremonial opening and closing hearings, two directions hearings on procedural matters and one 'in-depth inquiry'.

95. Public hearings served an important evidence-gathering function. Royal commissions have broad powers to call witnesses under oath and to compel evidence. We used these powers to collect information that we might not otherwise have had access to.

96. In our public hearings, we explored systemic issues and common themes relating to suicide and suicidality among serving and ex-serving ADF members. We examined risk and protective factors associated with suicide and suicidality, and the impact of policies, programs and institutional practice in the ADF, the Department of Defence and DVA. Our public hearings:

- enabled us to question and obtain evidence from key figures in government and senior leaders in the ADF
- enabled researchers, academics and subject matter experts to share their knowledge and insights
- provided us with an opportunity to hear from people with lived experience of suicide and suicidality, including serving and ex-serving ADF members and their families.

How we conducted public hearings

97. The themes and issues to be explored in our public hearings were determined by the Commissioners in consultation with Counsel Assisting, the Office of Solicitors Assisting, and Policy staff. They were often based on lines of inquiry established through our engagement activities, analysis of submissions, and themes consistently raised in private sessions.

98. Once the themes and issues for a public hearing were determined, we issued notices or summonses to individuals and organisations to produce relevant documents and data to be reviewed by Royal Commission staff. Staff then:

- identified and interviewed potential witnesses
- helped prepare witness statements
- sought statements from institutional representatives
- prepared documents to be tendered as evidence during the hearing
- engaged experts to advise the Royal Commission or to give public testimony.

99. All three Commissioners presided over every public hearing. Counsel Assisting questioned witnesses with support from the Office of Solicitors Assisting. Commissioners had the opportunity to question witnesses directly, following formal questioning by counsel.

100. During our hearings, we heard from many witnesses with lived experience of suicide and suicidality in a military context. It was agreed that lived experience witnesses appearing as such would not be subject to cross-examination. We therefore encouraged them to participate in a way that avoided making specific allegations against identifiable individuals. We did not make specific findings based on lived experience testimony. However, lived experience testimony greatly informed the direction of our work and revealed the human impact of the systemic issues at the heart of our inquiry.

101. Some witnesses who had lived experience of suicide and suicidality nevertheless appeared as witnesses of fact and were therefore open to being cross-examined.

102. On occasion, witnesses provided their evidence in a closed session. This took place when there were concerns about a witness speaking publicly, where the nature of their evidence was highly sensitive, or where there was a need to protect the identity of the witness. Where appropriate, Commissioners issued non-publication orders to further protect the identity of a witness or to ensure their personal details were not published or shared. In some instances, we provided pseudonyms to protect the identity of witnesses. These directions were issued pursuant to relevant provisions of the *Royal Commissions Act 1902* (Cth).[10]

103. All public hearings, including directions hearings, were livestreamed on our website, and transcripts of public proceedings were made available to view and download.

104. Many people with lived experience of suicide or suicidality attended our public hearings as witnesses or observers. Royal Commission counselling staff were present and available to provide support as and when needed. We also provided content warnings and crisis support information for people attending hearings in person and for those watching the livestream online.

105. As illustrated in the map in Figure 1, our public hearings were held in each capital city, as well as the garrison towns of Townsville and Wagga Wagga.

Figure 1 Public hearing locations around Australia

In-depth inquiry and closed hearing

106. In addition to our public hearings, we held a private hearing in the context of an 'in-depth inquiry' we conducted into allegations made by an ex-serving ADF member.

107. Our in-depth inquiry was undertaken over many months to aid our understanding of systemic issues related to the military employment classification (MEC) system. It specifically examined the circumstances in which an ADF member had been designated a MEC of 'J52', which stands for 'Not employable on medical grounds – Unable to be employed in the period leading up to separation'. We obtained documents from the Department of Defence, a formal statement from the ex-serving member outlining their experiences, and statements from relevant individuals in the Department of Defence and the ADF.

108. The in-depth inquiry hearing was held in Sydney behind closed doors to protect the ex-serving member's identity. Though the proceedings were recorded and transcribed, this material was not made publicly available.

109. We present a de-identified summary of our findings from the closed hearing in Public report of in-depth inquiry in Volume 2 of this report. It follows Chapter 5, The Military employment classification system and medical separation, which also discusses aspects of the inquiry. A lack of time precluded us from conducting more in-depth inquiries.

Research

110. We undertook research and data analysis to:

- examine systemic issues and common themes relating to suicide and suicidality
- fill critical evidence gaps in the existing research base
- identify practices to prevent and respond to suicide and suicidality, and related risk factors among serving and ex-serving military populations.

111. Our research program included quantitative research undertaken in collaboration with the Australian Institute of Health and Welfare. This work examined self-harm and mental health–related hospital admissions and emergency department presentations among serving and ex-serving ADF members. It also compared causes of death among ex-serving ADF members against the general Australian population.

112. Our qualitative research program reviewed, coded and analysed de-identified private session summaries and submissions to the Royal Commission, and documentation relating to the suicide deaths of serving and ex-serving ADF members since 2019.

113. We also commissioned nine external research projects, including:

- a literature review
- research into risk and protective factors relevant to suicide and suicidality
- data linkage projects
- reviews of best practice approaches to service delivery and suicide prevention.

114. These projects were supplemented by research shared in the form of expert evidence during our public hearings, research reports and data obtained via responses to compulsory notices to other agencies and organisations. We also conducted policy analysis of a much wider body of existing research and data on issues relevant to our terms of reference.

Interim report and other publications

115. We delivered our *Interim Report* to the Governor-General in August 2022.[11] As per the Letters Patent, our *Interim Report* focused on 'issues requiring urgent or immediate action'.[12] It outlined preliminary observations on matters relevant to our terms of reference, and made recommendations for urgent action across areas, including:

    - reform of the legislative framework for veterans' compensation and rehabilitation
    - improvements to claims processing practice and administration within DVA
    - improvements to assist serving and ex-serving ADF members to gain access to information held by Defence and DVA
    - enhancing legal protections for persons who sought to engage with the Royal Commission
    - addressing barriers to our inquiry that arose due to claims of parliamentary privilege and public interest immunity.

116. We also released a special publication titled *Shining a Light: Stories of Trauma & Tragedy, Hope & Healing*, which was delivered to the Governor-General in June 2024.[13] It was written for the Royal Commission by journalist Mr Patrick Lindsay AM.

117. This book pays tribute to the thousands of deeply personal stories of suicide and suicidality that were bravely and generously shared with us in submissions from serving and ex-serving ADF members and their families. It highlights themes that emerged from our analysis of submissions, including the systemic issues and risk factors that have contributed to suicide and suicidality.

118. Importantly, it also recognises and honours the resilience, recovery and growth experienced by serving and ex-serving ADF members and their families through their lived experiences of suicide and suicidality in a military context.

Impediments to our inquiry

119. This Royal Commission has been long-running and complex. It involved contributions from many individuals and organisations, for which we are grateful.

120. It also involved sustained engagement with Australian Government agencies. This was because they supported our establishment and operation, and were also involved in the production of evidence – including documents, data and information – that informed our work. We recognise that this is a substantial task, and we acknowledge the efforts of the lawyers, public servants and Defence members involved.

121. However, despite our best efforts, we experienced impediments to the conduct of our inquiry. In some cases, these resulted in significant delays and difficulties and affected the way in which we undertook our work.

122. We are of the view that it is important to raise these impediments as part of our final report. In doing so, we aim to:

- make clear the procedural and other issues we experienced
- encourage greater transparency, collaboration, provision of data, and efficiency during future royal commissions
- inform considerations around timeframes for future inquiries.

123. This chapter sets out the impediments we experienced in separate sections. Together, they inform actions the Australian Government should take to assist future royal commissions (see Recommendation 1).

Delays with producing material

124. Delays in producing information and documents by Australian Government agencies impeded this Royal Commission's work. This had serious practical implications for our inquiry, including the examination of witnesses.

125. For example, documents relevant to the statement and evidence of the then Chief of the Defence Force, General Angus Campbell AO DSC, were produced in tranches over a period of almost 18 months. Two tranches were produced on the day of his examination, and three tranches were produced more than a year after General Campbell first gave evidence to the Royal Commission.

126. When the Chief of the Defence Force began giving evidence, Senior Counsel Assisting noted that it would not be 'possible to examine General Campbell today and tomorrow with the benefit of a review of all the relevant materials', given their late delivery.[14] Three 'addenda' to General Campbell's statement (comprising documents referred to therein) had not been provided ahead of the examination.[15]

127. Similarly, Colonel Andrew Deacon (the then Commanding Officer of the 1st Recruit Training Battalion), Wing Commander Darren Dolan (the then Commanding Officer Number 1 Recruit Training Unit) and Commander Alisha Withers RAN (the then Commanding Officer at the Royal Australian Navy Recruit School) made statements ahead of their examinations in which they referred to a number of documents. Those documents were not provided by the witnesses.

128. Consequently, the Royal Commission was required to issue notices to seek production of those documents,[16] causing further delay and affecting how we could examine the witnesses.[17]

129. Confidentiality claims also delayed the production of documents, affecting how we could deal with witnesses. While we accept steps need to be taken with respect to confidentiality, the way claims were handled sometimes affected our inquiry.

130. For example, the day before the examination of Vice Admiral David Johnston AC RAN on 4 March 2024, there were unresolved 'full confidentiality' claims over documents that the Royal Commission proposed to tender during that examination.

131. Although we had provided notice that we intended to tender those documents on 24 February 2024, some of the claims were not resolved until the evening before (and, in some cases, until hours before) the examination.[18] Some of the 'full-confidentiality' claims were no longer pressed, and the scope of others was reduced.[19]

132. These unresolved claims and the late revision of certain claims impacted the examination of Vice Admiral Johnston, as they limited the material that could be used to support our preparation before the examination.

133. Ultimately, royal commissions rely on evidence, including documents and information, to support their inquiries. They have statutory powers to compel the production of documents and information, which they do by issuing notices. However, there are no penalties for non-compliance with a notice issued by a royal commission.

134. We believe this can impede a royal commission's ability to do its work effectively. At Recommendation 1, we propose the *Royal Commissions Act 1902* (Cth) is amended so there are meaningful consequences for non-compliance with a compulsory notice.

Public interest immunity

135. Public interest immunity allows the Australian Government to refuse to produce documents on the basis that it would be contrary to the public interest.[20] Public interest immunity is available to Australian Government agencies as a 'reasonable excuse' not to produce documents sought by a royal commission.[21]

136. While we recognise the importance of public interest immunity, refusing to produce documents on the basis of public interest immunity can make it difficult for a royal commission to fulfil its terms of reference and conduct a robust investigation. We ultimately developed an arrangement with relevant agencies to inspect some of the documents subject to public interest immunity claims.

137. We suggest that when future royal commissions are set up, the Australian Government proactively enter into similar arrangements. In this way, material subject to a public interest immunity claim can be accessed quickly.

138. Another way to address this issue would be to amend the *Royal Commissions Act 1902* (Cth) so public interest immunity is not a reasonable excuse to not comply with a notice issued by a royal commission.

The role of the Attorney-General's Department

139. The Australian Government Attorney-General's Department (AGD) plays a dual role regarding royal commissions. It provides administrative support to enable their establishment and operation, and also manages Australian Government agency engagement with royal commissions. We found aspects of this to be challenging, as these roles could be at odds. This is particularly the case when agencies are the main participants in a royal commission.

140. The AGD administers the *Royal Commissions Act 1902* (Cth) and is responsible for 'providing administrative support for Royal Commissions'. During our inquiry, the AGD maintained a branch to support royal commission set-up and decommissioning, and operated as the middle point between this Royal Commission and other Australian Government agencies, adding another layer to the engagement process. This was while the AGD was also supporting the Australian Government Solicitor (AGS) at hearings. Other AGD branches were also involved in budget allocation, expenditure and staff management for this Royal Commission.

141. The AGD is also the 'First Law Officer' representing the Australian Government's interests in legal proceedings.[22] It manages the Australian Government's engagement with a royal commission, including when its agencies will be represented. It also coordinates an agency's legal representation as a party to a royal commission.

142. We believe future royal commissions need a more independent voice in the Australian Government. This could be achieved by moving the royal commission support function from the AGD to a separate agency, such as the Department of Prime Minister and Cabinet. Or, if this function is to remain with the AGD, then it should set up:

    - a liaison person or team whose sole role is to deal with royal commissions
    - protocols to limit its engagement with the AGS, noting its adversarial approach discussed below.

Parliamentary privilege

143. The operation of the *Parliamentary Privileges Act 1987* (Cth) had adverse impacts on our inquiry. Section 16 of the Act placed significant limitations on our use of material that had been presented to Parliament, or was from a parliamentary report.

144. Practically, this meant we could not receive into evidence the findings or recommendations of reports published by Parliament or its committees where these would be used for the purposes of 'drawing an inference'.[23]

145. This was especially significant for this Royal Commission given the previous reports and parliamentary inquiries relevant to our terms of reference. In particular, we note the important work that formed:

- the 2016 Senate Foreign Affairs, Defence and Trade References Committee report, *Mental Health of Australian Defence Force Members and Veterans*
- the 2017 Senate Foreign Affairs, Defence and Trade References Committee report, *The Constant Battle: Suicide by Veterans*
- the 2019 Joint Standing Committee on Foreign Affairs, Defence and Trade report arising from the Inquiry into transition from the Australian Defence Force
- the 2021 Australian National Audit Office report on Defence's implementation of cultural reform.

146. Being able to use the work previously undertaken by parliamentary inquiries and reports is, without question, a more efficient and effective way for a royal commission to work.

147. Our *Interim Report* recommended: '[w]here their terms of reference require an examination of Government, royal commissions should be made exempt from section 16(3)(c)' of the Parliamentary Privileges Act (Recommendation 7).[24] The purpose of this recommendation was to address the adverse impacts of parliamentary privilege on future inquiries, while preserving its operation in other contexts.

148. The Australian Government noted this recommendation.[25] In subsequent correspondence to this Royal Commission, it put forward the view that royal commissions can carry out their functions without infringing the Parliamentary Privileges Act.

149. In the absence of legislative reform, the Australian Government should support future royal commissions to undertake their work efficiently, including to tender and receive evidence, without breaching the Parliamentary Privileges Act. It could, for example, provide clear guidance around the operation of the Act, and advice on which materials the Act may apply to. This could form part of the detailed guidelines we propose below. This Royal Commission's experiences are instructive and can inform this work.

Access to the work of past royal commissions

150. The Australian Government has to date established 140 royal commissions, eight of which were established from 2014 onwards.

151. Every royal commission is unique. However, each will obtain significant administrative and procedural knowledge throughout the course of its inquiry. This could benefit subsequent royal commissions if documented and shared.

152. Upon establishment, we were not given access to a complete compendium of relevant administrative and standard policies, operating procedures and templates (for example, to issue notices). Instead, we had to rely on staff members who had been retained from a previous inquiry to provide advice, or in most cases, develop our own. This is not an effective or efficient arrangement.

153. Future royal commissions would benefit from access to these materials, together with detailed guidelines to support their establishment and operation. This would promote efficiency, reduce establishment costs, and enable continued improvement in how royal commissions operate.

The approach taken by the Australian Government Solicitor

154. In an inquiry like ours, 'direct and robust correspondence' between legal representatives is essential.[26]

155. However, in our experience, engagement with the AGS was sometimes unnecessarily adversarial. Royal commissions are independent entities that establish and implement their own processes. However, the AGS wrote to us setting out the expectations of Australian Government agencies, and containing suggestions as to how the Royal Commission should manage its inquiry.[27]

156. It is important to understand that this Royal Commission was requested by the Australian Government to undertake a body of work and provide it with independent advice. We hope, for future royal commissions, this function is recognised and respected.

Assisting future royal commissions

157. By outlining our lessons and experiences in this section and the chapter more broadly, we hope to promote the improvement and efficiency of future royal commissions and inquiries.

158. Any steps that can be adopted to reduce delays, improve transparency, streamline communication and bolster the completeness of inquiries should be an important focus for the Australian Government for future royal commissions. We believe by addressing the above, the time and costs involved in future royal commissions may be significantly reduced.

Recommendation 1: Improve the capacity of future royal commissions to undertake their inquiries

To enable the efficient operation of future royal commissions:

(a) the Australian Government should amend the *Royal Commissions Act 1902* (Cth) so there are meaningful consequences for non-compliance with a compulsory notice

(b) the Australian Government should undertake measures to ensure that royal commissions benefit from more independent representation in government, either by:

  (i) setting up protocols that limit the engagement of the Royal Commissions Branch of the Attorney-General's Department with the Australian Government Solicitor (AGS), or

  (ii) moving the Royal Commissions Branch to a separate agency, for example to the Department of Prime Minister and Cabinet, or:

  (iii) setting up a liaison person or team in the Attorney-General's Department, whose role is to deal with royal commissions only

(c) the Australian Government should apply consistent and transparent arrangements to allow royal commissions timely access to material covered by public interest immunity, and consider legislative amendment to facilitate royal commissions' access to this material

(d) the Attorney-General's Department should provide settled advice and options on the operation of public interest immunity, Parliamentary privilege and procedural fairness in the operation of royal commissions.

Endnotes

1 The Hon Scott Morrison MP, Prime Minister, the Hon Darren Chester MP, Minister for Veterans' Affairs, Minister for Defence Personnel, and Senator the Hon Michaelia Cash, Attorney-General, Minister for Industrial Relations, *Establishment of a Royal Commission into Defence and Veteran Suicide*, media release, 19 April 2021 (Exhibit UU-01.002, DVS.6666.0001.5484).
2 Commonwealth of Australia, Letters Patent, 8 July 2021.
3 State of Tasmania, Letters Patent, 9 August 2021; State of South Australia, Letters Patent, 12 August 2021; State of New South Wales, Letters Patent, 18 August 2021; State of Queensland, Letters Patent, 19 August 2021; State of Western Australia, Letters Patent, 16 November 2021; State of Victoria, Letters Patent, 1 December 2021.
4 Commonwealth of Australia, Letters Patent, 10 April 2022; Commonwealth of Australia, Letters Patent, 7 December 2023.
5 *Royal Commissions Act 1902* (Cth) s 6OC.
6 Royal Commission into Defence and Veteran Suicide*, Practice Guideline 6 – Private Sessions*, November 2021; Royal Commission into Defence and Veteran Suicide, *A Guide to Your Private Session*, February 2022.
7 *Royal Commissions Act 1902* (Cth) ss 6OG–6OM, 6OQ.
8 *Royal Commissions Act 1902* (Cth) s 6OQ.
9 *Royal Commissions Act 1902* (Cth) ss 6OM, 6OQ.
10 *Royal Commissions Act 1902* (Cth) s 6D.
11 Royal Commission into Defence and Veteran Suicide, *Interim Report*, August 2022.
12 Commonwealth of Australia, Letters Patent, 8 July 2021, para (za)(i).
13 P Lindsay, *Shining a Light: Stories of Trauma & Tragedy, Hope & Healing,* Royal Commission into Defence and Veteran Suicide, 2024.
14 Transcript, Senior Counsel, Hearing Block 5, 23 June 2022, pp 35-3357 [15–20].
15 Transcript, Senior Counsel, Hearing Block 5, 23 June 2022, pp 35-3356 [5]–35-3357 [24]; Exhibit 40-05.010, Hearing Block 5, Angus Campbell, Witness Statement, DEF.9999.0011.0344_R at 0367, 0391, 0534
16 Exhibit T-01.036, OSA Letter dated 17 November 2022, DVS.0000.0001.7447_R.
17 Transcript, Senior Counsel, Hearing Block 8, 29 November 2022, pp 56-5498 [47]–56-4599 [33].
18 Exhibit T-01.047, AGS email dated 4 March 2024, DVS.0000.0001.7501_R.
19 Exhibit T-01.048, AGS email dated 5 March 2024, DVS.0000.0001.7512_R.
20 *Evidence Act 1995* (Cth) s 130; common law principles of public interest immunity are summarised in *Murrumbidgee Ground-Water Preservation Association v Minister for Natural Resources NSW* [2003] NSWLEC 322 at [19].
21 *Royal Commissions Act 1902* (Cth) s 1B.
22 PFLR-26 (Commonwealth/interaction with the Royal Commission, Commonwealth response), PFL.0002.0002.0001 at 0036.
23 *Parliamentary Privileges Act 1987* (Cth) s 16.
24 Royal Commission into Defence and Veteran Suicide, *Interim Report*, August 2022, p 268.
25 Australian Government, *Australian Government Response to the Interim Report of the Royal Commission into Defence and Veteran Suicide*, September 2022 (Exhibit ZZ-01.037, DVS.0000.0002.0816).
26 PFLR-26 (Commonwealth/interaction with the Royal Commission, Commonwealth response), PFL.0002.0002.0001 at 0047.
27 Exhibit T-01.028, AGS Letter dated 23 December 2022 regarding the conduct of Hearing Block 8, DVS.0000.0001.7453_R.

Glossary

Term	Definition
ab initio training	The period of initial training undertaken by ADF members when they enter into service. From the Latin phrase meaning ‘at the beginning’.
administrative termination	Defined by **Defence** as involuntary discharge from ADF service for conduct, performance, actions or behaviour considered to be below professional standards. Also called ‘administrative discharge’ and ‘separation for reason “retention-not-in-service-interest”’. See also: **involuntary separation**.
administrative violence	When a member in a command position abuses their power to harass and discriminate against a serving ADF member. See also: **military institutional abuse**.
allied health services	Services provided by health professionals who are not doctors, nurses or dentists; for example, physiotherapists and psychologists.
Australian Defence Force (ADF)	Australia’s national military organisation comprising the Royal Australian Navy, Australian Army and Royal Australian Air Force, as well as the Australian Defence Force Headquarters, Joint Capabilities Group and Joint Operations Command. The ADF is under the command of the Chief of the Defence Force.
Australian Defence Veterans’ Covenant	Formal recognition of the service and sacrifice of veterans and their families, comprising a declaration on behalf of the Australian people (the oath), and an entitlement to a Veteran Card and a lapel pin. See also **Gold Card**, **White Card**.
bastardisation	A term covering a range of unacceptable behaviours, including bullying, harassment, assault and illegitimate initiation practices, that are sometimes used to victimise an ADF member who is considered as ‘other’ and targeted for exclusion. See also: **hazing**.
chain of command	The line of authority and responsibility in the ADF along which orders are passed.
Comcare	Australia’s national authority for work health and safety, and workers compensation.
command and control	The hierarchical organisation of power in the ADF that enables its leaders to exercise power over, and lawfully direct, military forces to accomplish missions and tasks.
commissioned officer	A category of rank in the ADF with authority to command **other ranks** and lower-ranking officers. See also: **non-commissioned officer**.

Term	Definition
Comtrack	A Defence system for recording reported incidents of unacceptable behaviour and the outcomes of military justice proceedings and administrative actions.
Defence	The collective term for the Department of Defence and the **Australian Defence Force**, co-administered by the Secretary of the Department of Defence and the Chief of the Defence Force. See also: **diarchy**.
Defence Abuse Response Taskforce (DART)	A taskforce that operated between 2012 and 2016 to help people who made complaints about abuse they suffered while employed in the ADF. It applied only to people who experienced abuse before 11 April 2011. See also **Defence Force Ombudsman**.
Defence electronic Health System (DeHS)	A system used across Defence to manage the delivery of health services. It stores dental, medical, mental health and allied health records in a single location.
Defence Force Ombudsman	An independent complaints and investigatory function for serving and ex-serving ADF members. Since 2017, it has also received and investigated complaints of serious abuse in the ADF. The office of the Defence Force Ombudsman is held by the Commonwealth Ombudsman. See also **Defence Abuse Response Taskforce**.
Defence personnel	All employees of **Defence**, including serving ADF members, Australian Public Service employees and contractors.
Defence Policing and Security Management System (DPSMS)	Defence's main computerised management system for recording and investigating 'notifiable' incidents, including anything that may be an offence under the *Defence Force Discipline Act 1982* (Cth) and involves Defence personnel or property.
Department of Defence	The Australian Government department that is charged with defending Australia and its national interests. See also **Defence**, **diarchy**.
Department of Veterans' Affairs (DVA)	The Australian Government department that provides support, services and information to serving and ex-serving ADF members and their families, and war widows/widowers, among others.
deployment	A period in which a person is assigned for duty away from their **posting**, especially for military purposes. Deployments can involve **warlike**, **non-warlike** or peacetime service.
diarchy	The term used to describe the joint leadership of **Defence** by the Secretary of Defence and the Chief of the Defence Force. The diarchy is under the control of the Minister for Defence.

Term	Definition
discharge	Similar to **separation**, this term describes when a serving member leaves the ADF, voluntarily or involuntarily. See also: **administrative termination**, **involuntary separation**, **medical separation**, **voluntary separation**.
eligible service	ADF service that entitles an ex-serving member to compensation and/or services under one or more of the following relevant Acts: • *Veterans' Entitlements Act 1986* (Cth) • *Military Rehabilitation and Compensation Act 2004* (Cth) • *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (Cth).
ex-service organisation (ESO)	Similar to a **veteran support organisation**, this refers to an organisation that supports ex-serving ADF members and their families. ESOs are often formed by ex-serving members who held a particular role in the ADF or were members of a particular regiment or unit. See also: **member and veteran support and advocacy organisation**.
ex-serving member	In this Royal Commission, any person who has served in the ADF, whether in the **permanent forces** or **reserves**, and who served at least one day and has since **discharged** from the ADF.
Five Eyes nation	A member state of the intelligence alliance between the United States, the United Kingdom, Canada, Australia and New Zealand.
Gold Card	A treatment card that entitles eligible ADF members and war widows/widowers and dependants to clinically required medical treatment for all medical conditions, regardless of whether those conditions are connected to service. It also entitles eligible people to a range of services and support. Also known as the Veteran Gold Card or the Repatriation Health Card for All Conditions. See also: **White Card**.
hazing	A term covering a range of unacceptable behaviours, from pranks to physical and sexual assault, that are used to initiate new members into a group. A member is more likely to be hazed during basic training or when they arrive in a new unit. See also: **bastardisation**.
individual welfare board (IWB)	A forum for discussing the complex health needs of an ADF member. It is designed to track members' recovery and rehabilitation, coordinate their support, identify issues with their care and support them to return to work or **transition** out of the ADF.

Term	Definition
initial minimum period of service (IMPS)	The initial period of service an ADF member is required to complete when they enlist. It is distinct from the **return-of-service obligation**, which is accrued when the member undertakes additional training, education or special duties.
Inspector-General of the Australian Defence Force (IGADF)	A role responsible for overseeing, reviewing and coordinating the ADF military justice system. The IGADF is independent of the ADF **chain of command** and is appointed by the Minister for Defence under legislation.
institutional betrayal	The perception or experience of having been betrayed by an organisation's actions or failures to act. In the context of this report, institutional betrayal is usually felt to have been by the ADF or DVA. See also: **moral injury/moral trauma**.
involuntary separation	The involuntary termination of ADF service of personnel deemed unfit for further duty due to medical or non-medical reasons. Non-medical reasons include being physically unfit for service, failure in training or disciplinary matters. It is also called 'involuntary discharge'. See also: **administrative termination**, **medical separation**.
Joint Military Police Unit (JMPU)	The ADF unit that investigates complex or sensitive matters of a criminal or disciplinary nature, such as theft, fraud, assault, sexual offences, use of illicit drugs and sudden death.
Joint Transition Authority (JTA)	A body established in 2020 within the Department of Defence to better prepare ADF members and their families for the transition from military to civilian life.
lived experience	Personal knowledge and insights gained from experiencing events first hand.
malingerer/linger	A slang term used in the ADF for someone thought to be feigning sickness or injury to avoid duty or work.
medical separation	The involuntary termination of a member's service with the ADF on the grounds they are medically unfit for service. See also: **administrative termination**, **involuntary separation**, **military employment classification**.
mefloquine/tafenoquine	Medications used by the ADF to prevent malarial infection that have been found to cause adverse psychiatric reactions in some people.
member and veteran support and advocacy organisation	An organisation that provides advocacy and/or support to serving and ex-serving ADF members but does not describe itself as an **ex-service organisation**. See also: **veteran support organisation**.
mental ill health	A diagnosed mental disorder or a mental health issue that interferes with a person's cognitive, emotional or social abilities.

Term	Definition
mental illness	A disorder diagnosed by a medical professional that significantly interferes with a person's cognitive, emotional or social abilities. Examples include mood disorders (such as depression, anxiety and bipolar disorder), psychotic disorders (such as schizophrenia), eating disorders and personality disorders.
military cultural competency	An understanding of military service and the experiences of serving ADF members that allows health professionals, among others, to understand and respond to the needs of serving and ex-serving members.
military employment classification (MEC)	The ADF system of classifying members based on their fitness for **deployment**. Members whose MEC is downgraded to a certain level are discharged involuntarily from service. See also: **involuntary separation**, **medical separation**.
military institutional abuse	A term covering seven types of abuse experienced in the ADF: **administrative violence**, sexual assault, physical assault, **hazing** and **bastardisation**, extreme endurance training, reputational damage and sabotage. See also: **military sexual violence**.
Military Personnel Policy Manual (MILPERSMAN)	A document that provides guidance on all administrative and policy matters related to ADF service, except financial matters.
military sexual violence	Unwanted sexual activity perpetrated against an ADF member by a fellow member or members.
moral injury/moral trauma	The psychological, social and spiritual effects of having acted in a way that transgresses one's own deeply held moral values and beliefs, witnessing such actions or being on the receiving end of them. See also: **institutional betrayal**.
National Commissioner for Defence and Veteran Suicide Prevention	An independent position created to inquire into and support suicide prevention in the Defence community. The office was suspended in September 2021, shortly after this Royal Commission began.
National Suicide Prevention Office	An office established in May 2021 to help prevent suicide in Australia, working across government and informed by **lived experience**.
National Veterans' Data Asset	A database that we recommend be established to collate data from Australian, state and territory governments and non-government organisations to improve understanding of **suicide**, **suicidality**, and the health and wellbeing of serving and ex-serving ADF members.
non-commissioned officer	A category of rank in the ADF held by members who do not have a commission but do hold leadership positions over junior members. As distinct from many **commissioned officers**, non-commissioned officers enter the ADF as enlisted personnel.

Term	Definition
non-warlike service	A type of ADF service that usually occurs in the context of an operation where the application of force is limited to self-defence and where casualties, while they may occur, are not expected. Examples include peace-keeping operations, peace monitoring or United Nations assistance missions. The Minister for Defence decides whether a service is non-warlike. See also: **warlike service**.
One Defence	A reform initiated by the 2015 'First Principles Review' to better integrate Defence as a single, unified enterprise.
Open Arms	A provider of free and confidential counselling to anyone who has served at least one day in the ADF and their families. It is run through DVA.
optempo	Operating, operational or operations tempo. This is the rate at which the ADF can implement its operations. When there is 'high optempo', ADF personnel may experience periods of intense activity, such as repeated **deployments**.
other ranks	In the Navy, Army and Air Force, these encompass enlisted members, as distinct from **commissioned officers**.
permanent forces	According to the *Defence Act 1903* (Cth), these are the Permanent Navy, the Regular Army and the Permanent Air Force. The permanent forces are distinct from the **reserves/reserve force**.
PERSTEMPO	The ADF system that tracks and manages the deployments of members with the intention of balancing their time deployed and time at home.
posting	An assignment to a post or command at a specified location. It is through the posting system that vacancies are filled and ADF members are rotated through training, operational and general staff appointments.
Post-Operational Psychological Screen (POPS)	A compulsory mental health screening that ADF members undertake after being **deployed**.
post-traumatic stress disorder (PTSD)	Ongoing fear, anxiety or memories relating to an event that has put someone's life and safety, or the lives and safety of those around them, at risk.
postvention	Support provided to people bereaved by **suicide**, particularly to family members and colleagues of a deceased person, as well as to first responders to the scene of a suicide.
procedural fairness	The consistent use of fair and proper processes in an administrative decision. This is particularly important when a person might be adversely affected by that decision.

Term	Definition
protective factors	In the context of **suicide** and **suicidality**, these are individual behaviours, psychosocial and/or societal factors associated with a decreased risk of suicidality and death by suicide, or factors that counteract the effect of one or more **risk factors**.
psychosocial hazard	Anything that could cause psychological harm or harm to someone's mental health. Workplace psychosocial hazards include bullying and harassment. Under work health and safety legislation, these hazards are treated in the same way as physical hazards; that is, an employer has a duty to identify and mitigate them.
reserves/reserve force	As distinct from the **permanent forces**, the reserves are a supplementary workforce that can be mobilised when the ADF needs additional personnel.
return-of-service obligation (ROSO)	The period of service an ADF member is required to complete based on additional training, education and special duties they have undertaken. It is distinct from the **initial minimum period of service**, which is the contracted term of minimum service set at enlistment.
risk factors	In the context of **suicide** and **suicidality**, these are the individual behaviours, psychosocial and/or societal factors associated with an increased risk of suicidality and death by suicide. See also: **protective factors**.
Sentinel	The ADF system through which work health and safety incidents are notified and reported.
separation	Similar to **discharge**, this term describes when a serving member leaves the ADF, voluntarily or involuntarily. While **discharge** is a general term, separation refers to the date on which a member's service formally ends. See also: **administrative termination**, **involuntary separation**, **medical separation**, **transition**, **voluntary separation**.
serving ADF member	In this Royal Commission, any person currently serving as a member of the ADF, whether in the **permanent forces** or **reserves**, and who has served at least one day.
Sexual Misconduct Prevention and Response Office (SeMPRO)	A body in the Department of Defence that provides confidential support to current and former ADF members, Defence personnel, and their families who may have been affected by sexual misconduct. While SeMPRO provides advice and education to the ADF about managing incidents of sexual misconduct, it does not investigate alleged incidents. See also: **military sexual violence**.
suicidal ideation	Serious thoughts about taking one's own life.
suicidality	**Suicidal ideation**, suicide plans and suicide attempts.

Term	Definition
suicide	The act of deliberately ending one's own life.
suicide surveillance	The collection and use of data about suicide and suicide-related behaviours. Suicide surveillance often happens in real time.
transition	The process of a serving member transitioning from active service to civilian life when they separate from the ADF. See also: **discharge**, **separation**.
unacceptable behaviour	A term Defence uses to describe the conduct of its personnel that is considered offensive, belittling, abusive or threatening to another person, or adverse to morale, discipline or workplace cohesion. Examples include harassment, bullying, sexual assault, discrimination and inappropriate workplace relationships.
veteran	Defined in the Letters Patent of this Royal Commission as a person who has served, or is serving, as a member of the **permanent forces** or **reserves** as these forces are described in the *Defence Act 1903* (Cth).
veteran support organisation (VSO)	Similar to an **ex-service organisation**, this is an organisation that provides support to serving and ex-serving ADF members and their families. See also: **member and veteran support and advocacy organisation**.
voluntary separation	This phrase describes when a serving member leaves ADF service by choice, including by resigning or taking a voluntary redundancy. See also: **discharge**, **involuntary separation**.
warlike service	A type of ADF service that is usually undertaken in the context of an operation where the application of force is authorised to pursue specific military objectives and casualties are expected. Examples are a state of declared war, combat operations against an armed adversary or peace-enforcement operations. The Minister for Defence decides whether a service is warlike. See also: **non-warlike service**.
White Card	A treatment card that entitles serving and ex-serving ADF members to medical treatment for accepted service-related injuries or conditions. It also entitles eligible people to treatment for mental health conditions, cancer and pulmonary tuberculosis. It is also known as a Veteran White Card. See also: **Gold Card**.

List of acronyms

ADF	Australian Defence Force*
ADFA	Australian Defence Force Academy
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
CARM	Complaints and Alternative Resolutions Manual
CIMHS	Critical Incident Mental Health Support
CSC	Commonwealth Superannuation Corporation
DART	Defence Abuse Response Taskforce*
DeHS	Defence electronic Health System*
DFA	Defence Families Australia
DHM	Defence Health Manual
DII	Directorate of Inquiries and Investigations
DMFS	Defence Member and Family Support
DMHWS	Defence Mental Health and Wellbeing Strategy
DMJPR	Directorate of Military Justice and Performance Review
DMRR	Directorate of Military Redress and Review
DPSMS	Defence Policing and Security Management System*
DRCA	*Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (Cth)
DSIR	Directorate of Select Incident Review
DVA	Department of Veterans' Affairs*
ESO	ex-service organisation*
IGADF	Inspector-General of the Australian Defence Force*
IMPS	initial minimum period of service*
IWB	individual welfare board*
JHC	Joint Health Command

JMPU	Joint Military Police Unit*
JTA	Joint Transition Authority*
LGBTIQ+	lesbian, gay, bisexual, transgender, intersex, queer and others
M-CARM	Military-to-Civilian Adjustment and Reintegration Measure
MEC	military employment classification*
MECRB	Military Employment Classification Review Board
MHWB	Mental Health and Wellbeing Branch
MHWQ	Mental Health and Wellbeing Questionnaire
MILPERSMAN	Military Personnel Policy Manual*
MJSG	Military Justice Steering Group
MRCA	*Military Rehabilitation and Compensation Act 2004* (Cth)
MRCC	Military Rehabilitation and Compensation Commission
POPS	post-operational psychological screening*
PTSD	post-traumatic stress disorder*
RAAF	Royal Australian Air Force
RAN	Royal Australian Navy
ROG	redress of grievance
ROSO	return-of-service obligation*
RtAPS	Return-to-Australia Psychological Screen
SeMPRO	Sexual Misconduct Prevention and Response Office*
SRCA	*Safety, Rehabilitation and Compensation Act 1988* (Cth)
TPQ	Transition Preparedness Questionnaire
VEA	*Veterans' Entitlements Acts 1986* (Cth)
VSO	veteran support organisation*
WHS	work health and safety

* term is defined in the Glossary

Part 1

Understanding the fundamentals

1 Understanding suicide

Summary

According to our analysis, there were 2,007 confirmed suicide deaths between 1 January 1985 and 31 December 2021 among Australian Defence Force (ADF) members who served at least one day after 1 January 1985. On average, at least three serving or ex-serving members of the ADF die by suicide every fortnight. Despite 50 related inquiries preceding this Royal Commission since 2000, suicide rates have remained relatively unchanged over the past 20 years.

Suicidality is not an illness or disorder, although it can be exacerbated by physical and mental ill health. It is widely acknowledged that suicide risk is affected by a complex interaction of factors over the course of an individual's life. Broadly, these factors can be biological (such as disease or injury), psychological (such as mental ill health or substance abuse disorders) and/or psychosocial (such as family and education history). Extrapolating from Queensland data obtained between 2013 and 2018, it is estimated that one serving or ex-serving ADF member has suicide-related contact with emergency services every four hours across Australia.

The purpose of this chapter is threefold. First, it will present our findings on suicide and suicidality among ADF members within the context of suicide and suicidality prevalence in the broader Australian community. This will show, numerically, the size and scope of the problem. It will also demonstrate that serving in the permanent forces is not a protective factor against suicide, as was commonly held to be true when this Royal Commission began.

We found that:

- males currently serving in the permanent forces are 30% more likely to die by suicide than employed Australian males[1]
- ex-serving males who served in the permanent forces are 42% more likely to die by suicide than Australian males[2]
- ex-serving females who served in the permanent forces are 2.1 times (110%) more likely to die by suicide than Australian females[3]
- ex-serving females who served solely in the reserve forces are 2.04 times (104%) more likely to die by suicide than Australian females.[4]

Second, the chapter identifies particular cohorts of serving and ex-serving members associated with higher risk of suicide than comparable Australian populations. These include males serving in combat and security roles. It also includes ex-serving males and females who:

- separated involuntarily for medical reasons
- separated involuntarily for the reason 'retention-not-in-service-interest' (sometimes called 'administrative discharge')
- served in logistics or combat and security roles (males), or health or combat and security roles (females).

Cohorts of ex-serving males who served in the permanent forces were also found to be at risk if they:

- left during initial training for Army soldier combat and security roles[5]
- deployed in combat and security roles and were exposed to direct or indirect harm
- served as soldiers or sailors in the Army Trained Force or Navy Trained Force.

Third, it will draw on numerous expert sources and lived experience accounts to identify risk and protective factors and stressors for defence and veteran suicide and suicidality. Risk and protective factors can be deeply intertwined in a person's life and are highly contextual. Some aspects and stages of service life and culture give rise to both risk and protective factors.

While this chapter does not make any recommendations, it establishes the foundation for those that are made in subsequent chapters of this final report.

Military-related stressors and risk and protective factors affecting serving and ex-serving members are explored in greater detail across each of the chapters of our report.

1.1 Introduction

1. The terms of reference for this Royal Commission acknowledge the 'overrepresentation of defence and veteran deaths by suicide in Australia'. They state this 'should be acknowledged and understood to ensure that learnings are made and to prevent future deaths by suicide'.[6]

2. The terms of reference recognise that Australia as a nation 'must take action to examine and expose all systemic issues and risk factors related to suicide'.[7] They require us to conduct 'a systemic analysis of the contributing risk factors relevant to defence and veteran death by suicide' and inquire into 'protective and rehabilitative factors for defence members and veterans who have lived experience of suicide behaviours or risk factors'.[8]

3. In line with these terms, this chapter presents the Royal Commission's findings on the prevalence of suicide and suicidality in the Defence community. It is essential to establish the prevalence of the problem as accurately as possible before drawing inferences from the data regarding who is most at risk and when that risk is greatest.

4. This chapter also discusses risk and protective factors, key transition points, and stressors for suicide and suicidality. It outlines how this approach lays the foundation for our recommendations aimed at preventing future deaths by suicide. There is more extensive discussion of specific risk and protective factors, key transition points, and stressors related to service and post-service life in subsequent chapters.

1.1.1 What are risk and protective factors?

5. The National Suicide Prevention Adviser, Ms Christine Morgan, said:

> As people move through different stages in life, they will encounter a range of stressors, transition points and times of disconnection. These can contribute to distress, which can develop into suicidal behaviour in the context of other risk factors.[9]

6. Ms Morgan called for a change in how we think about suicidal behaviour:

> We must broaden our understanding to acknowledge the role of life stressors like unemployment, relationship breakdown and insecure housing, recognising how they can contribute to people feeling trapped and overwhelmed.[10]

7. That risk factors, stressors and transition points are not isolated is recognised in our terms of reference. They directed us to inquire into, among other things, training, postings, deployments, transition, separation and post-service issues, as well as serving and ex-serving members' social and family contexts, housing and employment, and economic and financial circumstances.

8. With this in mind, in this report, risk factors are considered to be factors that may contribute to suicidal distress and are potentially modifiable (non-modifiable factors are permanent or constant – for example, a personal history of self-harm or a childhood history of abuse). Modifiable risk factors can be reduced or mitigated through various interventions. They may include stressful life events or situational stressors ('stressors') such as financial issues, relationship breakdown or serious illness or injury. For military personnel, this may also include stressors that can be part of service life, such as disciplinary action, military employment classification reviews and separation from service.

9. Protective factors are those that promote resilience and maintain wellbeing among military members and that may act as protective factors against suicide.[11]

10. We also refer to 'at-risk' groups. At-risk ADF groups are those who have a higher rate of suicide compared to an age- and gender-matched Australian population. Identifying groups at higher risk of suicide indicates an 'association' between attributes of the members of those groups and death by suicide, but it does not tell us why these groups are at risk ('causation'). For these groups, underlying risk factors may be causing the higher rates of suicide.

11. The rest of this chapter is structured around three topics: suicide and suicidality in Australia; suicide and suicidality in the ADF; and military-related risk and protective factors, transition points and stressors.

Technical note: Associations, risk factors and causal risk factors

This technical note sets out observations by experts on terminology, methodology and the challenges of conducting suicide-related research that helped inform our definition of risk factors. Helena Kraemer and others stated in the 1997 paper 'Coming to Terms with the Terms of Risk':

> [a]s in many other fields, the suicidal thoughts and behaviours field has often been inconsistent and imprecise with how it has used terms such as associations, risk and risk factor.[12]

The risk factor typology they described distinguishes between three types:

> (a) risk associations or correlates, from which no causal inference may be established; risk factors, which are special types of correlates that temporally precede the outcome (suicide), derived from longitudinal evidence; and causal risk factors.[13]

Joseph C Franklin and others indicated in their article, 'Risk Factors for Suicidal Thoughts and Behaviors: a Meta-Analysis of 50 Years of Research':

> Causal risk factors (causality), in empirical research, may only be identified by manipulating independent variables (risk factors) under controlled conditions to change the probability of the outcome (suicide). Ethical and practical barriers mean suicide-related experiments are rare, and there is very little existing research on causal risk factors for suicidal thoughts and behaviours.[14]

Phoenix Australia's Tracey Varker and colleagues wrote in *ADF members and ex-members suicide literature review: An update:*

> Methods to predict suicide are inherently difficult due to the large number of possible risk factors that have been found to be associated with suicide, and the complexity of how these may interact with each other.[15]

This final report uses a range of longitudinal and observational data, and draws on extant suicide prevention research, to identify risk associations and risk factors with varying levels of predictive strength. Importantly, as Varker and others noted:

> Risk (and protective) factors are often not definitive because they are contextual, are interconnected, and operate at individual, interpersonal and systems levels.[16]

1.2 Suicide and suicidality in Australia

12. This section begins with a review of prevalence statistics for suicide and suicidality in the Australian population. It outlines risk and protective factors and life stressors that can occur across the lifespan for both the civilian and military population.

13. When this Royal Commission was called it was already known that serving ADF members experienced high rates of suicidality, and ex-serving ADF members experienced high rates of suicidality and death by suicide.[17] Many Australians experience suicidal distress and suicidal ideation (thoughts about taking one's own life without acting on the thoughts) at some point in their lives. Some of these will attempt suicide, and a small proportion will die by suicide.[18] Before outlining the prevalence of suicide and suicidality in our military population, we consider prevalence in the Australian population.

1.2.1 Prevalence of suicidality and self-harm in the Australian population

14. The term 'suicidality' refers to 'suicidal ideation (serious thoughts about taking one's own life), suicide plans and attempts'.[19] The experience of suicidality and self-harm varies from one individual to another. Some individuals experience only thoughts of suicide, others experience thoughts and develop suicide plans, while some experience thoughts, plans and make a suicide attempt.

15. In 2021–22, close to 26,900 people were hospitalised in Australia for intentional self-harm injuries – an average of around 74 hospitalisations per day.[20] Over this period, there were around 18,000 intentional self-harm hospitalisations for females (139 per 100,000 population) and around 8,800 for males (69 per 100,000 population).[21]

16. The actual prevalence of suicidality in the community is greater than is indicated by data on hospitalisations for intentional self-harm. This is because only those with serious physical injuries or mental ill health are admitted to hospital following intentional self-harm.[22]

17. In 2021, ambulances attended around 90,100 incidents that involved suicidal thoughts and behaviours (suicidal ideation or suicide attempt) throughout New South Wales, Victoria, Queensland, Tasmania and the Australian Capital Territory.[23]

18. However, not all people who experience suicidality contact emergency services. Results from the 2020–22 Australian Bureau of Statistics National Study of Mental Health and Wellbeing estimated that 3.3% of adult Australians (644,600 people aged 16–85) had experienced suicidal thoughts or behaviours in the previous 12 months. The report found:

    - 3.3% of people (644,600) had seriously thought about taking their own life
    - 1.2% of people (230,500) had planned to take their own life
    - 0.3% of people (54,800) had attempted to take their own life.[24]

1.2.2 Suicide rates in the Australian population

19. In 2022, there were 3,249 deaths by suicide in Australia (12.3 deaths per 100,000 people).[25] This is an average of about nine deaths per day.

20. The age-standardised suicide rate among males has been consistently higher (and more variable) than that for females, with 2,455 suicide deaths of males (18.8 deaths per 100,000 people) and 794 deaths of females (5.9 deaths per 100,000 people) in 2022.[26]

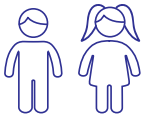
1.2.3 Risk factors and life stressors for the general population

21. Serving and ex-serving ADF members are also members of the general community. Many of the life stressors and risk factors that can occur across the lifespan for the civilian population also occur, and could be exacerbated, during and after military service.

22. In her report *Compassion First*, Ms Morgan summarised commissioned research from thousands of people with first-hand experience of suicidal behaviour. In the thousands of stories shared as part of the research, not one participant described a simple lead-up to a suicide attempt.[27] Suicidal behaviour was described as a passing event for some people, but others highlighted that thoughts of suicide did not resolve quickly or easily.[28] Some people who experienced suicidal thoughts and behaviours had childhood or adolescent experiences of abuse, violence, trauma, family conflict or bereavement.[29] Mental ill health, problems with alcohol and other drugs, stigma, discrimination and cultural taboos, as well as co-occurring complex life stressors, were also reported.[30]

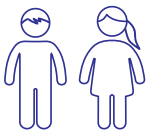
23. The report summarised some of the contributing factors for suicidality that were mentioned across life stages, set out in Figure 1.1. We note that for some people there were no clear or obvious contributing factors. The figure includes underlying factors and stressors, key transition points and points of disconnection during which people may be at increased risk, and factors that can affect families and communities across the lifespan.

Figure 1.1 Underlying factors, life stressors and key transition points across the lifespan



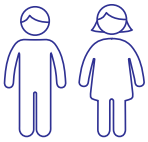
Children

A large proportion of people report risk factors that emerge in childhood — including sexual, verbal, psychological and physical abuse, exposure to family violence, trauma experienced during migration and settlement, and bereavement, including suicide bereavement, during childhood.



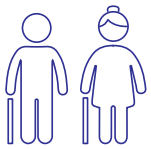
Young People

Adolescence and early adulthood is often when psychological and interpersonal risk factors emerge or are exacerbated. This includes onset of mental ill-health and alcohol and other drug problems, study and work stresses, challenges with interpersonal relationships, identity and cultural challenges for some young Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) people and those from a culturally and linguistically diverse background.



Adult

Most suicide deaths in Australia occur amongst adults (75% are males) with many experiencing multiple life stressors just prior to an attempt or death. Many people report a change in alcohol or drug use (AOD) in combination with relationship breakdown, family violence, legal and child custody issues, workplace stresses, injury or illness, unemployment and financial distress.



Older People

High rates of suicide occur among older men, however risk factors can be quite different and often include limitations on daily functioning due to illness, disability or chronic pain, social isolation, grief and bereavement.

Key transition points and points of disconnection across the lifespan present unique stressors and opportunities for intervention

Disengagement and transition from school or university, discharge from hospital following a suicide attempt, discharge from the Australian Defence Force to civilian life, release from correctional facilities, divorce or a change in family structures, impacts of migration and settlement, change in work status due to unemployment, illness or injury.

A range of factors have been identified that can impact on families and communities across the life course

Access to means of suicide or availability of information online Exposure to suicidal behaviours of family, peers or through media	Ineffective treatment for mental illness and alcohol and other drug problems Disadvantage, inequity and poverty Homophobia and transphobia	Stigma associated with mental illness and discrimination Intergenerational trauma and loss of connection to culture Cultural taboos about suicide	Having made a previous suicide attempt Ineffective responses to past suicidal behaviour

Source: National Suicide Prevention Taskforce, *Compassion First: Designing our national approach from the lived experience of suicidal behaviour*, Australian Government, December 2020, p 13 (Exhibit 45-01.004, Hearing Block 6, EXP.0006.0018.0017).

24. Most people reported that a number of stressors co-occurred in a short period of time before a suicide attempt. These included interpersonal conflict, intimate partner and family violence, relationship breakdown and/or child custody issues, being bereaved by suicide, as well as legal, financial or housing problems.[31]

25. These life stressors and events can also be experienced by serving and ex-serving members, and can co-occur with military-related stressors. Serving and ex-serving members are, therefore, more likely to accumulate more risk factors because they are also exposed to factors specific to service life and post-service life. Hence, they are at greater risk of suicide and suicidality.

26. While suicidal behaviour can be experienced by anyone, some populations and groups can be disproportionately affected, meaning targeted responses to tackling suicidality are required.[32] Ms Morgan identified veterans, and the other groups identified in Figure 1.2, as potentially being more vulnerable to suicidal behaviours, and recommended a comprehensive approach to suicide prevention. It must focus on the whole population, while also addressing the unique needs of specific groups through tailoring interventions and approaches that are most likely to reach them.

Figure 1.2 The experiences of some groups make them more vulnerable to suicidal behaviour than others

Adult and older men	Men are more than three times more likely to die by suicide than women are. They are also less likely to access health services before their death. Risk factors for male suicide include relationship breakdown, separation and post-separation parenting arrangements, unemployment, financial distress, alcohol or substance use, mental health issues, legal issues, experiences of childhood abuse and social isolation and loneliness in older age.[24]
Aboriginal and Torres Strait Islander Peoples	Aboriginal and Torres Strait Islander Australians are twice as likely to die by suicide as non-Indigenous Australians, with young Aboriginal and Torres Strait Islander people being four times more likely to die by suicide.[25] Systemic factors such as discrimination, intergenerational trauma, disadvantage and cultural factors like the experience of shame can all act as barriers to people receiving appropriate support.
Children and Young people	Suicide is a leading cause of death for children and young people. Adverse experiences in childhood and adolescence can increase vulnerability to suicide, with 75 per cent of mental illnesses and alcohol and other drug problems occurring by early adulthood – two key underlying risk factors for suicidality. Young people also present with self-harming behaviours at higher rates than other age groups which requires dedicated attention.[26]
People who identify as LGBTIQ+	Compared to the Australian population, LGBTIQ+ people are nearly twenty times more likely to have considered suicide and ten times more likely to have attempted suicide, with particularly high rates for transgender and gender diverse people.[27] LGBTIQ+ people often report feeling judged, stigmatised and discriminated against by broader society and can experience a lack of acceptance from those around them. The importance of an inclusive environment that supports the mental health and well-being of LGBTIQ+ people must be recognised and promoted.
People living in rural and remote communities	The suicide rate in Australia's rural and regional areas is 40 per cent higher than in major cities.[28,29] Rural and regional communities can experience sudden and ongoing adversity, which can lead to widespread financial hardship. There are also generally fewer supports and professional services available in rural and remote communities. Lived experience research has highlighted that people in rural areas may feel less comfortable seeking help through health services, while in other areas access to services may be limited.
Culturally and linguistically diverse communities	While there is limited data available on rates of suicide and suicide attempts within culturally and linguistically diverse communities, these communities can face distinct risks because of cultural stigma and taboos, combined with language barriers that can prevent help seeking and effective public health communications.
People living with mental illness	Many people who die by suicide in Australia have a prior experience of a mental illness. Suicide is a prominent cause of death for people with complex mental illness, with the risk increased for people with borderline personality disorder (45 times greater), anorexia nervosa (31 times greater), major depression (20 times greater), bipolar disorder (17 times greater) and schizophrenia (13 times greater).[31]
Women	Women, especially young women, are more likely to engage in self-harm and attempt suicide.[32] A range of risk factors have been identified for women that require attention, especially given increasing rates of suicide among women in recent years. These include mental illness, family and relationship issues, domestic violence, cultural expectations, and eating disorders.

Source: National Suicide Prevention Adviser, *Connected and Compassionate: Implementing a national whole of governments approach to suicide prevention, Final Advice*, December 2020, p 55 (Exhibit 45-01.005, Hearing Block 6, EXP.0006.0018.0069).

27. Similar to the Australian population, there are also groups within the ADF that can be disproportionately affected, which will be discussed later in this chapter.

28. Figure 1.3 groups risk and protective factors for suicidality by socio-ecological level – in other words, the individual, relationship/interpersonal, community and societal levels – for which there is a reasonable body of supportive evidence. Risk and protective factors with the strongest evidence are in bold, and risk or protective factors of importance for a specific population are identified with an asterisk.

Figure 1.3 Known risk and protective factors for suicidality

	Risk Factors	Protective Factors
Individual		
• **Biological**	▪ Male sex (completions)/Female sex (attempts)* ▪ **Family history of suicidal behaviour** ▪ Genetic factors (e.g., serotonin dysfunction)	▪ SSRI/Lithium/mood stabilizer/Clozapine usage
• **Socio-demographic**	▪ Gender (e.g., transgender status)* ▪ Lesbian, gay, or other sexual minority identity* ▪ Religiosity/spirituality (i.e., suicide as a solution to problems)* ▪ Ethnicity (e.g., Indigenous, other country specific)* ▪ Age (young adult, middle age)* ▪ Some professions (e.g., military, law enforcement)* ▪ Incarceration*	▪ Heterosexual sexual orientation ▪ Religiosity/ spirituality (i.e., beliefs about suicide being wrong)*
• **Psychiatric/ mental health issue**	▪ **Mental health diagnoses/symptoms (e.g., depression, bipolar, post-traumatic stress disorder)** ▪ **Personality disorders (e.g., Borderline Personality)** ▪ **Substance and alcohol use/abuse**	▪ Treatment motivation
• **Psychological**	▪ **Prior suicide attempt** ▪ **Current suicidal thinking** ▪ **Presence of suicidal intent** ▪ **Presence of suicide plan** ▪ **Hopelessness** ▪ **Feelings of burdensomeness** ▪ **Rejection/thwarted belongingness** ▪ Internalising/externalising psychopathology	▪ **Coping skills** ▪ **Hopefulness/positive future orientation** ▪ **Additional reasons for living**
• **Other Psychosocial**	▪ Chronic pain and illness ▪ High perceived/subjective stress ▪ Job loss/unemployment ▪ Financial strain ▪ Bullying/bias crime victimization ▪ Response to childhood abuse ▪ Experience of discrimination ▪ Housing instability	
Relationship/ interpersonal	▪ Family violence/trauma ▪ **Abuse** ▪ Relationship instability ▪ Death of a loved one ▪ Intimate relationship breakup ▪ Social isolation/withdrawal ▪ Combat exposure*	▪ **Social support** ▪ Social connectedness ▪ Help-seeking behaviour
Community	▪ **Exposure to suicide contagion/cluster in community** ▪ Barriers to access mental healthcare (local)	▪ Access to mental health treatment and **school-based support programs**
Societal and health system	▪ Economic depression/downturn/poverty ▪ War/conflict/ natural disasters ▪ Access to means ▪ Barriers to healthcare/mental healthcare (societal) ▪ Inappropriate media reporting and social media use	▪ Healthy economy ▪ Restrictive firearm laws ▪ Funding/availability of healthcare/mental healthcare

Source: A Flego and others, *Suicide and Self-harm Monitoring of the Serving and Ex-serving Australian Defence Force Member Population, Part 1: the Data Landscape and Short-term Opportunities*, Centre for Mental Health, Melbourne School of Population and Global Health, The University of Melbourne, 9 August 2022, p 43 (Exhibit K-01.048, DVS.2222.0001.1292).

1.3 Suicide and suicidality in the Australian Defence community

29. Our focus now turns to suicide in the Australian military context. We describe broad categories of ADF service to better understand the unique nature of military service. Next, we examine the prevalence of suicide and suicidality in the ADF, and then set out military-related risk and protective factors as they were understood at the start of this Royal Commission.

1.3.1 Understanding ADF service

30. To understand the prevalence of suicidality and death by suicide among serving and ex-serving members, it is first necessary to understand a little about service in the ADF.

31. In this section, we outline five key distinctions: service type, different phases of service life, service arm, rank and occupation group. These provide context for the prevalence data and findings about cohorts with increased risk of suicide and suicidality.

Service in the permanent forces versus the reserve forces

32. Service in the ADF permanent forces is full time and represents the maximum service obligation.[33] Permanent forces members must undertake military service on operations at the direction of the Australian Government. Operations can be domestic or around the world.[34] The majority of ADF members are members of the permanent forces.

33. Service in the reserve forces generally involves members working – or being available to work – 20 to 100 days of service a year.[35]

34. The level of service duties and obligations varies greatly between those who serve in the permanent forces and those who serve in the reserves.[36] Over the course of their career, a member may serve in the permanent or reserve forces, or a combination of both.

35. Service in the permanent forces is unique. It involves sacrifices by the member and their family that differ from the kinds of sacrifice and hardship typically experienced by those serving in the reserve forces.

36. Almost 600,000 Australians are serving or have served in the ADF.[37] This includes:

    - 57,346 serving members in the permanent forces
    - 32,049 serving members in the reserve forces
    - 321,800 ex-serving members who had served in the permanent forces
    - 174,500 ex-serving members who had served solely in the reserve forces.[38]

37. Some of the 32,049 serving members in the reserve forces had previously served in the permanent forces and others had served solely in the reserve forces.

Phases of the service life journey

38. A typical military permanent forces career has phases such as recruitment and initial training, serving as a member of the Trained Force, deployment (for some members) and post-service. Each phase is associated with different risks and challenges.

    - *Training* involves the transition from civilian to military life and includes a recruit or commissioning course and initial employment training.[39]
    - *Trained Force* is the phase following graduation from the recruit or commissioning course and initial employment training. Members are considered part of the ADF Trained Force and are posted to a unit, ship or base.[40]
    - *Deployment* (as defined in the *Military Personnel Policy Manual*) is when members of the Trained Force are deployed to warlike or non-warlike service overseas on ADF-approved operations.[41] Deployments can also be in support of operational and peacekeeping missions and responses to humanitarian assistance and disaster relief activities.[42]
    - *Post service* involves the transition from military to civilian life. During this phase an ex-serving member is likely to be involved with finding housing and employment, submitting claims and accessing support from the Department of Veterans' Affairs (DVA).

39. It can be tempting to picture all ex-serving members of the permanent forces as people who have been deployed and thus exposed to the kinds of trauma caused by military conflict that, for some people, are associated with an elevated suicide risk. However, the reality is that fewer than half of ex-serving members deployed while they served in the permanent forces. In the full cohort of ex-serving members for the period 1 January 2014 to 31 December 2023 who served in the permanent forces:

    - 16.1% did not complete initial training
    - 37.4% were in the Trained Force but were not deployed to a 'warlike' or 'non-warlike' operation – that is, their deployment did not carry a direct or indirect risk of harm through military conflict
    - 46.5% were in the Trained Force and were deployed to a 'warlike' or 'non-warlike operation' – that is, their deployment *did* carry the risk of direct or indirect harm through military conflict.[43]

Service in the Navy, Army or Air Force

40. There are three ADF service arms: Royal Australian Navy (Navy), Australian Army (Army) and Royal Australian Air Force (Air Force). Some members move between arms over the course of their career.[44]

41. Roles differ across the service arms. Roles are contingent on specific skills and contextual needs, such as warlike or non-warlike operation, and the posting and deployment cycle. Some service roles are more adaptable and transferable across service arms than others.

42. More than half (51%) of males serving in permanent positions in the Trained Force are in the Army; 25% are in the Navy and 24% in the Air Force. There is a more even distribution for females: 36% Army, 30% Navy and 34% Air Force.[45]

43. The majority of ex-serving members who served in the permanent forces at 30 June 2021 had been in the Army (68% of males and 62% of females); 16% of males and 18% of females served in the Navy, and 16% of males and 20% of females served in the Air Force.[46]

Category of rank: commissioned officers or other ranks

44. The ADF is a hierarchical organisation. A member's rank dictates their role and responsibilities, work conditions, opportunities and entitlements (such as pay and conditions).[47] Rank is presented in two broad groups: commissioned officers and 'other ranks'. For the purposes of this final report, a Defence member who holds a rank of midshipman or officer cadet or higher is a commissioned officer; and a Defence member who holds an equivalent rank to E00 (recruit seaman, private or aircraftman) to E10 (warrant officer of the Navy, regimental sergeant major of the Army or warrant officer of the Air Force) is designated other ranks.

45. Of the males and females serving in the permanent forces, 28% are officers and 72% are from other ranks.[48]

46. Data for 2021 shows that 14% of the ex-serving cohort were officers at the time of separation and 86% were from other ranks.[49]

Occupational groups

47. Every ADF member's basic training includes applying lethal force at the command of the Australian Government. However, many employment roles after basic training are not martial but support martial activities, including technical, caring, support and logistical roles.[50]

48. ADF occupations are split into eight groups, referred to within Defence as 'strategic workforce segments'. Each group encompasses roles that have different responsibilities, duties and tasks. Due to these differences, occupational groups may expose members to different degrees and types of risk.

49. ADF occupational groups are:

- aviation – roles that directly enable employment of aviation assets; except for aviation engineers, technicians and maintainers, who are classified under the engineering, maintenance and construction workforce segment[51]
- combat and security – roles that involve the direct or indirect application of physical force, including those that fill a security function domestically or operationally (such as military police)[52]
- communications and cyber – roles that enable communication, including the security of friendly force communications and the exploitation of adversary communications (such as cyber)[53]
- engineering, maintenance and construction – roles in engineering, design and compliance, maintenance and production, and vertical and horizontal construction. This includes all types of engineering, maintenance and construction roles, such as those supporting aviation and communication functions[54]
- enterprise and command support – roles that enable personnel management, training, workforce planning, organisational administration, governance and brand/reputation management that ultimately support command decisions, including senior officers, sailors, soldiers and airmen/women who enable the strategic functioning of Defence[55]
- health – roles that directly support the provision of health care[56]
- intelligence – roles that directly enable the collection, analysis and dissemination of military intelligence[57]
- logistics – roles that directly involve the supply, distribution and storage of equipment within the ADF.[58]

50. At 1 January 2024, of the serving cohort:

- 7.6% were serving in aviation roles
- 27.2% were in combat and security roles
- 7.5% were in communications and cyber roles
- 23.8% were in engineering, maintenance and construction roles
- 8.5% were in enterprise and command support roles
- 5.2% were in health roles
- 5.8% were in intelligence roles
- 14.4% were in logistics roles.[59]

51. Between 1 January 2014 and 31 December 2023, of the ex-serving cohort at their time of separation:

- 4.4% had served in aviation roles
- 33.1% in combat and security roles
- 6.6% in communications and cyber roles
- 21.5% in engineering, maintenance and construction roles
- 8.8% in enterprise and command support roles
- 4.6% in health roles
- 4.4% in intelligence roles
- 16.5% were in logistics roles.[60]

1.3.2 Suicide rates and suicidality prevalence

52. To better understand suicide in the military context we listened to the stories shared in almost 900 private sessions and 5,865 lived experience submissions, and heard from 70 lived experience witnesses who gave evidence at hearings.

53. Our research program included qualitative and quantitative work conducted by Royal Commission staff and quantitative research conducted by the Australian Institute of Health and Welfare (AIHW). The results of the Royal Commission's research are presented in the final report in Appendix H, Comparative rates of suicide – current serving ADF members, and Appendix I, Comparative rates of suicide – ex-serving ADF members, and the results of research by the AIHW are presented in Appendix J, Comparative hospital admissions for self-harm and mental health, and Appendix K, Comparative suicide rates and select causes of death. For the most part, they are age-adjusted comparisons between the suicide rate in ADF groups and the general Australian population, calculated using standardised mortality ratios.

54. We also commissioned work from external research organisations. These projects were in addition to information given as evidence in public hearings and through responses to compulsory notices and reviews of existing research, data and information.

55. According to an Australian Institute of Health and Welfare (AIHW) report on suicide among permanent, reserve and ex-serving ADF members, a total of 2,007 confirmed suicide deaths occurred between 1 January 1985 and 31 December 2021 among ADF members who had served at least one day since 1 January 1985.[61] This is a tragic and needless loss of life. In the 10 years from 2011 to 2021, an average of 78 serving or ex-serving members died by suicide each year.[62] This equates to, on average, three deaths by suicide every fortnight.[63] These are deaths of people who chose to defend and protect our nation. Suicide rates among ADF members have remained relatively unchanged over the past 20 years.[64]

56. The AIHW figures understate the actual number of suicide deaths. They do not include deaths not officially recorded as suicides, such as deaths where intent could not be determined. They underreport suicides before 1997 as details of deaths at that time were not as comprehensively recorded.[65] Nor do they include suicide deaths of members who separated before 1985, meaning the suicide deaths of many Vietnam and other veterans are excluded.[66] (For further information, see Chapter 29, Use of data and research by Defence and DVA.)

57. The death by suicide of each of these people, including those not captured in official statistics, has had a devastating impact on their family members, friends, colleagues and communities. Research shows that at least 135 people are exposed (meaning they knew the person) to every death by suicide, including many family members and friends who are profoundly affected.[67]

Prevalence of suicidality and self-harm in serving and ex-serving ADF members

58. In this section we provide data that supports our understanding of the scale of suicidality and self-harm among serving and ex-serving ADF members. The data presented looks at psychological distress, suicidality and self-harm, and death by suicide.

Psychological distress

59. It has long been established that prolonged psychological distress can have a detrimental impact on mental health, leading to conditions such as anxiety, depression, lack of sleep, hopelessness and poor interpersonal relationships.[68] These conditions are risk factors for suicidality.[69]

60. Research suggests the pathway to suicidal ideation, and suicidality more broadly, may begin with psychological distress or psychological pain, such as may be triggered by stressful life events.[70]

61. In 2018, DVA published the *Mental Health and Wellbeing Transition Study* on research done as part of its Transition and Wellbeing Research Programme. The research found that in 2015 the number of regular ADF members who reported 'very high psychological distress' was almost 2.5 times that of the general Australian population (10.8% compared to 4.5%).[71]

62. For ex-serving members, the difference was even more pronounced. The proportion of ex-serving members who had served in the permanent forces and who reported very high psychological distress was more than 4 times that of the Australian community. Nearly one in five ex-serving members (19.6%) reported experiencing 'very high psychological distress'.[72]

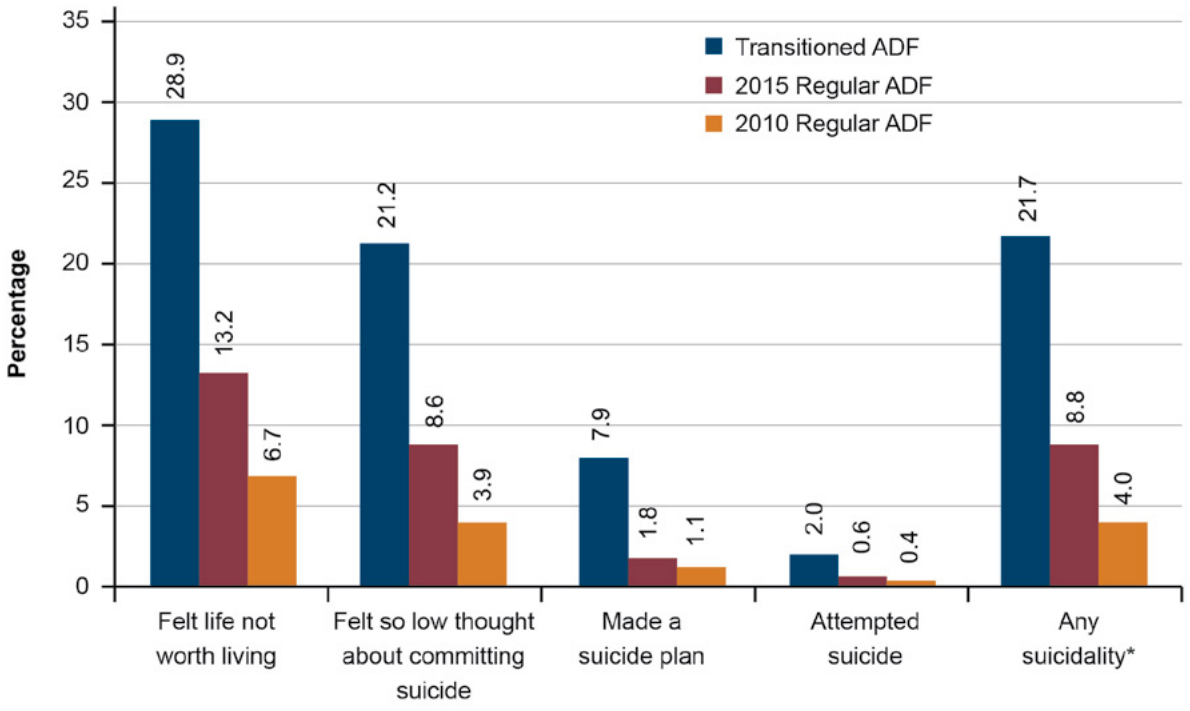
Suicidality

63. The 2010 ADF Mental Health Prevalence and Wellbeing Study found the prevalence of suicidal ideation and making a suicide plan was significantly higher in 2010 current serving members of the permanent forces than in the Australian community. The rate of suicidality in the ADF was more than double that in the Australian employed population.[73]

64. The Mental Health and Wellbeing Transition Study found that serving members of the permanent forces were significantly more likely to report suicidal ideation in 2015 than they were in 2010 (8.6% versus 3.9%). Suicidal ideation, but not plans and attempts, was also significantly more prevalent in 2015 regular ADF members.[74]

65. The high rate of suicidality in serving members increases further after transition. The Mental Health and Wellbeing Transition Study compared suicidality in ex-serving members who had served in the permanent forces with that of permanent serving members in 2010 and 2015. As shown in Figure 1.4, the study estimated that in 2015 more than 20% of ex-serving members who had served in the permanent forces had experienced suicidality in the previous 12 months. Specifically, it estimated:
    - 21.2% felt so low they thought about dying by suicide
    - 7.9% made a suicide plan
    - 2.0% reported having attempted suicide.[75]

Figure 1.4 Estimated proportions of suicidality in transitioned ADF members and 2010 and 2015 regular ADF members



* From the 2010 *ADF Mental Health Prevalence and Wellbeing Study*. 'Any suicidality' includes those who endorsed 'felt so low thought about committing suicide', 'made a suicide plan', 'attempted suicide'. Note: 95% confidence interval.

Source: M Van Hooff and others, *Transition and Wellbeing Research Programme, Mental Health and Wellbeing Transition Study: Mental Health Prevalence*, Department of Veterans' Affairs, 2018, p 180 (Exhibit 20-03.043, Hearing Block 3, DEF.0001.0001.0145).

Suicide-related contact with police or paramedics for current serving members

66. Recent evidence on suicidality for current serving members is limited. Defence has not undertaken any further surveys on the rate of suicidality in current or ex-serving members since the 2015-related data as part of the Transition and Wellbeing Research Programme.

67. However, this Royal Commission had research conducted using data between 2014 to 2017 for current serving members in the permanent forces in Queensland. It estimated they have 5.84 times higher odds of having suicide-related contact with police or paramedics than members serving in the reserves and ex-serving members.[76]

Hospitalisations and emergency department presentations of ex-serving members for self-harm

68. The alarming rate of suicidality reported in the Mental Health and Wellbeing Transition Study for ex-serving members is reflected in AIHW data on hospitalisations and emergency department presentations up to 30 June 2020.[77] The research did not include current serving members; however, the results demonstrated that ex-serving members who had served in the permanent forces had higher rates of suicidality than members who had served solely in the reserve forces.

69. First, we look at the data for ex-serving males and females of all age groups (except 65+) who had served in the permanent forces. They were more likely to be admitted to hospital or present to an emergency department for self-harm or suicidal behaviour than the general Australian population.[78]

70. The proportion of ex-serving male patients (who had served in the permanent forces) admitted to a public hospital for intentional self-harm was 1.6 to 1.8 times higher in all age groups (except 65+) when compared with male patients in corresponding age groups in the general Australian population.[79]

71. Ex-serving males of all age groups (17+) who served in the permanent forces and had presented to an emergency department were also 1.3 to 1.6 times more likely to present for self-harm or suicidal behaviour than civilian Australian males of the same age group who had presented to an emergency department.[80]

72. Admissions for self-harm or suicidal behaviour were even higher for ex-serving female patients who had served in the permanent forces. The proportion admitted to a public hospital for intentional self-harm was 1.4 to 2.6 times higher for all age groups (where data was available, and except for those aged 65+) than the corresponding age groups in civilian Australian female patients.[81]

73. Ex-serving females aged 17 and over who had served in the permanent forces and had presented to an emergency department were 1.2 to 1.9 times more likely to have presented for self-harm or suicidal behaviour than civilian Australian females of the same age group who had presented to an emergency department (where results are available).[82]

74. In contrast, ex-serving male patients of all age groups who had served solely in the reserve forces were not statistically more likely to be admitted to a public hospital for intentional self-harm than Australian male patients of the corresponding age group.[83]

75. Ex-serving males aged 25 to 44 who served solely in the reserve forces and presented to an emergency department were 20% less likely to present for self-harm injuries or suicidality than civilian Australian males of the same age group who had presented to an emergency department. However, males aged 45 and above and who served solely in the reserve forces were 1.2 to 1.6 times *more* likely to present for self-harm or suicidality than Australian males of the same age group who presented to an emergency department.[84]

76. In contrast, ex-serving female patients aged 35 to 64 (who served solely in the reserve forces) were 1.5 to 1.9 times more likely to be admitted to a public hospital for intentional self-harm than Australian female patients in the general female population of the same age group.[85]

77. Ex-serving females aged over 17, of all age groups above 35, who served solely in the reserve forces and presented to an emergency department (where data was available) were 1.2 to 1.9 times more likely to present for self-harm injuries or suicidality compared to Australian females in the same age group who presented to an emergency department.[86]

Suicide rates among serving ADF members

78. By definition, all serving members in the permanent forces are employed. We compared suicide rates of serving ADF members to those of the Australian employed population (matched for age, sex and employment status).

79. We strongly believe that the employed population is a more appropriate comparison group than the general population when determining at-risk groups. Not being employed is known to be associated with death by suicide. AIHW estimated that suicide risk among males and females of prime working age – 25 to 54 – who were not employed is at least 2.5 times higher than for those who are employed.[87]

80. The ADF population is also healthier than the general population. The ADF fosters physical fitness and has some programs designed to foster good mental health. The 2010 *ADF Mental Health Prevalence and Wellbeing Study* noted:

> The 'healthy worker effect' comes from the fact that, during recruitment, the ADF takes steps not to enlist individuals with pre-existing disorders. It then provides quality and accessible health services to all of its members. In addition, there is an occupational health service in the ADF that provides quality care at no cost to ADF members and, following deployment, ADF members are extensively screened to ensure they receive treatment if they need it. The ADF workforce should, therefore, be healthier than the general community.[88]

81. The Mental Health Prevalence and Wellbeing Study removed the potential confounding effect of employment status by comparing ADF prevalence rates to an Australian sample matched for age, sex and employment status.[89] The study examined the prevalence rates of the most common mental disorders, suicidality, and the impact of occupational stressors.[90]

82. Ideally, members currently serving in the permanent forces should be compared to healthy Australians engaged in full-time employment. However, due to data limitations, it is currently only possible to compare with employed Australians.

Suicide rates of current serving members compared to employed Australians

83. Age- and employment-adjusted suicide rates for the period 2011 to 2020 indicate that males who were serving in the permanent forces were 30% more likely to die by suicide than employed Australian males.[91]

84. Due to the small number of suicide deaths of females who were serving in the permanent forces during the same period, suicide rates are not reported for this cohort.[92]

85. To examine the higher rates of suicide in males serving in the permanent forces and identify at-risk groups, we studied suicide rates in five sub-populations within the ADF (see section 1.3.1). At-risk ADF groups are those with a higher rate of suicide compared to those in general Australian populations matched for age, sex and employment status. The categories studied were deployment history, enlistment age, occupational group, occupation and whether they had been involved in disciplinary action. The full results of this analysis, including confidence intervals, methodology and limitations, are in Appendix H, Comparative rates of suicide – current serving ADF members.

86. Identifying groups at higher risk of suicide indicates an 'association' between attributes of the members of those groups and death by suicide. They do not tell us why these groups are at risk. Further research, particularly advanced statistical modelling, can provide statistical information to add to the other sources to help establish causality.[93]

Occupational groups

87. We analysed suicide rates of current serving ADF members, split into eight occupational groups:

    - aviation
    - combat and security
    - communications and cyber
    - engineering, maintenance and construction
    - enterprise and command support
    - health
    - intelligence
    - logistics.

88. An occupational group shows the role a member was employed in at separation from the ADF.

89. Our results found that males serving in the permanent forces in combat and security roles have an increased risk of suicide, and are two times (100%) more likely to die by suicide than Australian employed males.[94] Males serving in other occupational groups in the permanent forces were found not to be at greater risk.[95]

90. Due to the small number of suicide deaths among current serving females, suicide rates could not be reported.

Occupations

91. In the ADF, roles associated with different professions and trades are filled by serving members.

92. We found that males serving in the permanent forces in certain occupations have an increased risk of suicide, with rifleman 2.53 times (153%) more likely to die by suicide than Australian employed males.[96]

93. Due to the small number of suicide deaths among serving females, suicide rates could not be reported.

94. We have only reported on the occupation of rifleman for males, as it is a larger cohort. The suicide rates for males serving in the permanent forces in most other occupations were too small to derive a reliable result.

Suicide rates of ex-serving ADF members

95. AIHW's *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021* report examined ADF suicide rates with comparable rates in the Australian population (among males or females, as appropriate) for the same period. It found suicide rates were:

    - 26% higher for ex-serving males who served in either the permanent or reserve forces
    - 107% (or 2.07 times) higher for ex-serving females who served in either the permanent or reserve forces.[97]

96. As explained in section 1.3.1, ex-serving ADF members may have served solely in the permanent forces or the reserve forces, or a combination of both. Service duties and obligations, possible career paths, exposure to ADF culture and time absent from loved ones typically vary depending on whether service is in the permanent forces or the reserve forces.[98]

97. We compared the suicide rates of ex-serving members who served in the permanent forces (which can include the reserves) or solely in the reserve forces, with those of Australian males and females as appropriate. We found the suicide rates were:

    - 42% higher for ex-serving males who served in the permanent forces[99]
    - similar to those of Australian males for ex-serving males who served solely in the reserve forces[100]
    - 110% (or 2.10 times) higher for ex-serving females who served in the permanent forces[101]
    - 104% (or 2.04 times) higher for ex-serving females who served solely in the reserve forces.[102]

98. These figures indicate that groups at higher risk of suicide than the age- and sex-adjusted Australian population include:

    - ex-serving males who served in the permanent forces
    - all ex-serving females, regardless of whether they served in the permanent forces or solely in the reserve forces.

99. It is important to note that these four groups of ex-serving males and females who had served in permanent or reserve forces are not homogeneous. We examined the underlying factors that differentiate people in these groups.

Suicide rates of ex-serving members who served in the permanent forces

100. We first discuss the finding that ex-serving males who served in the permanent forces were 42% more likely to die by suicide than Australian males.

101. We studied suicide rates in 13 sub-populations of ex-serving males who served in the permanent forces. The categories studied were:

- age
- service arm
- length of service
- time since separation
- rank
- separation reason
- deployment history
- enlistment age
- separation during initial training
- occupational group
- whether they were in the Trained Force, had reported a WHS injury or been involved in disciplinary action.

102. We set out the full results of this analysis, including confidence intervals, methodology and limitations, in Appendix I, Comparative rates of suicide – ex-serving ADF members.

103. Our analysis found the at-risk groups of ex-serving males who served in the permanent forces are those who:

- separated involuntarily for medical reasons
- separated involuntarily for the reason 'retention-not-in-service-interest' (sometimes called 'administrative discharge')
- served in logistics, or combat and security roles
- separated during initial training in Army soldier combat and security roles
- served as soldiers or sailors in Army Trained Force or Navy Trained Force
- deployed in combat and security roles and were exposed to direct or indirect harm.[103]

104. Second, we examined the higher rate of suicide in ex-serving females, finding that those who served in the permanent forces were 2.1 times (110%) more likely to die by suicide than Australian females.[104]

105. At-risk groups of ex-serving females who served in the permanent forces are those who:

- separated involuntarily for medical reasons
- separated involuntarily for the reason 'retention-not-in-service-interest'
- served in combat and security or health roles.[105]

106. As noted previously, these at-risk groups help us identify which ADF groups *are associated with* higher rates of suicide, but they do not tell us why these groups are at risk (what *causes* that higher risk). Further research, particularly advanced statistical modelling, is required to answer that question.

Medical separation

107. Medical separation, or medical discharge, is the involuntary termination of a member's ADF service on the grounds of permanent or long-term unfitness to serve or unfitness for operational deployment.[106]

108. Our research found that ex-serving males who served in the permanent forces and who separated involuntarily for medical reasons are 2.84 times (184%) more likely to die by suicide than Australian males.[107]

109. Ex-serving females who served in the permanent forces and separated involuntarily for medical reasons are almost five times (398%) more likely to die by suicide than Australian females.[108]

110. Of the sub-populations studied in the AIHW ADF suicide monitoring report, the cohort with the highest suicide rate was ex-serving males who separated involuntarily for medical reasons.[109] However, new research found other cohorts with equal or higher rates.

Separation for reason 'retention not-in-service interest'

111. Separation for the reason 'retention-not-in-service-interest' is a form of involuntary separation when retention of the member is deemed to be no longer in the interest of the ADF. This usually means a decision was made that:

- the member was underperforming
- the member's behaviour was not acceptable (for instance, they were convicted of a criminal or service offence)
- the member was no longer deemed suitable to serve in a particular role or at a particular rank

- the member failed to meet one or more conditions of their appointment, enlistment or promotion
- the role filled by the member was not aligned with workforce planning; measures to improve effectiveness and efficiency; or measures to improve the morale, welfare and discipline of the Defence Force, or its reputation and standing in the community.[110]

112. The suicide rate for ex-serving males who served in the permanent forces and separated involuntarily for the reason 'retention-not-in-service-interest' was around three times (197%) higher that the rate for Australian males.[111]

113. The suicide rate for this cohort within one year of separation was six times higher than that of Australian males.[112]

114. Females who served in the permanent forces and separated involuntarily for the reason 'retention-not-in-service-interest' were 3.45 times (245%) more likely to die by suicide than Australian females.[113]

Occupational group

115. Our analysis also determined the suicide rates of ex-serving members from the various occupational groups. Ex-serving males who served in the permanent forces in logistics roles were 69% more likely to die by suicide. Those who served in combat and security roles in the Army were over two times (112%) more likely to die by suicide than Australian males. Other occupational groups of ex-serving males who served in the permanent forces were not found to be at risk.[114]

116. Ex-serving females who served in the permanent forces in combat and security roles were 5.52 times (452%) more likely to die by suicide than Australian females. Those who served in health roles were 3.12 times (212%) more likely to die by suicide. Other occupational groups of ex-serving females who served in the permanent forces were not found to be at risk.[115]

Separation during initial training

117. Our analysis found that ex-serving males who served in the permanent forces and separated during Army soldier initial training had an increased risk of suicide.

118. On joining the ADF as a general entry sailor, soldier or aviator, all recruits complete a training course of around 11 weeks at the recruit school of their respective service. The purpose of recruit training is to induct recruits into the ADF through intensive training in basic military skills, knowledge and required behaviour. Following the recruit course, they commence initial employment training, which can include workplace experience and periods of on-the-job training. It is approximately 9 months in duration for members of the permanent forces.[116]

119. Our research found that ex-serving males who were recruited for combat and security roles in the permanent forces and separated during Army soldier initial training were 2.70 times (170%) more likely to die by suicide than Australian males. Other groups of ex-serving males who served in the permanent forces in combat and security roles and separated during initial training – including officers, Navy sailors and Air Force aviators – were found not to be at greater risk.[117]

120. Ex-serving females who were recruited for the permanent forces and separated during initial training and were 'other ranks' (that is, not training to be officers) were 5.33 times more likely to die by suicide than Australian females (433%). Other groups of ex-serving females who were recruited for the permanent forces and separated during initial training were found not to be at greater risk.[118]

Trained force

121. After graduating from initial training and entering service life, members serving in 'other ranks' in the Army (soldier) or Navy (sailor) had an increased risk of suicide.

122. On graduation from their respective recruit or commissioning course and initial employment training, members are assigned to a specific branch of the Army, Navy or Air Force. These members – referred to as the Trained Force – are considered trained and can be used in their role or occupation.[119] They undertake military service duties and obligations, and pursue career paths. They are exposed to ADF service culture and likely experience time away from family, friends and support networks. Their experience differs from that of members undertaking recruit or commissioning courses or initial employment training.

123. We found that ex-serving males who served in the permanent forces in combat and security roles, as soldiers of the Army Trained Force or as sailors of the Navy Trained Force, were around twice as likely to die by suicide as Australian males (117% and 95% higher, respectively). Other groups of ex-serving males who served in the permanent forces in combat and security roles in the Trained Force, including officers and Air Force aviators, were not found to be at risk.[120]

124. Ex-serving females who served in the permanent forces as soldiers in the Army Trained Force are 2.67 times (167%) more likely to die by suicide than Australian females. Other groups of ex-serving females who served in the permanent forces in the Trained Force were found not to be at greater risk.[121]

Deployment

125. Our analysis found that ex-serving males who served in combat and security roles in the permanent forces and who were deployed where there was direct or indirect risk of harm, have an increased risk of suicide.

126. For the purposes of our analysis, 'deployment' refers to ADF approved operations, including:

- *warlike* – where ADF members are exposed to a direct risk of harm from hostile forces
- *non-warlike* – where ADF members are exposed to an indirect risk of harm from hostile forces, and have not been to a warlike deployment
- *peacetime* – where ADF members have been deployed to peace-keeping missions, border-protection activities outside of Australia, operations to deliver humanitarian aid or domestic service in providing aid to the civilian community during emergency situations.[122]

127. Ex-serving males who served in the permanent forces in combat and security roles with warlike or non-warlike operational service are over twice as likely to die by suicide than Australian males (108% and 116% higher, respectively).

128. Ex-serving males who served in the permanent forces in combat and security roles with 'peacetime' operational deployment only were found not to be at greater risk.[123]

129. No groups of ex-serving females who served in the permanent forces with operational deployment were found to be at risk.[124]

Suicide rates of ex-serving members who served solely in the reserve forces

130. Our analysis of rates of suicide revealed different findings for ex-serving males and females who served soley in reserve forces when compared to those who had served in permanent forces.

Ex-serving males who served solely in the reserve forces

131. In contrast to the high rates of suicide for males who had served in the permanent forces, ex-serving males who served solely in the reserve forces are no more or less likely to die by suicide than Australian males.[125]

132. To explore whether this finding holds for various sub-populations, we studied rates of suicide in various sub-populations of ex-serving males who served solely in the reserve forces. The categories studied were:

- age
- service arm
- length of service
- time since separation
- rank

- separation reason
- deployment history
- enlistment age
- occupational group
- occupation
- separation during initial training
- whether they were in the Trained Force, had reported a WHS injury or been involved in disciplinary action.

133. Ex-serving males who served solely in the reserve forces for less than a year were the only sub-population of this cohort that we identified as having an increased risk of suicide. We found they were 56% more likely to die by suicide than Australian males.

134. Suicide rates for the remaining sub-populations were not statistically significantly higher than those of Australian males. This included those who separated involuntarily for medical reasons or for the reason 'retention-not-in-service-interest'.

135. Given that many of these sub-populations were 'at-risk' for ex-serving males who had served in the permanent forces, this finding is significant. It suggests that factors related to service *in the permanent forces* result in higher suicide rates in ex-serving males but not in ex-serving males who served solely in the reserve forces. It may be that males serving in the permanent forces are exposed to, or are more susceptible to, one or more risk factors that are different from those to which males serving in the reserve forces are exposed. It could also be that the former are lacking access to one or more protective factors. Or it could be some other unknown influence. (For further information, see Part 2, Serving the nation.)

Ex-serving females who served solely in the reserve forces

136. Ex-serving females who served solely in the reserve forces are 2.04 times (104%) more likely to die by suicide than Australian females. As outlined above, this differs from the outcome observed for males who served solely in the reserve forces, where only those who separated within one year were at greater risk of suicide than Australian males.

137. In particular, we found sub-populations of ex-serving females who served solely in the reserve forces that were at greater risk of suicide are those of 'other ranks' (that is, not training to be officers) who separated during initial Army training, and females who enlisted as minors.

138. Ex-serving females who served solely in the reserve forces and who separated during initial Army training and were other ranks are 3.25 times (225%) more likely to die by suicide than Australian females.

139. Ex-serving females who served solely in the reserve forces and enlisted as minors (aged 16 or 17) are almost three times more likely to die by suicide than Australian females (189% higher). 'Enlistment age' refers to the age a member was hired by the ADF. The minimum age members can join the ADF is now 17, but used to be 16.

1.4 Military-related risk and protective factors, transition points and stressors

140. As with the general population, there is no definitive list of military-related causal risk factors or protective factors for suicide, and little recent progress has been made in the identification of such factors.[126]

141. The National Suicide Prevention Adviser, Ms Christine Morgan said:

> Understanding more about the diversity of stressors and life events that can set someone on a trajectory towards suicide is essential for delivering effective early intervention.[127]

142. In this section, we identify military-related stressors, transition points and risk factors identified by expert sources that can contribute to distress. We discuss them in connection to findings from our research program.

143. We draw on nearly 900 private sessions, 5,865 lived experience submissions and 70 lived experience witness accounts of serving and ex-serving members and their families. From this, we build a picture of key military-related risks and stressors that can contribute to – and protective factors that can protect against – suicidal distress, suicidality and death by suicide.

144. In section 1.4.2, we draw on representative examples of lived experience accounts. With each passage and quote from those with lived experience of suicidal behaviour, we build a case that ADF service involves factors and stressors that increase the risk of suicide for both serving and ex-serving members. These experiences are cumulative and affect the lives of serving and ex-serving members both during and after service.

1.4.1 What did the experts say?

145. In this section, we discuss military-related suicide risk and protective factors. We begin by reviewing what the experts have said over the past 30 years in key academic literature and recent government reports.

146. A military career has a number of typical phases, including initial training, serving as a member of the Trained Force, deployment (for some members), transition and post-service, as discussed in section 1.3.1. Each phase can be associated with different stressful events or situational stressors related to military life.

Surgeon General ADF directive

147. These phases and, in particular, the acknowledgement of different stressors experienced by ADF members in initial training compared to those in the Trained Force are reflected in the 1991 Surgeon General Australian Defence Force Health Policy Directive 209. It states:

> There are some aspects of Service life which may put particular stress on individual serving members:
>
> For new recruits undergoing the intense period of initial training and induction into Service life, some may have difficulty coping with:
>
> - removal from the family environment,
> - strict disciplinary standards of the military;
> - requirement to reach and maintain high standards of physical fitness;
> - the need to successfully complete a number of academic requirements in a limited time; and
> - uncertainties regarding their decision to join the ADF.
>
> Serving members [in the Trained Force], in addition to the above, may also experience the following stresses to a greater degree than their civilian counterparts:
>
> - posting turbulence, with the associated difficulties of settling a family into a new area (this may occur every couple of years and more frequently for some);
> - operational requirements, entailing deployment to potentially hostile areas or to regions with only a limited support infrastructure;
> - separation from family at frequent intervals, such as for training requirements;
> - financial difficulties, arising from family separation and frequent removals, often exacerbated by the inability of spouses to pursue a settled career;
> - increased work-related pressures, in association with financial and manpower constraints; and
> - the ever-present disciplinary requirements of the ADF.[128]

148. The ADF health policy directive discusses how serving members who are deployed may also experience the following stressors to a greater degree than their civilian counterparts:

> - operational requirements, entailing deployment to potentially hostile areas; …
> - separation from family at frequent intervals, such as for overseas service …[129]

149. From other reviews and inquiries, we have identified that ADF members leaving service may also experience the following stressors to a greater degree than their civilian counterparts:

- family and relocation-related stressors[130]
- claims processes[131]
- discontinuity between the healthcare systems of the ADF to the DVA system[132]
- looking for new employment.[133]

Australian Institute for Suicide Research and Prevention

150. A 2012 Australian Institute for Suicide Research and Prevention report, led by Professor Kairi Kõlves, was prepared as part of the first review of the ADF Suicide Prevention Program.[134] In-depth interviews with international experts in military suicide identified risk and protective factors for serving and ex-serving members.

151. For risk factors, the report stated:

> **Military culture** itself is considered as a risk factor, in that it is more masculine and aggressive, involves a large amount of training, and is not conducive to help-seeking behaviour (promotes stigma). More specifically, the environment may act as a stressor for pre-existing vulnerabilities, such as traumatic childhood experiences.[135]
>
> The **young age** of many soldiers may also be a factor in that they are less resilient.[136]
>
> **Deployment** is also a risk factor, given the increased exposure to stressful situations and higher incidence of psychological conditions, such as depression and PTSD.[137]
>
> **Military lifestyle** itself is a major risk factor; … the decrease in the level of social support and integration as well as the frequent relocations due to deployment and the nature of the military career.[138]
>
> **Exposure to traumatic stress** is another risk factor; … the military [is] a 'crisis organisation', in that it prepares people to be able to deal with highly stressful situations that would otherwise potentially cause post-traumatic conditions. Of all professions, the military is at the highest risk for traumatic stress.[139]
>
> The **code of honour** and the separate set of military laws may also increase the risk, as they may unfairly disgrace, dishonour, and punish military members, as the system (of honour and judgment) is not always reasonable. The 'offence' may have occurred due to something that could be treatable by a mental health care professional. For example, those that are repatriated from abroad are at a much higher risk of suicide, especially due to the perceived shame of not having completed their full assignment period, whether it is for misconduct or medical reasons.[140]

Disciplinary action. Those undergoing disciplinary action can be shunned for dishonouring or discrediting the unit and their colleagues, resulting in a sense of burdensomeness or thwarted belongingness.[141]

The **lack of social support** either from family or friends or just not being part of the group is considered as a risk factor. This may be associated with the stress placed on intimate relationships due to frequent relocations (making it difficult for the partner to retain employment) and periods of separation while on deployment, which potentially increases the risk of infidelity.[142]

152. For protective factors, the report identified:

- Psychological and psychiatric screening of would-be soldiers
- Higher level of medical care (including mental health care) than the civilian population
- [That] the degree of organisation in the military makes it easier to implement a suicide prevention program than in the civilian community
- The 'healthy force effect' (that people who join the military are generally healthier)
- Leadership
- Morale
- Cohesion
- A guaranteed job
- Participation in a socially valued and rewarding profession
- Group cohesion.[143]

The Boss Report

153. In September 2021, Dr Bernadette Boss CSC, Interim National Commissioner for Defence and Veteran Suicide Prevention, released her *Preliminary Interim Report* (the Boss Report).[144] In it, Dr Boss, identified the following as potential risk factors for suicide for both serving and ex-serving members:

- younger age
- being a general enlistee
- shorter length of service
- experience of unacceptable behaviour (including bullying and sexual abuse)
- post-traumatic stress disorder
- traumatic brain injury
- moral injury
- inadequate sleep

- anxiety and depression
- schizophrenia or bipolar disorder
- chronic pain
- cognitive or biological problems
- anger
- alcohol misuse
- involuntary discharge
- unemployment
- loss of identity on discharge
- homelessness
- deployment
- interactions with DVA
- insufficient access to mental health service.[145]

154. Regarding protective factors, Dr Boss noted:

> Veterans may also possess unique protective factors related to their service, such as resilience or a strong sense of belonging to a unit. Community veteran support, organisation assistance and access to supports and entitlements may have a protective effect.[146]

Phoenix Australia

155. The 2023 Phoenix Australia report, *ADF members and ex-members suicide literature review: An update,* identified risk factors for current serving members. These included:

- the presence of mental or physical health problems
- cumulative trauma exposure (including military sexual trauma and bullying)
- chronic pain
- involuntary (medical or administrative) discharge from the military.[147]

156. In ex-serving members, they may also include loneliness and lack of life purpose.[148]

157. There are also factors that promote resilience and maintain wellbeing among military members and may act as protective factors against suicide. Among early career ADF members, more frequent use of adaptive cognitive coping styles, such as acceptance and reappraisal, was associated with fewer symptoms of posttraumatic stress and psychological distress over time. The same protective association was found for adequate levels of sleep. Higher levels of social support from friends, family and colleagues, higher unit morale and lower levels of negative interactions with others were also associated with fewer symptoms of psychological disorder.[149]

158. Other protective factors included high levels of bonding or connectedness to family, positive temperament, high future expectation/orientation, high social competency and problem-solving skills. Pets and hobbies were also protective.[150]

159. As the three reports note that while military service may convey protective factors, it also exposes serving members to risk factors. Although not all serving and ex-serving members are at higher risk of suicide, we have identified that some of the same factors that are protective during service, can also make service a risk factor, both during and post service.

1.4.2 Protective and risk factors can be two sides of the same coin

160. Aspects of military culture and service life such as hierarchy, training and tempo give rise to various organisational structures and norms, and patterns of behaviour and experience. Some of these are rightly identified as protective against suicide and suicidality and others are clearly risk factors. In this section we discuss how a single aspect of Defence culture can give rise to both risk and protective factors.

161. Risk and protective factors are highly contextual, so a characteristic that is protective within one context can be highly detrimental in another. For instance, a high degree of self-reliance is protective in combat situations and service life generally. However, it can be a risk factor in the context of the member experiencing mental ill health, as they are more likely to stay silent and not seek help or treatment.

162. This section explores three aspects of military culture and service life that give rise to protective factors and risk factors:

- a worldview of 'insiders' and 'outsiders'
- the culture of military masculinity
- the intensive training that is part of service life.

A worldview of 'insiders' and 'outsiders'

163. Recruits are often excited to join the military as it can offer purpose, identity, belonging and prospects of career advancement. However, to become a serving member requires a transformation on multiple levels. As Professor Ben Wadham wrote in the *Mapping Service and Transition to Suicide and Suicidality* report:

> Any form of basic training involves learning to prosecute violence using weapons, or hand-to-hand combat. To be effective, this training requires the *resocialisation* of the civilian into a service member. The changes are cultural, psychological, and physical – the member is transformed by the process.[151]

164. One aspect of this transformation is being socialised into military culture. A fundamental aspect of military culture that underpins the capability of members to use lethal weapons against Australia's enemies is a worldview of 'us and them', or insiders and outsiders.

165. According to Professor Wadham, 'this separation is the basis of any form of violence; to be able to see "the other" in terms of "them" permits their violation or termination'.[152] A worldview based on insiders and outsiders distances serving members from civilians and civilian ways of thinking, strengthens bonds within the military unit and generates the 'esprit de corps' that is foundational to military culture.[153]

166. The positive side of esprit de corps is well known and well documented. It is behind several of the protective factors against suicide that then Chief of the Defence Force, General Angus Campbell AO DSC, outlined in evidence. These include a 'strong sense of purpose, meaning and identity … social support, high unit morale and fewer negative interactions with others'.[154]

167. This very same socialisation into 'military ways of thinking and doing' has a negative dimension as well. This worldview cannot be quarantined to one domain, but pervades military culture.[155]

168. This was examined in a 2011 report by Major General Craig Orme AM CSC (Retd). Major General Orme led an investigation into ADF culture following an incident of military sexual abuse that became known as the 'Skype sex scandal'. His report, *Beyond Compliance: Professionalism, Trust and Capability in the Australian Profession of Arms* (the Orme report), stated:

> Social stratification coupled with a male-dominated cultural model can lead to multiple variations of the 'winners' or 'insiders'; and 'losers' or 'outsiders'. The 'insiders' are those who are socially strong and conform to the cultural ideal; the 'outsiders' are those who are judged to fail in or pose a risk for the culture or are not accepted as part of the winning group.[156]

169. Major General Orme called it a paradox that 'a root cause of poor conduct in the ADF … is also a driver of exemplary performance and cohesion in military culture'.[157] He called it 'tribalism' and said:

> [it] can become an extreme expression of group cohesion … [and is] often associated with a cultural world-view that sees things in competitive terms and regards one's group as 'better', 'more effective' or 'more worthy' than others.[158]

170. This 'extreme expression of group cohesion' frequently plays out in the marginalisation of those within the ADF who are not deemed to belong to the 'in-group' – something we heard in submissions, private sessions and in evidence. For instance, we heard from serving and ex-serving members who were ostracised, bullied and targeted for being female,[159] gay,[160] First Nations,[161] lower rank[162] and for speaking up against unacceptable behaviour.[163]

171. The very dimension of military culture that strengthens group bonds for the insiders (and legitimately is a protective factor against suicide and suicidality) can make those who are deemed outsiders disproportionately susceptible to the negative effects of marginalisation. These effects include isolation, thwarted belongingness[164] and the devastating effects of bullying,[165] ostracism[166] and military sexual violence,[167] all of which are risk factors for suicide and suicidality.

172. The mentality of insiders and outsiders can play out between the service arms of Navy, Army and Air Force, between different corps and regiments, between commissioned officers and enlisted personnel, between those with overseas deployment and those with domestic experience, between males and females, and between people of majority cultures and sexualities and those of minority cultures and sexualities. While identifying as part of these 'tribes' can offer belonging, support and connection, being on the outside of them can engender exclusion, harassment and assault. These experiences, particularly when the victimised person doesn't perceive them to be well handled by Defence, are risk factors for suicide and suicidality.

173. As one submission author wrote:

> I was subjected to being bullied and bastardised on HMAS [redacted] and I only was on the ship for three months before I was psychologically taken off the ship. Granted, the care I received to get my headspace better was done really well, the main issue that lead to this in the first place was the absolutely appalling Navy culture that is on the ships. Tribalism is massive, people of a higher rank being able to do anything they practically want because they are too valuable to the ship no matter how cruel that person is.[168]

174. The culture of insiders and outsiders can also mean transition from the ADF is extremely challenging because a member's sense of purpose, meaning, identity and fraternity suddenly disappears. They are no longer an insider. When transition is also entwined with experiences of trauma – such as military administrative or disciplinary action, abuse or institutional betrayal – the risk compounds.[169]

175. As another submission author wrote:

> It is hard to settle back into civilian life after service. When you leave the military, you leave behind your social connection, your identity, your profession and your cultural way of life. It's hard to settle back in. There needs to be more help. You are trained and indoctrinated to kill the enemy. Transition is not that simple.[170]

176. To conclude, as Major General Orme states:

> while a sense of solidarity and 'tribalism' is a great strength of our military culture, we must guard against such tribalism leading to patterns of dominance, exclusivity and divisiveness between supposed 'in-groups' and 'out-groups'.[171]

177. We could not agree more.

Military masculinity

178. Military masculinity is another aspect of ADF culture that promotes some characteristics that are protective factors against suicide and suicidality, and others that are risk factors.

179. As discussed in the Phoenix Australia report, *ADF members and ex-members suicide literature review: An update,* masculinity is associated with attributes such as self-reliance, strength, power, competitiveness, suppressed emotionality and aggression.[172] These qualities are fostered and encouraged in the military.

180. The authors of the report stated that 'conformity to masculine norms may be beneficial within the military setting, due to the highly masculine culture of the military where adherence to these norms is likely to be socially rewarded'.[173] These qualities are also highly adaptive in certain contexts (on deployment, for example).[174]

181. However, the culture of military masculinity can also foster unhelpful behaviour, such as a reluctance to seek help.[175] There is a stigma in the ADF associated with any admission of physical or mental weakness. This results in a culture of stoicism around injury and a lack of help seeking.[176]

182. For example, a serving Air Force member requiring multiple back surgeries told us of his reluctance to seek help for fear of retribution from his chain of command:

> I had extensive physical and mental trauma including contemplation of suicide … This was significantly aggregated or caused from unit command level bullying, lack of unit support for extensive lower back related surgeries, including been posted across the country against specialist medical advice. The unit I was posted into treated me vindictively due to loss of capability as I had to undergo 2nd major lower back surgery exemplified through lack of unit support even after been in a major vehicle accident during duty (~ 4 months after 2nd surgery). These experiences fundamentally shaped and ingrained a fear of seeking help from Defence on legitimate medical issues due to fear of negative repercussions through CoC [chain of command]. The immediate CoC at the time also constantly harassed me including employing guilt tactics and threatening to reveal my medical in confidence issues to Officer Commanding of Wing which was several levels above (unreasonable).[177]

183. Its extreme form, sometimes referred to as 'toxic masculinity', may contribute to inappropriate sexual behaviour (resulting in military sexual trauma) and bullying.[178]

184. As a serving member told us in their submission:

> I had not even gotten through Initial Employment Training before I was sexually harassed and nearly assaulted by an Instructor. I was verbally and physically bullied as a young soldier. I was sexually assaulted as a soldier whilst deployed to [redacted]. Throughout my career as a soldier and young officer, I was pressured to do things I didn't want to do through peer pressure and workplace culture and rituals [and] have been verbally abused and threatened. The sexual harassment and assault have been reported to the Ombudsman and been 'resolved' … but it, along with the history of harassment, bullying, abuse and toxic workplace cultures have left me with a feeling of being raped by the organisation and cast aside.[179]

Intensive training

185. Physical training for serving members can be extremely demanding. It is designed to lead to strength, resilience and physical fitness. General Campbell named '[being] recruited and trained to be fit and resilient' as a protective factor against suicide and suicidality.[180]

186. However, intensive physical training in the military is also associated with high rates of injury. In the context of a military identity that is stoic, highly masculinised and resistant to admitting vulnerability, seeking early treatment for an injury is not always straightforward. As Professor Wadham put it:

> physical injuries were often treated as a source of shame and an indication of moral weakness … Injury was perceived to be weakness and often resulted in ostracism, exclusion and further bullying. Being labelled a 'linger' (malingerer) meant you were cast out of the tribe.[181]

187. Defence has an extensive multidisciplinary healthcare system that is provided at no cost to members,[182] yet even when members do seek medical help they may not receive adequate care. As this serving member told us in their submission:

> Access to ADF HealthCare is painfully slow … and ineffectively administered. I have had severe back pain and numb feet for years but I can't even be bothered with the medical system and so I know this lack of assessments will impact DVA support down the track. Many members are now just using external health care providers as it's far quicker and simpler to access and treat healthcare needs. Free healthcare is great, when it works.[183]

188. Involuntary separation on medical grounds is a risk factor for suicide and suicidality in all cohorts of ex-serving members who served in the permanent forces, whether male or female. Military capability relies on serving members who are physically fit, strong and resilient and this means that intensive training is necessary. However, the injuries that inevitably result from intensive training frequently lead to medical discharge, a risk factor for suicide and suicidality. This is in the context of other related factors including stigma around perceived weakness, the reality that an injury can be career ending, and a healthcare system that doesn't meet all needs.

189. Risk and protective factors of military service are complex and interrelated.[184] Some aspects of military life and culture, including a worldview of insiders and outsiders, military masculinity, and intensive training are associated with both risk and protective factors for suicide and suicidality. Some factors are protective in some contexts and convey risk in others. We believe these complexities need to be more widely understood and recognised.

1.4.3 Factors of service life that may contribute to suicidal distress

190. Suicide and suicidality are not simple problems. Indeed, as Ms Tracey Varker and her colleagues from Phoenix Australia wrote: 'human beings are infinitely complex and multiple proximal and distal … factors interact in unique individual ways to influence the risk of suicide behaviour'.[185] Many risk and protective factors may interact within an individual's life.

191. While suicidal behaviour can be experienced by anyone, some populations and groups can be disproportionately affected, so targeted preventive responses are required.[186]

192. Our inquiry listened to the lived experience of serving and ex-serving members of the ADF and their families, including those with first-hand experience of suicidal behaviour. This is similar to the approach taken by the National Suicide Prevention Adviser, discussed in section 1.2.3. We used these personal accounts to better understand the stressors and risk factors that serving and ex-serving members can experience across a military career.

193. We conducted almost 900 private sessions, reviewed 5,865 submissions of personal accounts written by serving and ex-serving members, their families and supporters, and heard evidence from 70 lived experience witnesses at hearings.

194. We combined these lived experience accounts with our analysis of the risk factors for defence and veteran suicide, together with academic findings from reports commissioned by this Royal Commission and independent research. From this, a picture emerged of:

- experiences that left people more vulnerable to suicidal behaviour
- the key transition points across service life
- military-related factors and stressors that contributed to suicidal distress in some serving and ex-serving ADF members.

195. Following the structure of Figure 1.1 that outlined risk factors, stressors and significant transition points for the general population across the lifespan, Figure 1.5 summarises military experiences at each service life phase explored in section 1.3.1.

Figure 1.5 Military-related factors and stressors that can occur during and after service

Training

Higher rates of suicide occur for those who separate during initial training.*[187]

Many members reported experiencing stressors including:

- removal from family environment
- strict disciplinary standards of the military
- requirement to reach and maintain high standards of physical fitness
- uncertainties regarding their decision to join the ADF.[i]

Trained Force

After graduating from initial training members are posted to a unit, ship or base.

Higher rates of suicide occur for those in the Army and Navy Trained Forces cohorts.*[188]

Risk factors can emerge or be exacerbated in this phase of service life, with additional stressors such as:

- separation from family and family disruption
- having to adjust to a new geographical location
- shifts in role and responsibilities
- changes to support networks and leadership structures
- difficulties of settling a family into a new area
- financial difficulties, arising from family separation and frequent removals, often exacerbated by the inability of spouses to pursue a settled career.[i]

Deployment

Members of the Trained Force can be deployed to conflict zones.

Higher rates of suicide occur for those who served in combat and security roles and were deployed in warlike or non-warlike operational service.** [189]

Stressors can include:

- operational requirements, entailing deployment to potentially hostile areas or to regions with only a limited support infrastructure.[iii]

Post-service

Members can separate from the ADF voluntarily or involuntarily.

Higher rates of suicide occur for those who separated involuntarily for medical reasons or for reason 'retention-not-in-service-interest'.**[190]

Many members reported experiencing multiple life stressors including:

- loss of belonging and identity
- feelings of institutional betrayal
- financial stress
- finding employment
- finding accommodation.[iv]

Key transition points and periods of vulnerability across service life present unique stressors and opportunities for intervention

- Recruit or commissioning course and initial employment training[i]
- Posting to a new unit, ship or base[v]
- Deployment[vi]
- Exposure to traumatic events[vii]
- Experiencing injury or illness[viii]
- Interaction with the military justice system[ix]
- Transition from military to civilian life[x]

Key military-related factors identified as potentially detrimental to ADF members' mental health across their life course

- Separation from family and family disruption[xi]
- Administrative termination[xii]
- Barriers to and stigma in relation to seeking care[xiii]
- Poor support or victimisation from peers and supervisor[xiv]
- Burnout[xv]
- Unacceptable behaviour[xvi]
- Downgrade in military employment classification[xvii]
- Administrative violence[xiii]
- Moral injury[xix]
- Military institutional betrayal[xx]
- Prohibition of reporting (code of silence)[xxi]
- Lack of transition support and continuity of care[xxii]
- Inadequate record keeping making post-service DVA claims difficult to prove[xxiii]
- Inadequacies in healthcare provision[xxiv]

Notes:

i–xxiv: Refer to Annexure 1.1 for expert references to military-related stressors, transition points and risk factors

* Compared with Australian males or females (whichever is appropriate)

** Compared with Australian males

196. The rest of this chapter builds on this information to explore the experiences of serving and ex-serving members that increase their risk of suicidal distress and suicidality.

197. Exposure to traumatic events that can increase members' risk of suicidal distress and suicidality is discussed throughout this report. Key transition points and periods of vulnerability across service life are examined in:

- Chapter 3, Recruitment and initial training
- Chapter 4, Postings and deployments
- Chapter 10, The ADF military justice system
- Part 5, Health care for serving and ex-serving members
- Chapter 23, Transition from military to civilian life.

198. Key military-related factors that are modifiable and can negatively affect ADF members across the life course are discussed in later chapters, including:

- separation from family and family disruption (discussed in Chapter 4, Postings and deployments and Chapter 27, Importance of families)
- administrative termination, which is involuntary discharge from ADF service for conduct, performance, actions or behaviour considered to be below professional standards (discussed in Chapter 10, The ADF military justice system)
- barriers to and stigma in relation to seeking help (discussed in Chapter 14, Introduction to health care for members and veterans)
- bullying, victimisation or abuse from peers and supervisors (discussed in Chapter 8, Military sexual violence and Chapter 9, Unacceptable behaviour and complaints management)
- burnout (discussed in Chapter 6, Retention issues and voluntary separation)
- downgrade in military employment classification (discussed in Chapter 5, The military employment classification system and medical separation)
- administrative violence, described as when a member in a command position abuses their power to harass and discriminate against a more junior ranked member (discussed in Chapter 10).
- moral injury, described as the psychological, social and spiritual effects of having acted in a way that transgresses one's own deeply held moral values and beliefs, witnessing such actions or being on the receiving end of them (discussed in Chapter 21, Moral injury)
- military institutional betrayal (discussed in Chapter 21)
- the code of silence, an informal norm of military culture (discussed in Chapter 7, Culture and leadership)

- lack of transition support (discussed in Chapter 23, Transition from military to civilian life)
- lack of continuity of care (as discussed in Chapter 16, ADF healthcare services)
- inadequate record keeping during service life, making DVA claims difficult to prove after separation (discussed in Chapter 25, Entitlements and claims processing)
- inadequate access to health care (discussed in Part 5, Health care for serving and ex-serving members).

The experiences of some serving members make them more vulnerable to suicidal behaviour

199. Figure 1.5 outlines four potential phases of a military career – training, Trained Force, deployment and post-service – along with military-related stressors and risk factors that can occur during each phase, and at-risk ADF groups. The figure also identifies key transition points and periods of vulnerability across service life, which present important opportunities for intervention.

200. Following the structure of Figure 1.2 that outlined groups more vulnerable to suicidal behaviour than others, Figure 1.6 provides more information on service life phases. Each presents different opportunities to support people through periods of potential vulnerability, helps focus research priorities and assists in the design of targeted suicide prevention approaches for ADF groups that are disproportionately affected by suicide. It elaborates on the at-risk groups already identified and describes additional at-risk cohorts such as female ADF members who are at risk across all phases of service life.

201. While suicidal behaviour can be experienced by anyone, the experiences of some groups can make them more vulnerable than others to suicidal behaviour. Targeted preventive responses are required for these cohorts. Each of the risk factors identified here will be explored in more detail in the following chapters of this final report.

Figure 1.6 In-depth analysis of service life risks and protective factors

Training	Ex-serving members who served in the permanent forces in 'other ranks' and separated during their initial recruitment course or initial employment training are more likely to die by suicide than the Australian population.[191] *Known risk factors and stressors associated with this group to which recruits may be exposed include physical or psychological injury such as mental illness, separation from family and family disruption or experiencing bullying and/or administrative violence.*[a] *Training institutions appear to be high-risk environments for unacceptable behaviour.*[192]
Trained Force	Ex-serving members who served in the permanent forces as soldiers of the Army Trained Force or sailors of the Navy Trained Force are more likely to die by suicide than the Australian population.[193] *These members are more likely to be exposed to non–combat related traumatic events, experience moral injury, sustain physical or psychological injury and be separated from their family, increasing their vulnerability to suicidality.*[b] *Armed units and Navy ships (and other closed, male-dominated units) appear to be high risk environments for military institutional abuse, which in turn places those abused at risk of self-harm and suicidality.*[194]
Deployed	Ex-serving males who served in the permanent forces in combat and security roles with warlike or non-warlike operational service are more likely to die by suicide than Australian males.[195] *These members are more likely to have been exposed to combat-related trauma and traumatic events, to have experienced moral injury, to have sustained physical or psychological injury and to have been separated from their family.*[c] *Research shows that trauma experienced is exacerbated when not addressed adequately by ADF systems (e.g. health) and when members are not supported to 'stand down' upon return.*[196]
Post-service Military administrative and discipline systems	Ex-serving members who served in the permanent forces and separated involuntarily for the reason 'retention-not-in-service-interest' are more likely to die by suicide than the Australian population.[197] *Members subjected to military discipline systems are often charged with offences relating to anger, alcohol or drug misuse, which are known side effects/coping mechanisms for dealing with traumatic experiences and poor mental health.*[198] *They are likely to have been exposed to traumatic events, to have experienced moral injury, to have sustained physical or psychological injury and to have been separated from their family during their service career.*[d,199] *Administrative violence was found to be particularly damaging, leading to the experience of institutional betrayal.*[200] *Administrative discharge can lead to a sense of personal failure. Abrupt separation due to administrative discharge can lead to the feeling of institutional betrayal and issues with loss of identity, purpose, status, social disconnection and ongoing trauma leading to self-harm and suicidality.*[e]

Post service Members who suffered a physical injury during service	Ex-serving members who served in the permanent forces and separated involuntarily for medical reasons are more likely to die by suicide.[201] *The nature of military service carries inherent risks of physical injury that can end a military career.*[202] *Members often sustain multiple injuries throughout their career. They can cause physical and mental pain and impairment. ADF members rightly expect that their health and welfare needs are met during and after service. However, research and submissions showed that many members experience a failure of health service provision and duty of care at some point in their service. Physical injury and chronic health conditions are known risk-factors for suicide.*[f] *The speed of discharge for this cohort can also lead to an experience of institutional betrayal.*[203]
Post-service Engagement with DVA	Ex-serving members who experience difficulties with DVA identified claims processes as a risk factor for self-harm and suicidality. *Claim processes were deemed unnecessarily complex, difficult to understand and prolonged, which contributed to health decline.*[204] *Some ex-serving members who engage with DVA experience hopelessness and distress when attempting to have their injuries and illnesses recognised, because they are faced with lengthy delays and/or their claims are denied.*[205]
Post-service Females	Ex-serving females who served in the permanent forces and who served solely in the reserve forces are more likely to die by suicide than Australian females.[206] *Additional risk factors this group may be exposed to include unacceptable behaviour, including military sexual assault during service, experienced in different contexts and ways than males. Females also report misogyny and exclusion by some of their male counterparts, and are encouraged not to report exclusion and abuse.*[g,207]

Notes:

[a] Refer to (i, xi, xiv, xvi, xxi) in Annexure 1.A for expert references to military-related stressors, transition points and risk factors

[b] Refer to (ii, vii, xi, xix, xv) in Annexure 1.A for expert references to military-related stressors, transition points and risk factors

[c] Refer to (iii, vii, xi, xv, xix) in Annexure 1.A for expert references to military-related stressors, transition points and risk factors

[d] Refer to (iv, vii, xi, xii, xiii, xix, xx) in Annexure 1.A for expert references to military-related stressors, transition points and risk factors

[e] Refer to (iv, viii, xiv, xvii, xx, xxiv) in Annexure 1.A for expert references to military-related stressors, transition points and risk factors

f Refer to (iv, viii, xiv, xxiv, xx, xxii, xxiv) in Annexure 1.A for expert references to military-related stressors, transition points and risk factors

[g] Refer to (iv, xvi, xx, xxi) in Annexure 1.A for expert references to military-related stressors, transition points and risk factors

1.4.4 Aspects of military service may be risk factors for suicide

202. The *Defence Mental Health and Wellbeing Strategy 2018–2023* states:

> Working in Defence can provide individuals with a range of unique opportunities and challenges. Life in the ADF provides our serving members with many protective factors for good mental health and wellbeing but there are also unique occupational risks associated with military service both for members and their families.[208]

203. Yet this Royal Commission was told, including by Defence, that serving in the ADF is a protective factor against suicide.[209] This was based on an AIHW finding that being a serving member is associated with a reduced risk of suicide compared to the Australian general population. However, as we discussed at section 1.3.2, there is a confounding effect of employment status. We note AIHW informed this Royal Commission that its finding 'alone cannot prove or disprove the claim that being a serving ADF member is a protective factor against suicide and/or suicidality'.[210]

204. The research we have conducted and commissioned, the third-party research we have reviewed and the lived experience evidence we heard, as summarised in section 1.4.3 and Figure 1.5, indicates that serving members are exposed to a diverse range of military-related risk factors, transition points and stressors through their career. These factors increase the risk of suicide and suicidality for ADF members who serve and have served. This increased risk is partially mitigated, but not removed, by protective factors present while in service.[211]

205. In 2024, during the final hearing block of this Royal Commission, Chief of Army, Lieutenant General Simon Stuart AO DSC, acknowledged both that Defence service can harm members and there is a link between operational service and suicide and suicidality.[212]

206. When he gave evidence in March 2024, then Chief of Air Force, Air Marshal Robert Chipman AO CSC, conceded the ADF had been wrong to think there was no link between service experience and suicide and suicidality. He said:

> I think we now clearly understand the nexus between an individual's experience in service, particularly if they experience negative outcomes where they're involuntarily separated or they're a victim of unacceptable behaviour, and their wellbeing after they leave.[213]

207. Then Chief of Navy, Vice Admiral Mark Hammond AO RAN, acknowledged:

> We do place our people in challenging, risky environments and sometimes harrowing environments, and it leaves a mark.[214]

208. Early in our inquiry, Dr Boss said:

> Service in the military is clearly a unique profession, and distinct from other occupations. It can involve frequent exposure to high-risk environments and engagement in actions, such as the application of lethal force, that are not permitted in any other context. It involves being subject to military law and discipline, and forgoing a number of personal freedoms; including the freedom to make independent decisions and the freedom to choose to avoid the risk of injury or death during armed conflict. As such, there is a moral imperative on the Australian Government to ensure that decisive changes are made to the Defence processes – not only to mitigate risks of suicidal behaviours and prevent future harm, but also to support our ADF members to flourish and enjoy fulfilling and productive lives following their military service.[215]

209. In 2024 General Campbell said:

> Our people deserve and should rightly expect the wellbeing, support and care they need, both during and after their service. I acknowledge that this has not always been the case and has tragically led to the death by suicide of some of our people. I apologise unreservedly for these deficiencies.[216]

210. We agree that Defence and the Australian Government have a duty and obligation to ADF members to mitigate risks of suicidal behaviours and prevent future harm, both during and after their service. It should not have taken a Royal Commission for Defence to concede service is a risk factor, or to acknowledge their duty to their members.

1.5 Conclusion

211. At least three serving or ex-serving members die by suicide on average every fortnight.[217] Suicide and suicidality are complex phenomena and result from the interaction of many risk and protective factors within a person's life. These factors affect people differently, and the nature of that impact may also change over time.[218]

212. We have presented our understanding of the prevalence of suicide and suicidality in the ADF, and military-related risk and protective factors and stressors. This view is informed after hearing 5,865 personal accounts. We have combined this lived experience evidence with our analysis of the contributing risk factors relevant to defence and veteran death by suicide, together with academic findings from reports and other research this Royal Commission commissioned.

213. This research identifies at-risk groups and different factors that can contribute to a person's suicidal distress across the service life journey. More detailed examination of military-related risk and protective factors and stressors for serving and ex-serving members is set out in Part 2, Serving the nation, Part 5, Health care for serving and ex-serving members and Part 6, Transition and support for ex-serving members, of this report.

Annexure 1.1 References for military-related stressors, transition points and risk factors

214. The following table lists sources and expert references related to the different stressors and factors in relation to Figure 1.5 and Figure 1.6. The roman numerals i, ii, iii onwards in the left-hand column refer to the notes within those tables.

Table A1 References related to Figures 1.5 and 1.6

Note	Factor	References
i	Training stressors	Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360. L Dell and others, *The Longitudinal Australian Defence Force Study Evaluating Resilience (LASER-Resilience): Patterns and Predictors of Wellbeing*, Phoenix Australia – Centre for Posttraumatic Mental Health, 2019, p 10 (Exhibit ZZ-03.004, STU.0000.0002.4585). K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP). Report to the Department of Defence, p 53 (Exhibit 20-03.021, DEF.1000.8002.9688). Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, pp 75-81 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584). T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 4 (Exhibit F-01.061, DVS.0011.0001.1192).
ii	Trained Force stressors	Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360. K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP), Report to the Department of Defence, p 37, 53 (Exhibit 20-03.021, DEF.1000.8002.9688). Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, pp 75–81 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584). T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531).

Note	Factor	References
iii	Deployment stressors	Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360. K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP), Report to the Department of Defence, p 39, 53 (Exhibit 20-03.021, DEF.1000.8002.9688). Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, pp 75–81 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584). T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531).
iv	Post-service Stressors	Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360. K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP), Report to the Department of Defence, p 53 (Exhibit 20-03.021, DEF.1000.8002.9688). Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, pp 75–81 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584). T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp xi, 96–101, 101–107 (Exhibit F-01.061, DVS.0011.0001.1192).
v	Posting to a new unit, ship or base	K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP), Report to the Department of Defence, p 37, 53 (Exhibit 20-03.021, DEF.1000.8002.9688). Australian Commission on Safety and Quality in Health Care, *Final Report – Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative Analysis of Coronial and Defence Documents*, November 2021, p 82 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552). PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0061–0064 [7].

Note	Factor	References
vi	Deployment	B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp 35–40 (Exhibit F-01.061, DVS.0011.0001.1192). Australian Institute of Health and Welfare, *Independent Review of Past Defence and Veteran Deaths by Suicide: Final Report*, p 72 and K Jones and others, *Defence Force and Veteran Suicides: Literature Review*, p 26 cited in Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report,* p 81 (Exhibit 01-01.013, INQ.0000.0001.1584). PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0067–0068 [11].
vii	Exposure to traumatic events	Department of Defence, Department of Veterans' Affairs, *Impact of Combat Summary Report*, Transition and Wellbeing Research Programme Impact of Combat Study, 2019, p viii (Exhibit 20-03.053, Hearing Block 3, DEF.0001.0001.5892). J Belding and others, 'The Millennium Cohort Study: The First 20 Years of Research Dedicated to Understanding the Long-term Health of US Service Members and Veterans', *Annals of Epidemiology*, vol 61, 2021, pp 63–67, 93 (Exhibit 75-02.043, Hearing Block 10, STU.0000.0002.7713). Department of Defence, Department of Veterans' Affairs, Australian Institute of Family Studies, The University of Adelaide, *Transition and Wellbeing Research Programme, Key Findings,* 2019, p 46 (Exhibit 20-03.056, Hearing Block 3, DEF.1029.0002.0066). K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP), Report to the Department of Defence, 2012, pp 38–39 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688). T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531).

Note	Factor	References
viii	Experiencing injury or illness	T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, p 43 (Exhibit L-01.026, DVS.2222.0001.0531). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp 135, 45-47 (Exhibit F-01.061, DVS.0011.0001.1192). Australian Commission on Safety and Quality in Health Care, *Final Report – Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative Analysis of Coronial and Defence documents*, November 2021, p 62 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552). T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531).
ix	Interaction with the military justice system	M Clemente and D Padilla-Racero, 'The effects of the justice system on mental health,' *Psychiatry, Psychology and Law*, vol 27, 5, 2020, (DVS.1111.0001.4812, Exhibit F-03.008). Exhibit 86-03.014, Hearing Block 12, Minutes of Military Justice Legal Forum Meeting 04/2022, IGD.0032.0001.0001. B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 48 (Exhibit F-01.061, DVS.0011.0001.1192). K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP), Report to the Department of Defence, pp 37, 53 (Exhibit 20-03.021, DEF.1000.8002.9688). Australian Commission on Safety and Quality in Health Care, *Final Report – Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative Analysis of Coronial and Defence documents*, November 2021, p 59 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552). PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0077-0080 [16].

Note	Factor	References
x	Transition from military to civilian life	B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 4 (Exhibit F-01.061, DVS.0011.0001.1192). Transcript, David Forbes, Hearing Block 6, 9 August 2022, p 46-4547 [35–36]. Australian Institute of Health and Welfare, *Final Report to the Independent Review of Past Defence and Veteran Suicides*, 2021, p 19 (Exhibit F-03.007, SUB.0000.0002.0059). NC Kerr and others, 'The 'Transition' to Civilian Life from the Perspective of Former Serving Australian Defence Force Members', *Journal of Veterans Studies*, vol 9, 1, 2023, p 130 (Exhibit L-01.105, DVS.2222.0001.4848). Exhibit 21-01.024, Department of Defence, Response to Notice to Give, NTG-DEF-012 (DEF.9999.0004.0001_R at 0002 [4]). Romaniuk and C Kidd, 'The Psychological Adjustment Experience of Reintegration Following Discharge from Military Service: A Systemic Review', *Journal of Military and Veterans' Health*, vol 26, 2, 2018 (Exhibit L-01.103, DVS.2222.0001.4829). K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP). Report to the Department of Defence, pp 38, 53 (Exhibit 20-03.021, DEF.1000.8002.9688). Australian Institute of Health and Welfare, *Independent Review of Past Defence and Veteran Deaths by Suicide: Final Report* and K Jones and others, *Defence Force and Veteran Suicides: Literature Review*, p 42 cited in Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report,* p 19 (Exhibit 01-01.013 INQ.0000.0001.1584). PFLR-55.1 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0001 at 0017-0024 [23].

Note	Factor	References
xi	Separation from family and family disruption	K Jones and others, *Defence Force and Veteran Suicides: Literature Review*, Phoenix Australia, July 2020, pp 41, 45 (Exhibit 08-06.017, Hearing Block 1, EXP.0001.0015.0004). Exhibit 68-02.001, Hearing Block 10, Department of Defence, Response to Notice to Give, NTG-DEF-124, DEF.9999.0096.0001 at 0025 [102]. J Hughes and others, Australian Institute of Family Studies, *Strengthening Defence and Veteran Couple Relationships Through Relationship Education*: *Final Report,* September 2023, pp 1–2 (Exhibit L-01.007, DVS.2222.0001.0414). T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 8 (Exhibit L-01.026, DVS.2222.0001.0531). Australian Commission on Safety and Quality in Health Care, *Final Report – Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative Analysis of Coronial and Defence documents*, November 2021, p 82 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552). K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP): Report to the Department of Defence, 2012, pp 37–41 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688). Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360.
xii	Administrative termination	T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531). Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360.

Note	Factor	References
xiii	Barriers to and stigma in relation to seeking care	Australian Commission on Safety and Quality in Health Care, *Final Report – Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative Analysis of Coronial and Defence documents*, November 2021 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552 at 2646). Varker and others*, ADF members and ex-members suicide literature review: An update,* Phoenix Australia – Centre for Posttraumatic Mental Health, Report, October 2023 (Exhibit L-01.026, DVS.2222.0001.0531 at 0594). AC McFarlane and others, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full Report*, p 10 (Exhibit A-01.009, DEF.0001.0001.1093). T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, pp 8–9 (Exhibit L-01.026, DVS.2222.0001.0531). K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP): Report to the Department of Defence, 2012, pp 37–41 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp ix, xi, 40–42, 45–47, 76–79 (Exhibit F-01.061, DVS.0011.0001.1192). PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0068-0070 [12].
xiv	Poor support or victimisation from peers and supervisors	AC McFarlane and others, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full Report*, p 10 (Exhibit A-01.009, DEF.0001.0001.1093). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p viii, 64 (Exhibit F-01.061, DVS.0011.0001.1192). K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP): Report to the Department of Defence, 2012, pp 37–41 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688). Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360. PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0070-0072 [13].

Note	Factor	References
xv	Burnout	DJ Oh and others, 'Examining the Links Between Burnout and Suicidal Ideation in Diverse Occupations', *Frontiers in Public Health*, vol 11, 2023, p 3 (Exhibit 90-03.024, Hearing Block 12, DVS.0012.0001.1479). Transcript, Gordon Parker, Hearing Block 10, 20 July 2023, p 71-6911 [1–25]. Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360. PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0072-0073 [14].
xvi	Unacceptable behaviour	Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, p 147 [5.5] (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584). Exhibit 24-02.001, Hearing Block 4, Air Commodore Lara Gunn, Response to Notice to Give, NTG-LGU-001, EXP.0004.0015.0023 at 0032 [13.1]. Appendix L, Defence survey data. Exhibit 38-01.001, Hearing Block 5, The Hon Leonard Roberts-Smith RFD QC, Response to Notice to Give, NTG-LRS-001, LRS.0001.0001.0001 at 0019 [143]. Exhibit 66-02.001, Hearing Block 9, Kate Jenkins, Response to Notice to Give, NTG-KJE-001, KJE.0000.0001.1492 at 1516. GA Rumble and others, *Report of the Review of Allegations of Sexual and Other Abuse in Defence: Facing the Problems of the Past*, General findings and recommendations, October 2011, vol 1, p xlviii (Exhibit 17-03.017, Hearing Block 3, EXP.0003.0010.0319). Defence Abuse Response Taskforce, *Report on Abuse in Defence*, Progress Report, November 2014, pp 351–352 (Exhibit 26-02.006, Hearing Block 4, EXP.0004.0010.0009 at .0032). Inspector-General of the Australian Defence Force, *Own Initiative Inquiry: Implementation of Military Justice Arrangements for Dealing with Sexual Misconduct in the Australian Defence Force*, December 2021, pp 60–61 (Exhibit 24-01.040, Hearing Block 4, KJE.0000.0001.1390). Exhibit 101-03.128, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-270, DEF.9999.0182.0001 at 0006–0007. B Wadham, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p viii (Exhibit F-01.061, DVS.0011.0001.1192). Transcript, General Angus Campbell AO DSC, Hearing Block 12, 28 March 2024, p 101-10281 [41–44]. Transcript, General Angus Campbell AO DSC, Hearing Block 12, 28 March 2024, pp 101-10281 [46]–101-10282 [4].

Note	Factor	References
xvi	Unacceptable behaviour	Transcript, General Angus Campbell AO DSC, Hearing Block 12, 28 March 2024, p 101-10281 [30–39]. Transcript, Lieutenant General Natasha Fox AO CSC, Hearing Block 12, 20 March 2024, p 96-9638 [16]. Australian Human Rights Commission, *Review into the Treatment of Women in the Australian Defence* Force, Phase 2 Report, August 2012, pp 75-76 (Exhibit 01-01.04, Hearing Block 1, INQ.0000.0001.0349). Transcript, Justine Grieg, Hearing Block 3, 7 March 2024, p 16-1428 [16–22]. Transcript, David Johnston, Hearing Block 12, 4 March 2024, p 86-8538 [20–38]. Exhibit 24-02.001, Hearing Block 4, Air Commodore Lara Gunn, Response to Notice to Given, NTG-LGU-001, EXP.0004.0015.0023 at 0032 [13.1]. A Rumble and others, *Report of the Review of Allegations of Sexual and Other Abuse in Defence: Facing the Problems of the Past*, General findings and recommendations, October 2011, vol 1, p xlviii (Exhibit 17-03.017, Hearing Block 3, EXP.0003.0010.0319). Defence Abuse Response Taskforce, *Report on Abuse in Defence*, Progress Report, November 2014, pp 351–352 (Exhibit 26-02.006, Hearing Block 4, EXP.0004.0010.0009 at .0032). Exhibit 24-01.040, Hearing Block 4, Inspector-General of the Australian Defence Force, Own Initiative Inquiry: Implementation of Military Justice Arrangements for Dealing with Sexual Misconduct in the Australian Defence Force, KJE.0000.0001.1390 at 1462–1463. See also: Exhibit 101-03.128, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-270, DEF.9999.0182.0001 at 0006–0007. T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, pp 41–54 (Exhibit L-01.026, DVS.2222.0001.0531). AC McFarlane and others, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full Report*, p 10 (Exhibit A-01.009, DEF.0001.0001.1093). K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP), Report to the Department of Defence, 2012, pp 37–41 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688). T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531). PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0073-0077 [15].

Note	Factor	References
xvii	Downgrade in military employment classification	Australian Commission on Safety and Quality in Health Care, *Final Report – Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative Analysis of Coronial and Defence documents*, November 2021 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552 at 2646). National Study of Mental Health and Wellbeing – Summary Statistics, (Exhibit Z-01.018, DVS.3333.0001.4816). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp x, xi, 56–66 (Exhibit F-01.061, DVS.0011.0001.1192. T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531).
xviii	Administrative violence	B Wadham and others, *Research into Defence Abuse 2018–2022*, Flinders University, ORAMA Institute, Open Door, October 2021, pp 2–3 (Exhibit 01-02.006, EXP.0001.0012.0041). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp x, xi, 56–66 (Exhibit F-01.061, DVS.0011.0001.1192). Interim National Commissioner for Defence and Veteran Suicide Prevention, Preliminary Interim Report, September 2021, p 163 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584).
xix	Moral injury	Transcript, Nikki Jamieson, Hearing Block 1, 2 December 2021, p 4-358 [12–24]. B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p x, xi, 42–45 (Exhibit F-01.061, DVS.0011.0001.1192).

Note	Factor	References
xx	Military institutional betrayal	Transcript, Jacqueline Drew, Hearing Block 10, 19 July 2023, p 70-6757 [21–22]. Exhibit G-01.001, Chrystina Stanford, Witness Statement, DVS.2222.0001.0314 at 0323. LL Monteith and others, 'Perceptions of Institutional Betrayal Predict Suicidal Self-directed Violence Among Veterans Exposed to Military Sexual Trauma', *Journal of Clinical Psychology*, vol 72(7), 2016, pp 743–55 (Exhibit 01-05.008, Hearing Block 2, EXP.0001.0020.0160). B Litz and others (2009) 'Moral Injury and Moral Repair in War Veterans: a Preliminary Model and Intervention Strategy', *Clinical Psychology Review*, p 695–706. Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Repor*t, September 2021, p 170 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp x, xi, 56–66 (Exhibit F-01.061, DVS.0011.0001.1192).
xxi	Prohibition of reporting (Code of silence)	B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p ix (Exhibit F-01.061, DVS.0011.0001.1192). Australian Human Rights Commission, *Review into the Treatment of Women in the Australian Defence Force, Phase 2 of the Review into the Treatment of Women in the Australian Defence Force*, August 2012, p. 56 (Exhibit 01-01.004, Hearing Block 1, INQ.0000.0001.0349). Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, p 54 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584). K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program* (ADF SPP), Report to the Department of Defence, pp 37, 53 (Exhibit 20-03.021, DEF.1000.8002.9688). PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0083-0084 [19].

Note	Factor	References
xxii	Lack of transition support and continuity of care	B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp xi, 90–95 (Exhibit F-01.061, DVS.0011.0001.1192). Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report,* September 2021, p 175 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584). AC McFarlane and others, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full Report*, p 10 (Exhibit A-01.009, DEF.0001.0001.1093). PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0084–0087 [20].
xxiii	Inadequate record keeping making post-service DVA claims difficult to prove	Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, p 208 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 66 (Exhibit F-01.061, DVS.0011.0001.1192). B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp xi, 96–101, 106–107 (Exhibit F-01.061, DVS.0011.0001.1192). PFLR-55.2 (Understanding Suicide, Commonwealth response), PFL.0005.0002.0032 at 0087-0089 [21].
xxiv	Inadequacies in healthcare provision	A Flego and others, *Suicide and Self-harm Monitoring of the Serving and Ex-serving Australian Defence Force Member Population Part 1: the Data Landscape and Short-term Opportunities*, p 43 (Exhibit D-01.040, DVS.0000.0001.6527). Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, p 175 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584)

Annexure 1.2 A note on theory

215. Although theories of suicide were not part of our terms of reference, we have considered the value of theory at certain points during our inquiry and while writing this report. We have not leaned on one particular theory of suicide. Instead, our core approach has been to identify and work with risk and protective factors in accordance with our terms of reference in designing the suite of recommendations presented in this report. A brief overview of theories of suicide is presented here.

216. Suicide and suicidality among serving and ex-serving members of the ADF is a significant issue affecting individuals, family and friends, communities and the nation. As a veteran's widow stated:

> I am but one lived experience, one voice out of hundreds of experiences you will listen to throughout these hearings. I have engaged with the veteran community and DVA's Veteran Family Strategy Engagement Forums, I became a member of the Australian War Widows NSW, I have shared my experiences … in the hopes of raising awareness and fund raising for Legacy. [Redacted] has a long way to go. Her father's suicide has set off a chain of events whereby due to her young age, her resilience and coping mechanisms were severely tested. I have not even discussed what the impact of [redacted] suicide and [redacted] mental health problems have had on her brother's life or my own mental health, or the inter-generational trauma that it will have on us as a family going forward.[219]

217. Key theories of suicide have helped us understand the broader issue of suicide. While theories alone cannot solve the complex problem examined by this Royal Commission, they provide insights into why individuals or groups of individuals may die by suicide and/or experience suicidality. For researchers and practitioners, theories underpin evidence-based practice and help understand suicide prevention.

218. There are a large number of theories about suicide and it is neither possible nor necessary to present an overview of each one in this report. Suffice to say, theories and/or models of suicide can be categorised into three main groups: single-factor, stress-diathesis (or stress-predisposition) and ideation-to-action.[220] They are set out below to illustrate their differences.

219. Our very first witness, Ms Nikki Jamieson, a suicidologist who soon afterwards was awarded a doctorate for her research on suicidality[221] and was testifying about the death by suicide of her own son, Private Daniel Garforth, told us about Daniel's decline in mental health and the complex nature of suicide:

> there are a number of different factors. So, posted away from home, being away from his family, he was very isolated. When problems with leadership began, his mental health and wellbeing was impacted. These impacts led to his suicide but I want to make it very, very clear, we have already talked about the complex nature of suicide. Suicide is very, very complex, it is a multifaceted constellation of distal and proximal risk factors that at some point or another combine to result in suicide. It is never just one factor, it is often a lot of the distal factors that create an environment for a suicidal mind to flourish.[222]

220. No single theory can precisely predict an individual's risk of suicide. A theoretical understanding, however, helps to explain certain behaviours and patterns, including the risks and protective factors for suicide. Theories can also inform approaches to suicide prevention and support.[223]

Single-factor theories

221. Early theories of suicide relied on sociological and psychoanalytical concepts. Early theorists included Sigmund Freud, Émile Durkheim, Jean Baechler and Edwin Shneidman. It is now accepted that 'single factors' cannot account for the complexity of factors that lead to death by suicide. However, elements of these theories have been incorporated into later models.

Stress/stress-diathesis theories

222. Stress, or 'stress-diathesis', theories acknowledge that suicide results from a combination of many intersecting factors.[224] These theories centre around an individual having vulnerability or biological predisposition (diathesis) who are then exposed to stressful life events.[225]

223. Dr Alan Woodward spoke of the usefulness of the stress-diathesis model of suicidal behaviour as it considers both life events and biological factors:

> it merged biology that may leave [a person] vulnerable to suicidal behaviour in life, alongside the influence of crisis or life events in a person's life. And it explored the interplay between the two. So I think it is a very useful model.[226]

Neurobiological and psychopathological

224. Recent stress theories stem from John Mann and Victoria Arango's framework, which integrated neurobiological (that is, related to the biological study of the nervous system) and psychopathological (that is, related to the study of psychological and behavioural dysfunction) factors.[227] A combination of genetics and early stressful life experiences predisposes some individuals to suicide more than others.[228]

225. Other factors include anxiety, impulsivity, depression, aggression and maladaptive thinking (that is, cognitive biases in attention, information processing and memory).[229]

Cultural factors

226. In 1986, Donald Rubenstein, in his biocultural model, argued that understanding cultural factors is important for stress-diathesis theories.[230]

227. Roy Baumeister proposed the 'escape from self' model − suicide as an escape from a painful state of mind that comes from an unbearable situation.[231]

Biological predisposition and stressful life events

228. Mark Williams and Leslie Pollock proposed a version of the stress-diathesis model combining biological predisposition and stressful life events. This model draws on Baumeister's escape from self and Paul Gilbert and Steven Allan's arrested flight theories.[232] The cry of pain/arrested flight model depicts suicide as a situation characterised by three elements: defeat, no escape and no rescue.[233]

Fluid vulnerability

229. Trying to account for the uncertainty of suicide risk, David Rudd proposed the 'fluid vulnerability theory'.[234] This theory suggests that suicide risk differs from person to person. It proposes that an individual's level of risk has stable and dynamic properties that change over time depending on cognitive, emotional, behavioural and physiological domains.[235]

230. Kees van Heeringen noted the limitation of stress-diathesis theories, questioning how it is that most people who experience extreme stress do not attempt suicide.[236]

Ideation-to-action theories

231. Ideation-to-action theories acknowledge that the mind may be affected by various stress and protective factors.[237] These theories consider suicidal behaviour to be driven by a reduced desire to live, an increased desire to die, or both.[238] Three such theories are the 'interpersonal theory of suicide', the 'integrated motivational–volitional model' and the three-step model of David Klonsky and Alexis May.[239]

Interpersonal theory of suicide

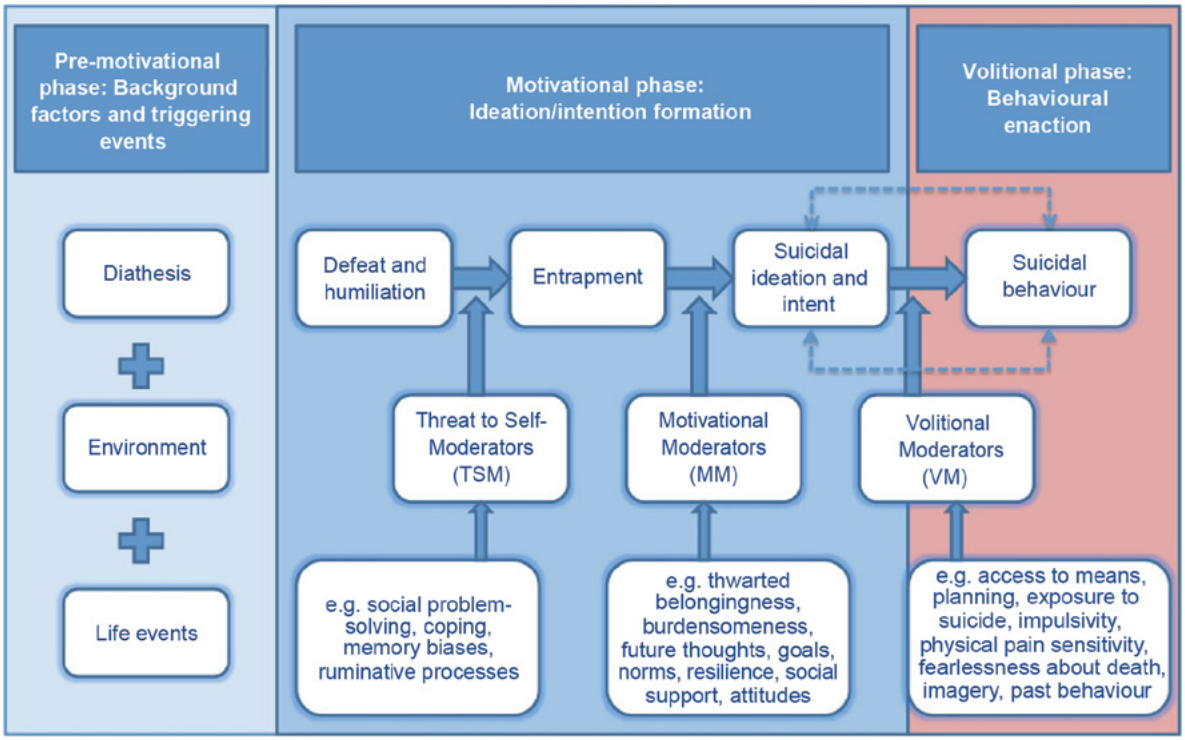
232. Professor Thomas Joiner developed the interpersonal theory of suicide.[240] Professor Joiner was the first to suggest the 'desire' for suicide is distinct from suicidal behaviours (such as suicidal thoughts and plans).[241] His theory argued that 'thwarted belongingness and perceived burdensomeness' coupled with a level of hopelessness create a desire for death.[242] This desire for death may result in suicidal ideation but will not lead to suicide unless the individual has the capability to suicide.[243] It is thought this capability is acquired through repeated exposure to physical pain and provocative experiences that reduce the individual's fear of death.[244]

233. Professor Joiner's premises are consistent with the evidence Dr Kairi Kõlves, Professor at the Australian Institute for Suicide Research and Prevention and Director of the WHO Collaborating Centre for Research and Training in Suicide Prevention, presented at Hearing Block 1. Dr Kõlves stated the capability to suicide is built on 'developing fearlessness, seeing death and … normalising the feeling of being capable to die'.[245]

Integrated motivational–volitional theory

234. In 2011, Professor Rory O'Connor developed the integrated motivational–volitional theory, which proposes how suicidal ideation can progress to suicidal behaviour[246] (see Figure A1). The theory views suicide as a behaviour that develops through three phases: a pre-motivation phase (where background factors and trigger events may operate), a motivational phase (where suicidal ideation may develop) and a volitional phase (where suicidal behaviour may occur).[247]

Figure A1 The integrated motivational–volitional model of suicidal behaviour



Source: R O'Connor and OJ Kirtley, 'The Integrated Motivational–Volitional Model of Suicidal Behaviour', *Philosophical Transactions of the Royal Society B*, vol 373, 1754, 2018.

235. During the motivational phase, defeat and humiliation can lead to entrapment, and then suicidal ideation/intent may develop. A range of factors can moderate the likelihood that entrapment leads to suicidal ideation. For example, a sense of burdensomeness or thwarted belonging may increase the risk, whereas future goals, resilience and social support may decrease the risk. Likewise, a range of moderating factors increase the risk of ideation progressing to suicidal behaviour including capability, impulsivity, access to means and previous exposure to suicidal behaviour.[248]

Three-step theory of suicide

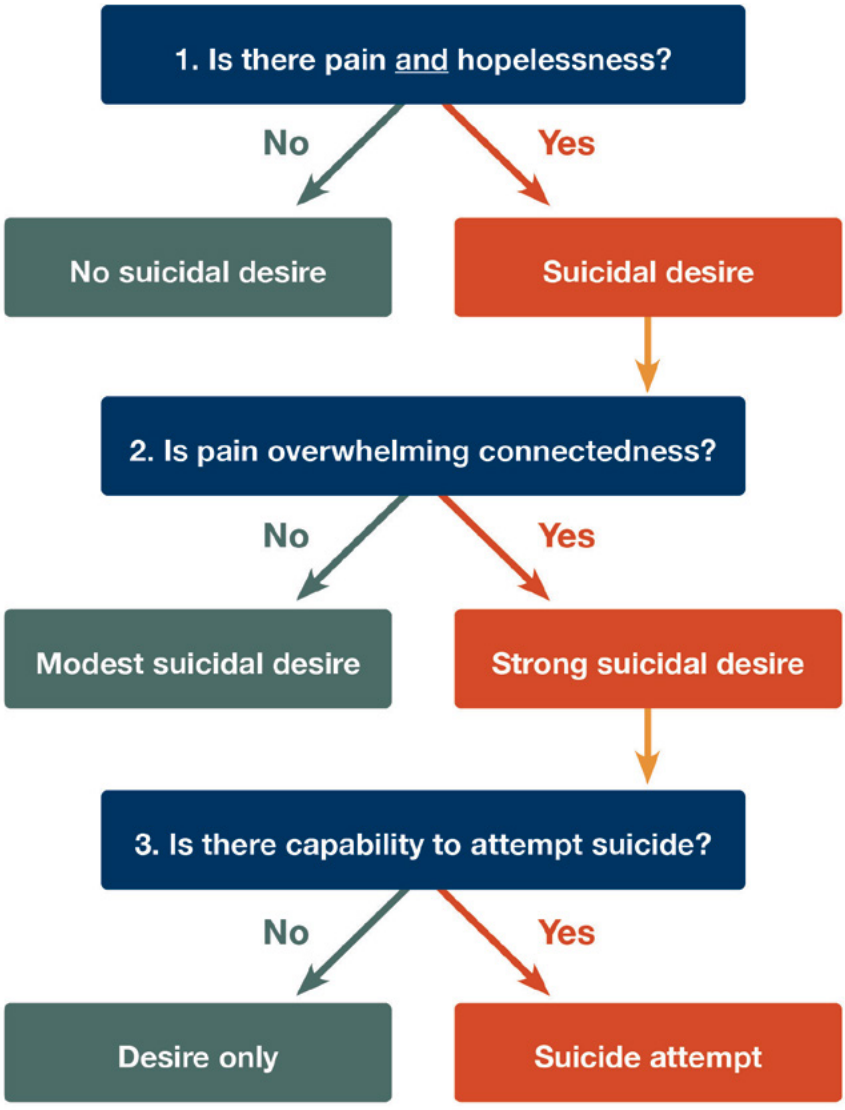
236. In 2015, David Klonsky and Alexis May suggested a relatively simple three-step theory of suicide[249] (see Figure A2). This model explains suicidal ideation and attempts, in terms of: 1) pain and hopelessness, 2) pain overwhelming connectedness and 3) capability to attempt suicide.[250]

237. The three-step theory is based on the premise that many kinds of pain can lead to a reduced desire to live. However, pain alone is not enough to bring about a desire to suicide. The first step, according to the theory, is when an intense or prolonged experience of pain is combined with hopelessness (that is, 'this physical/psychological/emotional pain will not change or get better'), which can bring about suicidal desire.

238. The second step considers whether a person's connectedness to others (for example, sense of belonging, social support and positive relationships) is enough to counterbalance their experience of pain and hopelessness.

239. The third step considers a person's capability for suicide in much the same way that Joiner's interpersonal theory and O'Connor's integrated motivational–volitional model do, except the three-step theory suggests that three different kinds of contributors create capability: dispositional (biological or genetic), acquired (learned) and practical (access and knowledge) factors.[251]

Figure A2 The three-step theory of suicide



Source: ED Klonsky and others, 'The Three-Step Theory of Suicide: Description, Evidence, and Some Useful Points of Clarification', *Preventive Medicine*, 2021, vol 152 p 2.

Summary

240. Theorising suicide has a long history, with models first being discussed at least from the late eighteenth century.[252]

241. In 2002, Emeritus Professor Diego De Leo called for an integrated approach. He said 'many things need to be considered here, including changes in attitude throughout history, gender and age differences, socio-economic factors, influence of race and ethnicity, and the impact of religion'.[253]

242. Suicidality is complex, with multiple interconnected factors that contribute to suicide and suicidal behaviours. While no single theory can precisely predict an individual's risk of suicide, a theoretical understanding helps to explain certain behaviours and patterns, and the role of risk and protective factors for suicide. Theories can also inform approaches to suicide prevention and support.[254]

243. In the context of this Royal Commission, we acknowledge that our exploration of suicide and suicidal behaviour focuses on those who have died by suicide. It is not the role of this inquiry to test theory. Yet we must remain mindful of those who have also experienced great stress and have not attempted suicide.

Endnotes

1 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
2 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 1, cell C8.
3 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 1, cell C44.
4 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 1, cell J44.
5 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
6 Commonwealth of Australia, Letters Patent, 8 July 2021, p 1.
7 Commonwealth of Australia, Letters Patent, 8 July 2021, p 1.
8 Commonwealth of Australia, Letters Patent, 8 July 2021, pp 2–3.
9 National Suicide Prevention Taskforce, *Shifting the Focus: A National Whole-of-Government Approach to Guide Suicide Prevention in Australia*, Australian Government, August 2020, p 11 (Exhibit 47-04.011, Hearing Block 6, EXP.0006.0018.0364).
10 National Suicide Prevention Adviser, *Connected and Compassionate: Implementing a national whole of governments approach to suicide prevention*, Final Advice, December 2020, p 5 (Exhibit 45-01.005, Hearing Block 6, EXP.0006.0018.0069).
11 T Varker and others, *ADF members and ex-members suicide literature review: An Update*, Phoenix Australia – Centre for Posttraumatic Health, Melbourne, 17 October 2023, p 51 (Exhibit L-01.026, DVS.2222.0001.0531).
12 H Kraemer and others, 'Coming to Terms with the Terms of Risk'*, Archives of General Psychiatry,* vol 54, 1997, p 337.
13 H Kraemer and others, 'Coming to Terms with the Terms of Risk', *Archives of General Psychiatry*, vol 54, 1997, p 337.
14 JC Franklin and others, 'Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research', *Psychological Bulletin*, vol 143, 2, 2017, pp 187–232.
15 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health, p 62 (Exhibit L-01.026, DVS.2222.0001.0531).
16 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health, p 62 (Exhibit L-01.026, DVS.2222.0001.0531).
17 National Suicide Prevention Adviser, *Connected and Compassionate: Implementing a national whole of governments approach to suicide prevention*, Final Advice, December 2020, p 42 (Exhibit 45-01.005, Hearing Block 6, EXP.0006.0018.0069); Exhibit 30-03.009, Hearing Block 4, Royal Commission into Defence and Veteran Suicide: Introductory Briefing, STU.0001.0001.5446 at 5461.
18 Everymind, *National Communications Charter: A Unified Approach to Mental Health and Suicide Prevention,* Version 3, 2024.
19 M Van Hooff and others, *Transition and Wellbeing Research Programme, Mental Health and Wellbeing Transition Study: Mental Health Prevalence*, Department of Veterans' Affairs, 2018, p 337 (Exhibit 20-03.043, Hearing Block 3, DEF.0001.0001.0145).
20 Australian Institute of Health and Welfare, 'Intentional self-harm hospitalisations by states & territories', webpage, last updated 15 September 2023, www.aihw.gov.au/suicide-self-harm-monitoring/data/intentional-self-harm-hospitalisations/intentional-self-harm-hospitalisations-by-states, viewed 29 July 2024.
21 Australian Institute of Health and Welfare, 'Intentional self-harm hospitalisations by age groups', webpage, last updated 24 January 2024, www.aihw.gov.au/suicide-self-harm-monitoring/data/intentional-self-harm-hospitalisations/intentional-self-harm-hospitalisations-by-age-sex, viewed 5 May 2024.
22 Australian Institute of Health and Welfare, 'Ambulance attendances: suicidal and self-harm behaviours', webpage, last updated 6 May 2024, www.aihw.gov.au/suicide-self-harm-monitoring/data/ambulance-attendances, viewed 29 July 2024.
23 Australian Institute of Health and Welfare, 'Ambulance attendances: suicidal ideation, and suicidal and self-harm behaviours', webpage, last updated 6 May 2024, www.aihw.gov.au/suicide-self-harm-monitoring/data/ambulance-attendances/ambulance-attendances-for-suicidal-behaviours, viewed 29 July 2024.

24 Australian Bureau of Statistics, 'National Study of Mental Health and Wellbeing', webpage, last updated 5 October 2023, Table 10 – Lived experience – Whether close to someone who took or attempted to take own life, www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-2022#data-downloads, viewed 4 April 2024; Australian Bureau of Statistics, 'National Study of Mental Health and Wellbeing', webpage, last updated 5 October 2023,Table 9 – Lived experience – Suicidal thoughts and behaviours, www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-2022#data-downloads, viewed 4 April 2024.

25 Australian Institute of Health and Welfare, 'Deaths by Suicide Over Time', webpage, last updated 3 November 2023, www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-over-time, viewed 29 July 2024.

26 Australian Institute of Health and Welfare, 'Deaths by suicide over time', webpage, last updated 3 November 2023, www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-over-time, viewed 29 July 2024.

27 National Suicide Prevention Taskforce, *Compassion First: Designing our national approach from the lived experience of suicidal behaviour*, Australian Government, August 2020, p 6 (Exhibit 47-04.009, Hearing Block 6, EXP.0006.0018.0227).

28 National Suicide Prevention Taskforce, *Compassion First: Designing our National approach from the lived experience of suicidal behaviour*, Australian Government, August 2020, p 6 (Exhibit 47-04.009, Hearing Block 6, EXP.0006.0018.0227).

29 National Suicide Prevention Taskforce, *Compassion First: Designing our national approach from the lived experience of suicidal behaviour*, Australian Government, August 2020, p 6 (Exhibit 47-04.009, Hearing Block 6, EXP.0006.0018.0227).

30 National Suicide Prevention Taskforce, *Compassion First: Designing our national approach from the lived experience of suicidal behaviour*, Australian Government, August 2020, p 6 (Exhibit 47-04.009, Hearing Block 6, EXP.0006.0018.0227).

31 National Suicide Prevention Taskforce, *Compassion First: Designing our national approach from the lived experience of suicidal behaviour*, Australian Government, December 2020, p 14 (Exhibit 45-01.004, Hearing Block 6, EXP.0006.0018.0017)

32 National Suicide Prevention Adviser, *Connected and Compassionate: Implementing a national whole of governments approach to suicide prevention*, *Final Advice*, December 2020, p 10 (Exhibit 45-01.005, Hearing Block 6, EXP.0006.0018.0069).

33 Exhibit 30-03.009, Hearing Block 4, Royal Commission into Defence and Veteran Suicide: Introductory Defence Briefing, STU.0001.0001.5446 at 5470.

34 Exhibit 30-03.009, Hearing Block 4, Royal Commission into Defence and Veteran Suicide: Introductory Defence Briefing, STU.0001.0001.5446 at 5469.

35 ADF Careers, 'ADF Reserves', webpage, www.adfcareers.gov.au/careers/reserves, viewed 7 August 2024.

36 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 60 (Exhibit K-01.123, DVS.2222.0001.3284).

37 Australian Bureau of Statistics, 'Service with the Australian Defence Force: Census', webpage, last updated 28 June 2022, www.abs.gov.au/statistics/people/people-and-communities/service-australian-defence-force-census/latest-release, viewed 26 May 2024.

38 Australian Bureau of Statistics, 'Characteristics of Previous Australian Defence Force Personnel', webpage, last updated 31 October 2022, www.abs.gov.au/articles/characteristics-previous-australian-defence-force-personnel, viewed 26 May 2024.

39 L Dell and others, *The Longitudinal Australian Defence Force Study Evaluating Resilience (LASER-Resilience): Patterns and Predictors of Wellbeing*, Phoenix Australia – Centre for Posttraumatic Mental Health, 2019, p 10 (Exhibit ZZ-03.004, STU.0000.0002.4585).

40 Exhibit 82-03.036, Hearing Block 11, Military Personnel Policy Manual, ACA.1001.0005.2002 at 2037.

41 Exhibit 82-03.036, Hearing Block 11, Military Personnel Policy Manual, ACA.1001.0005.2002 at 2021.

42 Exhibit 82-03.036, Hearing Block 11, Military Personnel Policy Manual, ACA.1001.0005.2002 at 2062.

43 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0004, Table 3.1.

44 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 19 (Exhibit K-01.123, DVS.2222.0001.3284).
45 As at 30 June 2023. Department of Defence, *Defence Annual Report 2022–23*, September 2023, p 98 (Exhibit I-01.004, DVS.2222.0001.5087).
46 As at 31 December 2021. Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 19 (Exhibit K-01.123, DVS.2222.0001.3284).
47 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 34 (Exhibit K-01.123, DVS.2222.0001.3284).
48 As at 30 June 2023. Department of Defence, *Defence Annual Report 2022–23*, September 2023, p 98 (Exhibit I-01.004, DVS.2222.0001.5087).
49 As at 31 December 2021. Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 34 (Exhibit K-01.123, DVS.2222.0001.3284).
50 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 130 (Exhibit F-01.061, DVS.0011.0001.1192).
51 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0006, Table 4.1.
52 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0006, Table 4.1.
53 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0006, Table 4.1.
54 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0006, Table 4.1.
55 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0006, Table 4.1.
56 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0006, Table 4.1.
57 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0006, Table 4.1.
58 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0006, Table 4.1.
59 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0006–0007, Table 1.1.
60 Exhibit EE-01.001, Department of Defence, Response to Notice to Give, NTG-DEF-284, DEF.9999.0196.0001 at 0003, Table 2.1.
61 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 58 (Exhibit K-01.123, DVS.2222.0001.3284).
62 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, Supplementary tables at Table S2.2: Number of suicide deaths by service status and year, 1997–2021, sum of cells d20-d29 (789 suicide deaths) / 10 (years) = 78.9 deaths per year between 2012 and 2021 (Exhibit EE-01.014, DVS.3333.0001.6453).
63 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, Supplementary tables at Table S2.2: Number of suicide deaths by service status and year, 1997–2021, sum of cells d20-d29 (789 suicide deaths) / 10 (years) = 78.9 deaths per year between 2012 and 2021 (Exhibit EE-01.014, DVS.3333.0001.6453).
64 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 58 (Exhibit K-01.123, DVS.2222.0001.3284).
65 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 58 (Exhibit K-01.123, DVS.2222.0001.3284).

66 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 58 (Exhibit K-01.123, DVS.2222.0001.3284).
67 J Cerel and others, 'How Many People are Exposed to Suicide – Not Six', *Suicide and Life-Threatening Behaviour*, 2018, p 4 (Exhibit 23-03.052, Hearing Block 3, STU.0003.0001.0522).
68 ED Klonsky and AM May, 'The Three-Step Theory (3ST): A New Theory of Suicide Rooted in the "Ideation-to-Action" Framework', *International Journal of Cognitive Therapy*, vol 8, 2, 2015, pp 114–129 (Exhibit Z-01.024, DVS.3333.0001.6325).
69 TE Joiner, 'Why People Die by Suicide', *Harvard University Press*, 2005; R O'Connor and OJ Kirtley, 'The Integrated Motivational–Volitional Model of Suicidal Behaviour', *Philosophical Transactions of the Royal Society B*, vol 373, 1754, 2018; ED Klonsky and AM May, 'The Three-Step Theory (3ST): A New Theory of Suicide Rooted in the "Ideation-to-Action" Framework', *International Journal of Cognitive Therapy*, vol 8, 2, 2015, pp 114–29 (Exhibit Z-01.024, DVS.3333.0001.6325).
70 As measured by the Kessler Psychological Distress Scale 10 [K10] to assess psychological distress and to monitor depressive and anxiety symptomatology; A Junus and P Yip, 'Preventing Comorbidity Between Distress and Suicidality: a Network Analysis', *npj Mental Health Research*, 2, 2023; RC Campos and others, 'Does Psychache Mediate the Relationship Between General Distress and Suicide Ideation?', *Death Studies*, vol 41, 4, 2017, pp 241–245; JJ Carballo and others, 'Psychosocial Risk Factors for Suicidality in Children and Adolescents', *European Child and Adolescent Psychiatry*, vol 29, 6, 2020, pp 759–776; V Hinze and others, 'Does Depression Moderate The Relationship Between Pain And Suicidality In Adolescence? A Moderated Network Analysis', *Journal of Affective Disorders*, vol 292, 2021, pp 667–677.
71 M Van Hooff and others, *Transition and Wellbeing Research Programme, Mental Health and Wellbeing Transition Study: Mental Health Prevalence*, Department of Veterans' Affairs, 2018, pp 144–145, 202–203 (Exhibit 20-03.043, Hearing Block 3, DEF.0001.0001.0145).
72 M Van Hooff and others, *Transition and Wellbeing Research Programme, Mental Health and Wellbeing Transition Study: Mental Health Prevalence*, Department of Veterans' Affairs, 2018, pp 202–203 (Exhibit 20-03.043, Hearing Block 3, DEF.0001.0001.0145).
73 A McFarlane and others, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full Report*, Department of Defence, 2011, pp xx, 15 (Exhibit A-01.009, DEF.0001.0001.1093).
74 M Van Hooff and others, *Transition and Wellbeing Research Programme, Mental Health and Wellbeing Transition Study: Mental Health Prevalence*, Department of Veterans' Affairs, 2018, pp 180 (Exhibit 20-03.043, Hearing Block 3, DEF.0001.0001.0145).
75 M Van Hooff and others, *Transition and Wellbeing Research Programme, Key Findings Report*, Department of Veterans' Affairs, 2019, p 46 (Exhibit 20-03.056, Hearing Block 3, DEF.1029.0002.0066).
76 C Meurk and others, *Understanding and enhancing responses to suicide crises involving current serving and ex-serving members of the ADF: A data linkage study*, commissioned by the Royal Commission into Defence and Veteran Suicide, April 2024, pp 69–70 (Exhibit 101-03.023, Hearing Block 12, DVS.0012.0001.2838).
77 See: Appendix J Comparative hospital admissions for self-harm and mental health.
78 See: Appendix J Comparative hospital admissions for self-harm and mental health.
79 See: Appendix J Comparative hospital admissions for self-harm and mental health.
80 Exhibit EE-01.011, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-013, Attachment A, AHW.9999.0007.0002 at Table 5 [H10 to H15].
81 See: Appendix J Comparative hospital admissions for self-harm and mental health.
82 Exhibit EE-01.011, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-013, Attachment A, AHW.9999.0007.0002 at Table 5 [S10 to S15].
83 See: Appendix J Comparative hospital admissions for self-harm and mental health.
84 Exhibit EE-01.011, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-013, Attachment A, AHW.9999.0007.0002 at Table 5 [L10 to L15].
85 See: Appendix J Comparative hospital admissions for self-harm and mental health.
86 Exhibit EE-01.011, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-013, Attachment A, AHW.9999.0007.0002 at Table 5 [W10 to W15].
87 Australian Institute of Health and Welfare, 'Education, and employment as risk factors for suicide', webpage, last updated 15 August 2023, www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/social-factors-suicide/education-employment-as-risk-factors-for-suicide, viewed 25 June 2024.

88 A McFarlane and others, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report*, Department of Defence, 2011, p 2 DEF.0001.0001.1093).
89 A McFarlane and others, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report*, Department of Defence, 2011, p xv (Exhibit A-01.009, DEF.0001.0001.1093).
90 A McFarlane and others, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report*, Department of Defence, 2011, p 2 (Exhibit A-01.009, DEF.0001.0001.1093).
91 See: Appendix H Comparative rates of suicide – current serving ADF members.
92 See: Appendix H Comparative rates of suicide – current serving ADF members.
93 Australian Bureau of Statistics, 'Correlation and causation', webpage, no date, www.abs.gov.au/statistics/understanding-statistics/statistical-terms-and-concepts/correlation-and-causation#:~:text=Causality%20is%20the%20area%20of,of%20establishing%20causality%20between%20variables, viewed 25 June 2024.
94 See: Appendix H Comparative rates of suicide – current serving ADF members.
95 The suicide count for ex-serving males who served in the permanent forces in aviation; communications and cyber; enterprise and command support; health roles; and intelligence roles were too small to derive a reliable suicide rate. No statistically significant differences in the suicide rates were found for ex-serving males who served in engineering, maintenance and construction roles or logistics roles.
96 See: Appendix H Comparative rates of suicide – current serving ADF members.
97 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, November 2023, p 10 (Exhibit K-01.123, DVS.2222.0001.3284).
98 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 60 (Exhibit K-01.123, DVS.2222.0001.3284).
99 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 1, cell C8.
100 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 1, cell J8.
101 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 1, cell C44.
102 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 1, cell J44.
103 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
104 106 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 1, cell C44.
105 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
106 Department of Veterans' Affairs, 'Incapacity Policy Manual', webpage, last updated 13 September 2017, p 12 (Exhibit ZZ-03.003, EXP.0003.0015.0338).
107 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 2, cells C27, C51.
108 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 2, cells C27, C51.
109 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 24 (Exhibit K-01.123, DVS.2222.0001.3284).
110 Exhibit 82-03.036, Hearing Block 11, Military Personnel Policy Manual, ACA.1001.0005.2002 at 2752.
111 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 2, cells C19.
112 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 at Table 3, cells J34.
113 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
114 No statistically significant differences in the suicide rates were found for ex-serving males who served in aviation; communications and cyber; engineering, maintenance and construction; enterprise and command support; health; or intelligence roles.

115 The suicide count for ex-serving females who served in the permanent forces in aviation roles, communications and cyber roles, engineering maintenance and construction roles, and intelligence roles are too small to derive a reliable suicide rate. No statistically significant differences in the suicide rates were found for ex-serving females who served in enterprise and command support roles or logistics roles.
116 L Dell and others, *The Longitudinal Australian Defence Force Study Evaluating Resilience (LASER-Resilience): Patterns and Predictors of Wellbeing*, Phoenix Australia – Centre for Posttraumatic Mental Health, 2019, p 30 (Exhibit ZZ-03.004, STU.0000.0002.4585).
117 The suicide count for ex-serving males who served in the permanent forces in combat and security roles and separated during Navy sailor initial training, Air Force aviator initial training, and officer initial training are too small to derive a reliable suicide rate.
118 The suicide count for ex-serving females who served in the permanent forces and separated during initial training and were officers is too small to derive a reliable suicide rate.
119 Exhibit 82-03.036, Hearing Block 11, Military Personnel Policy Manual, ACA.1001.0005.2002 at 2037; L Dell and others, *The Longitudinal Australian Defence Force Study Evaluating Resilience (LASER-Resilience): Patterns and Predictors of Wellbeing*, Phoenix Australia – Centre for Posttraumatic Mental Health, 2019, p 30 (Exhibit ZZ-03.004, STU.0000.0002.4585).
120 The suicide count for ex-serving males who served in the permanent forces in combat and security roles, as aviators of the Air Force Trained Force and officers of the Trained Force is too small to derive a reliable suicide rate.
121 The suicide count for ex-serving females who served in the permanent forces as aviators of the Air Force Trained Force is too small to derive a reliable suicide rate. No statistically significant differences in the suicide rates were found for ex-serving females who served in the permanent forces and were sailors of the Navy Trained Force, or officers of the Trained Force.
122 Department of Defence, 'Division 1: Introduction to deployment', webpage, no date, https://pay-conditions.defence.gov.au/pacman/chapter-17/part-1/div-1, viewed 26 May 2024.
123 No statistically significant differences in the suicide rates were found for ex-serving males who served in the permanent forces in combat and security roles with peacetime operational service only.
124 The suicide count for ex-serving females who served in the permanent forces with non-warlike operational service and peacetime operational service only was too small to derive a reliable suicide rate. No statistically significant differences in the suicide rates were found for ex-serving females who served in the permanent forces with warlike operational service.
125 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
126 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 96 (Exhibit L-01.026, DVS.2222.0001.0531).
127 National Suicide Prevention Adviser, *Connected and Compassionate: Implementing a national whole of governments approach to suicide prevention*, December 2020, p 24 (Exhibit 45-01.005, Hearing Block 6, EXP.0006.0018.0069).
128 Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360.
129 Exhibit F-03.061, Department of Defence, Response to Notice to Give, NTG-DEF-002, DEF.1002.0092.8183 at 8360.
130 National Mental Health Commission, *Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families*, *Final report: Findings and Recommendations*, 2017, pp 21–22 (Exhibit 01-01.008, Hearing Block 1, INQ.0000.0001.1488).
131 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health, Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531).
132 Productivity Commission, *A Better Way to Support Veterans*, no 93, June 2019, vol 1, p 311 (Exhibit 01-01.010, Hearing Block 1, INQ.0000.0001.2299).
133 Productivity Commission, *A Better Way to Support Veterans*, no 93, June 2019, vol 1, p 311 (Exhibit 01-01.010, Hearing Block 1, INQ.0000.0001.2299).
134 K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688).

135 K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012, p 52 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688) (emphasis added).
136 K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012, pp 52–53 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688) (emphasis added).
137 K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012, p 53 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688) (emphasis added).
138 Sourced from interview with Professor Lars Mehlum, in K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012, p 53 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688) (emphasis added).
139 Sourced from interview with Professor Lars Mehlum, in K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012, p 53 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688) (emphasis added).
140 Sourced from interview with Professor Lars Mehlum, in K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012, p 53 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688) (emphasis added).
141 Sourced from interview with Dr Mark Zamorski, in K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012, pp 53–54 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688) (emphasis added).
142 Sourced from interview with Dr Mark Zamorski, in K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012, p 54 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688) (emphasis added).
143 K Kõlves and others, *A Review of the Australian Defence Force Suicide Prevention Program (ADF SPP): Report to the Department of Defence*, 2012, p 55 (Exhibit 20-03.021, Hearing Block 3, DEF.1000.8002.9688).
144 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, pp 75–81 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584).
145 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, pp 75–81 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584).
146 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, p 81–83 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584).
147 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531).
148 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 97 (Exhibit L-01.026, DVS.2222.0001.0531).
149 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 51 (Exhibit L-01.026, DVS.2222.0001.0531).
150 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 51 (Exhibit L-01.026, DVS.2222.0001.0531).
151 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 3 (Exhibit F-01.061, DVS.0011.0001.1192) (emphasis added).
152 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 3 (Exhibit F-01.061, DVS.0011.0001.1192).

153 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 3 (Exhibit F-01.061, DVS.0011.0001.1192).
154 Exhibit 35-02.002, Hearing Block 5, Angus J. Campbell, Response to Notice to Give, NTG-ACA-001, DEF.9999.0011.0344 at 0376-0377.
155 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 3 (Exhibit F-01.061, DVS.0011.0001.1192).
156 C Orme, *Beyond Compliance: Professionalism, Trust and Capability in the Australian Profession of Arms*, Report of the ADF Personal Conduct Review, 2011, p 17 (Exhibit 101-01.024, Hearing Block 12, DVS.3333.0001.0390).
157 C Orme, *Beyond Compliance: Professionalism, Trust and Capability in the Australian Profession of Arms*, Report of the ADF Personal Conduct Review, 2011, p 17 (Exhibit 101-01.024, Hearing Block 12, DVS.3333.0001.0390).
158 C Orme, *Beyond Compliance: Professionalism, Trust and Capability in the Australian Profession of Arms*, Report of the ADF Personal Conduct Review, 2011, p 17 (Exhibit 101-01.024, Hearing Block 12, DVS.3333.0001.0390).
159 Transcript, Penelope Looker, Hearing Block 12, 13 March 2024, p 91-9094 [1–13].
160 Transcript, Paul Morgan, Hearing Block 12, 21 March 2024, pp 97-9746 [23–44], 97-9753 [8–36].
161 Submission, Madonna Palmer on behalf of Damien John Palmer, ANON-Z1E7-QQHM-X, p [1–6].
162 Bernard Smith, Submission, ANON-Z1E7-QQ5S-H, p [1–2].
163 Andira Kauer, Submission, ANON-Z1E7-QQ27-J, p [3].
164 Name withheld, Submission, ANON-Z1E7-QZ6U-W, p [2].
165 Name withheld, Submission, ANON-Z1E7-QQ3Z-P, p [2]; Name withheld, Submission, ANON-Z1E7-QQUZ-R, p [2].
166 Name withheld, Submission, ANON-Z1E7-QQDW-4, p [2].
167 Name withheld, Submission, ANON-Z1E7-QMWE-1, p [2].
168 Name withheld, Submission, ANON-Z1E7-QMN5-8, p [2].
169 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp 3–5 (Exhibit F-01.061, DVS.0011.0001.1192).
170 Name withheld, Submission, ANON-Z1E7-QZKP-D, p [16] of supplementary material.
171 C Orme, *Beyond Compliance: Professionalism, Trust and Capability in the Australian Profession of Arms*, Report of the ADF Personal Conduct Review, 2011, p 65 (Exhibit 101-01.024, Hearing Block 12, DVS.3333.0001.0390).
172 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 55 (Exhibit L-01.026, DVS.2222.0001.0531).
173 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 58 (Exhibit L-01.026, DVS.2222.0001.0531).
174 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 55 (Exhibit L-01.026, DVS.2222.0001.0531).
175 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 55 (Exhibit L-01.026, DVS.2222.0001.0531).
176 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 197 (Exhibit F-01.061, DVS.0011.0001.1192).
177 Name withheld, Submission, ANON-Z1E7-QQAY-3, p [2].
178 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 55 (Exhibit L-01.026, DVS.2222.0001.0531).
179 Name withheld, Submission, ANON-Z1E7-QXAR-3, p [2].
180 Exhibit 35-02.002, Hearing Block 5, Angus J Campbell, Response to Notice to Give, NTG-ACA-001, DEF.9999.0011.0344 at 0376-0377.

181 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 46 (Exhibit F-01.061, DVS.0011.0001.1192).
182 Exhibit 35-04.001, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-001, DEF.9999.0008.0055 at 0090 [172].
183 Name withheld, Submission, ANON-Z1E7-QZ4P-P, p [3].
184 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, p 203 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584)
185 T Varker and others, *ADF members and ex-members suicide literature review: An update*, Phoenix Australia – Centre for Posttraumatic Health: Melbourne, 17 October 2023, p 96 (Exhibit L-01.026, DVS.2222.0001.0531).
186 National Suicide Prevention Adviser, *Connected and Compassionate: Implementing a national whole of governments approach to suicide prevention*, Final Advice, December 2020, p 9 (Exhibit 45-01.005, Hearing Block 6, EXP.0006.0018.0069).
187 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
188 See: Appendix H Comparative rates of suicide – current serving ADF members.
189 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
190 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
191 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
192 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p ix (Exhibit F-01.061, DVS.0011.0001.1192).
193 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
194 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p ix (Exhibit F-01.061, DVS.0011.0001.1192).
195 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
196 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p x (Exhibit F-01.061, DVS.0011.0001.1192).
197 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
198 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
199 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
200 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p xi (Exhibit F-01.061, DVS.0011.0001.1192).
201 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
202 KR Kaufman and others, 'Military Training-related Injuries: Surveillance, Research and Prevention', *American Journal of Preventive Medicine*, vol 18, 3, 2000, pp 54–63.
203 B Wadham and others, Mapping Service and Transition to Self-Harm and Suicidality, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp 96, 135 (Exhibit F-01.061, DVS.0011.0001.1192).
204 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p x (Exhibit F-01.061, DVS.0011.0001.1192).
205 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp 90–107 (Exhibit F-01.061, DVS.0011.0001.1192).
206 See: Appendix I Comparative rates of suicide – ex-serving ADF members.
207 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp viii, x (Exhibit F-01.061, DVS.0011.0001.1192).
208 Department of Defence, *Defence Mental Health and Wellbeing Strategy 2018–2023*, 2017 (Exhibit R-01.007, ACA.1001.0002.0403 at 0435.
209 Exhibit 30-03.009, Hearing Block 4, Royal Commission into Defence and Veteran Suicide: Introductory Defence Briefing, STU.0001.0001.5446 at 5461.
210 Exhibit EE-01.011, Australian Institute of Health and Welfare, Response to Notice to Give, NTG-AHW-014, AHW.9999.0008.0001 at 0002.

211 K Jones and others, *Defence Force and Veteran Suicides: Literature Review*, Phoenix Australia – Centre for Posttraumatic Mental Health, 2020, p 42 (Exhibit 08-06.017, Hearing Block 1, EXP.0001.0015.0004).
212 Transcript, Simon Stuart, Hearing Block 12, 22 March 2024, p 98-9945 [23–40].
213 Transcript, Robert Chipman, Hearing Block 12, 13 March 2024, p 91-9177 [3–6].
214 Transcript, Mark Hammond, Hearing Block 12, 14 March 2024, p 92-9270 [41–42].
215 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, September 2021, p 192 (Exhibit 01-01.013, Hearing Block 1, INQ.0000.0001.1584).
216 Transcript, Angus Campbell, Hearing Block 12, 28 March 2024, pp 101-10256 [46-47]–101-10257 [1–2].
217 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021,* November 2021, at Table S2.2: Number of suicide deaths by service status and year, 1997–2021, sum of cells d20-d29 (789 suicide deaths) / 10 (years) / 26.2 (fortnights in year) = 3.01 deaths per fortnight between 2012 and 2021 (Exhibit EE-01.014, DVS.3333.0001.6453).
218 Australian Institute of Health and Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, 2023, p 11 (Exhibit K-01.123, DVS.2222.0001.3284).
219 Name withheld, Submission, ANON-Z1E7-QMRM-4, p [4].
220 ED Klonsky and others, 'Ideation-to-Action Theories of Suicide: a Conceptual and Empirical Update', *Current Opinion in Psychology*, vol 22, 2018; DH Rubenstein, 'A Stress-diathesis Theory of Suicide', *Suicide and Life-Threatening Behavior*, vol 16, 1986, pp 182–97.
221 N Jamieson, *Darkest Before Dawn: Australian Veterans' Accounts of Moral Injury*. PhD Thesis, University of New England, 2023.
222 Transcript, Nicola Jamieson, Hearing Block 1, 29 November 2021, p 1-53 [25–32].
223 TE Joiner, *Why People Die by Suicide*, Harvard University Press, 2005; R O'Connor and OJ Kirtley, 'The Integrated Motivational–Volitional Model of Suicidal Behaviour', *Philosophical Transactions of the Royal Society B*, vol 373, 1754, 2018; ED Klonsky and AM May, 'The Three-Step Theory (3ST): A New Theory of Suicide Rooted in the "Ideation-to-Action" Framework', *International Journal of Cognitive Therapy*, vol 8, 2, 2015, pp 114–29; ED Klonsky and others, 'Recent Advances in Differentiating Suicide Attempters from Suicide Ideators', *Current Opinion in Psychiatry*, vol 30, 1, 2017, pp 15–20; R O'Connor, *When it is Darkest: Why People Die by Suicide and What We Can Do To Prevent It?,* Vermillion, 2021, pp 166–168.
224 DH Rubenstein, 'A stress-diathesis theory of suicide', *Suicide and Life-Threatening Behavior*, vol 16, 1986, pp 182–97.
225 DH Rubenstein, 'A stress-diathesis theory of suicide', *Suicide and Life-Threatening Behavior*, vol 16, 1986, pp 182–97.
226 Transcript, Alan Woodward, Hearing Block 6, 8 August 2022, p 45-4397 [21–23].
227 JJ Mann and V Arango, 'Integration of Neurobiology and Psychopathology in a Unified Model of Suicidal Behavior', *Journal of Clinical Psychopharmacology*, vol 12, 2, 1992.
228 JJ Mann and V Arango, 'Integration of Neurobiology and Psychopathology in a Unified Model of Suicidal Behavior', *Journal of Clinical Psychopharmacology*, vol 12, 2, 1992
229 A Apter and others, 'Anxiety, Impulsivity and Depressed Mood in Relation to Suicidal and Violent Behavior', *Acta Psychiatrica Scandinavia*, vol 87, 1993, pp 1–5; R Plutchik, 'Outward and Inward Directed Aggressiveness: the Interaction Between Violence and Suicidality', *Pharmacopsychology*, vol 28 suppl. 2, 2, 1995, pp 47–57; A Wenzel and AT Beck, 'A Cognitive Model of Suicidal Behaviour: Theory and Treatment', *Applied and Preventive Psychology*, vol 12, 4, 2008, pp 189–201; A Wenzel and others, *Cognitive Therapy for Suicidal Patients: Scientific and Clinical Application*, American Psychological Association, 2009.
230 DH Rubenstein, 'A Stress-Diathesis Theory of Suicide', *Suicide and Life-Threatening Behavior*, vol 16, 1986, pp 182–97.
231 RF Baumeister, 'Suicide as Escape from Self', *Psychological Review*, vol 97, 1, 1990, pp 90–113.
232 P Gilbert and S Allan, 'The Role of Defeat and Entrapment (Arrested Flight) in Depression: an Exploration of an Evolutionary View', *Psychological Medicine*, 1998, 28, pp 585–98.
233 JMG Williams and LR Pollock, 'The Psychology of Suicidal Behaviour', in K Hawton and K van Heeringen (eds), *The International Handbook of Suicide and Attempted Suicide*, John Wiley & Sons, Ltd 2000, pp 79–93.

234 MD Rudd, 'Fluid Vulnerability Theory: a Cognitive Approach to Understanding the Process of Acute and Chronic Suicide Risk', in TE Ellis (ed), *Cognition and Suicide: Theory, Research and Therapy*, American Psychological Association, 2006, pp 355–68.

235 A Wenzel and AT Beck, 'A Cognitive Model of Suicidal Behaviour: Theory and Treatment', *Applied and Preventive Psychology*, vol 12, 4, 2008, pp 189-201; JJ Mann, 'A Current Perspective of Suicide and Attempted Suicide', *Annals of Internal Medicine*, vol 136, 4, 2002, pp 302–11; JJ Mann and others, 'Suicide Prevention Strategies: a Systematic Review', *JAMA*, vol 294, 16, 2005, pp 2064–74.

236 K van Heeringen, 'Stress-Diathesis Model of Suicidal Behavior', in Y Dwivedi (ed), *The Neurological Basis of Suicide*, CRC Press/Taylor & Francis, 2012.

237 ED Klonsky and others, 'Ideation-to-action Theories of Suicide: a Conceptual and Empirical Update, *Current Opinion in Psychology*, vol 22, 2018, pp 38–43.

238 ED Klonsky and others, 'Ideation-to-action Theories of Suicide: a Conceptual and Empirical Update, *Current Opinion in Psychology*, vol 22, 2018, pp 38–43.

239 TE Joiner, *Why People Die by Suicide*, Harvard University Press, 2005; R O'Connor and OJ Kirtley, 'The Integrated Motivational–Volitional Model of Suicidal Behaviour', *Philosophical Transactions of the Royal Society B*, vol 373, 1754, 2018; ED Klonsky and AM May, 'The Three-Step Theory (3ST): A New Theory of Suicide Rooted in the "Ideation-to-Action" Framework', *International Journal of Cognitive Therapy*, vol 8, 2, 2015, pp 114–29.

240 TE Joiner, *Why People Die by Suicide*, Harvard University Press, 2005.

241 TE Joiner, *Why People Die by Suicide*, Harvard University Press, 2005 p 136.

242 TE Joiner, *Why People Die by Suicide*, Harvard University Press, 2005 p 136.

243 TE Joiner, *Why People Die by Suicide*, Harvard University Press, 2005 p 136.

244 TE Joiner, *Why People Die by Suicide*, Harvard University Press, 2005 p 136.

245 Transcript, Kairi Kõlves, Hearing Block 1, 6 December 2021, p 6-538 [1–9].

246 RC O'Connor, 'Towards an Integrated Motivational–Volitional Model of Suicidal Behaviour' in RC O'Connor, S Platt and Jacki Gordon (eds), *International Handbook of Suicide Prevention*: *Research, Policy and Practice*, vol 1, 181–198, 2011; R O'Connor and OJ Kirtley, 'The Integrated Motivational–Volitional Model of Suicidal Behaviour', *Philosophical Transactions of the Royal Society B*, vol 373, 1754, 2018.

247 R O'Connor and OJ Kirtley, 'The Integrated Motivational–Volitional Model of Suicidal Behaviour', *Philosophical Transactions of the Royal Society B*, vol 373, 1754, 2018.

248 R O'Connor and OJ Kirtley, 'The Integrated Motivational–Volitional Model of Suicidal Behaviour', *Philosophical Transactions of the Royal Society B*, vol 373, 1754, 2018.

249 ED Klonsky and AM May, 'The Three-Step Theory (3ST): A New Theory of Suicide Rooted in the "Ideation-to-Action" Framework', *International Journal of Cognitive Therapy*, vol 8, 2, 2015, pp 114–29.

250 ED Klonsky and others, 'The Three-Step Theory of Suicide: Description, Evidence, and Some Useful Points of Clarification', *Preventive Medicine*, 2021, vol 152, p 2.

251 ED Klonsky and others, 'The Three-Step Theory of Suicide: Description, Evidence, and Some Useful Points of Clarification', *Preventive Medicine*, 2021, vol 152, p 2.

252 C Moore, *A Full Inquiry into the Subject of Suicide*, Boughton-Blean, 1790; F Winslow, *Anatomy of Suicide*, Renshaw, 1840; H Morselli, *Suicide: an essay on comparative moral statistics*, C. Kegan Paul & Co., 1881*;* W James, *Is Life Worth Living?*, Kessinger Publishing, 1904.

253 D De Leo, 'Struggling Against Suicide: The Need for an Integrative Approach', *The Journal of Crisis Intervention and Suicide Prevention*, vol 23,1, pp 23–31.

254 TE Joiner, *Why People Die by Suicide*, Harvard University Press, 2005; O'Connor RC and others, 'The Integrated Motivational–Volitional Model of Suicidal Behaviour' *Philosophical Transactions of the Royal Society B*, vol 373, 1754, 2018; ED Klonsky and AM May, 'The Three-Step Theory (3ST): A New Theory of Suicide Rooted in the "Ideation-to-Action" Framework', *International Journal of Cognitive Therapy*, vol 8, 2, 2015, pp 114–29; ED Klonsky and others, 'Recent Advances in Differentiating Suicide Attempters from Suicide Ideators', *Current Opinion in Psychiatry*, vol 30, 1, 2017, pp 15–20; R O'Connor, *When it is Darkest: Why People Die by Suicide and What We Can Do To Prevent It?,* Vermillion*,* 2021, pp 166–68.

2 Lessons learnt from overseas

Summary

As required by our terms of reference, we considered how suicide and suicidality have been managed in comparable organisations globally. Our learnings include valuable and contemporary evidence about organisational stressors that are pertinent to the Australian Defence Force (ADF).

We travelled to each of the other Five Eyes nations – the United States, the United Kingdom, Canada and New Zealand – in search of information that might assist Defence and the Department of Veterans' Affairs (DVA) to improve serving and former members' health and wellbeing outcomes. We heard about similarly high rates of suicide and suicidality from overseas partners, and the impacts of their interventions over the past few decades. A clear theme in our engagement was recognition that leaders' willingness to embrace change is a critical enabler of success.

2.1 Introduction

1. In this chapter, we discuss the most useful and relevant findings from our visits to the other Five Eyes countries. It includes these countries' programs and approaches to improve member and veteran experiences across the military life cycle.

2. We set out the rates of member and veteran suicide in each of these countries to highlight the extent of the problem. Our focus then turns to the military culture review processes that are common to all Five Eyes countries. We also examine overseas approaches to military oversight mechanisms that could help guide the improvement of oversight mechanisms in Australia.

3. We examine how the United States has used data, research and reporting mechanisms to improve the knowledge base and the accountability of organisations and their leaders, in a way that offers valuable lessons for Australia.

4. We also examine overseas experiences in relation to transition, health services for serving and ex-serving members, veterans' affairs, discharge, national approaches to coordinating veterans' organisations, and support for families.

2.2 Insights from overseas tours

5. Between August 2022 and June 2023, we visited the United States (US), the United Kingdom (UK), Canada and New Zealand. We spoke to policymakers, armed forces leaders, academics and representatives of serving and ex-serving members. They generously shared their insights and reflections on tackling the tragedy of defence and veteran suicide, and we learnt a lot from them.

6. Suicide among serving members and veterans is an issue of concern in every country. No country has developed a successful suite of policies to reduce serving member and veteran suicide over the long term. All are grappling with problems arising from military culture, poor transition outcomes, complex veteran service delivery requirements and the need for institutional change, not merely within the military but also across government.

7. In each country we visited, policymakers and armed forces leadership noted that social attitudes towards mental health are changing. This presents an opportunity to reduce the stigma around mental illness in the military, improve the mental health management of serving personnel, and integrate health and wellbeing into the broader suite of services military bodies provide to members and their families.

2.2.1 Country visits

8. We met with a cross-section of stakeholders to better understand the individual contexts of the four countries. They included officials across government, not-for-profit and research entities; personnel from all three military services; and staff in roles spanning leadership, operations, data and reporting, clinical work and research. Each generously gave their time to discuss our areas of interest. See Annexure 2.1 at the end of this chapter for a complete list of the people and organisations we met with during our visits.

9. The four countries we visited grapple with many of the same issues as the Australian Defence Force (ADF), which meant we had a wealth of program and policy responses to consider. While some of these are not relevant in the Australian context, elements of certain programs and policies are worth considering for adaptation in Australia. What has been found to succeed or fail elsewhere can provide valuable lessons.

2.2.2 A shared problem

10. The suicide rates of serving and ex-serving military members vary between countries and trend differently in each country. Different reporting methods, periods and protocols mean that relatively few statistics can be directly compared to those in Australia. A like-for-like comparison of suicide prevalence across countries is difficult. However, we discussed veteran suicide rates in general terms and in relation to trends over time and within sub-groups of serving and ex-serving populations. For example, the suicide rates of young ex-serving members are a significant issue in Canada, the United Kingdom and the United States.[1]

11. All representatives noted that stigma around mental ill health presents a significant barrier to help seeking among serving and ex-serving members. All nations are seeking to normalise mental health issues through programs that encourage open conversations about personal experiences, including through the chain of command.

12. We are pleased to note that in all the countries we visited, we heard that social attitudes to mental health are changing, encouraging more open discussion about mental wellbeing and vulnerabilities. We believe this trend will improve mental health services and outcomes over the long term and prompt necessary cultural change within institutions.

Australia

13. There were 2,007 confirmed suicide deaths between 1 January 1985 and 31 December 2021 among ADF members who had served at least one day since 1 January 1985.[2]

14. The issue has long been recognised, with multiple inquiries over the years, along with the introduction of a suicide monitoring report of current and ex-serving ADF members, conducted by the Australian Institute of Health and Welfare (AIHW). Despite the implementation of some recommendations from these inquiries, veteran suicide remains a significant issue, and AIHW has reported that the suicide rate for ex-serving males has remained relatively constant for almost 20 years.[3]

15. Ex-serving males who served in the permanent forces are 42% more likely to die by suicide than Australian males. Serving males in permanent service are 30% more likely to die by suicide than employed Australian males. Males who have served solely in the reserve forces are not at a higher risk than other Australian males.

16. Ex-serving females are at a higher risk regardless of service type. Ex-serving females with permanent or reserve-only service are more than twice as likely to die by suicide than Australian females. Chapter 1, Understanding suicide, provides more detail on the suicide rates of serving and ex-serving ADF members.

17. This Royal Commission's research has further identified sub-groups that are at particular risk. This includes ex-serving members, both men and women, who have separated involuntarily for medical and 'retention not in service interest' reasons.

United Kingdom

18. Overall, the UK regular armed forces had seen a declining trend in male suicide rates since the 1990s, and that rate has been consistently lower than for the UK general population over the past 35 years. However, since 2017, there has been an increase in the number of suicides by males in the army. The prevalence of suicide among this cohort in 2023 was the same as for the UK general population for the first time since the mid-1990s.[4] This increase was driven by deaths among younger army males with suicide rates among army males aged 20 to 24 significantly higher than for the UK general population.[5]

19. Official government data is unavailable for the number of veteran suicide deaths in the United Kingdom, but the government has committed to publishing an official figure for England and Wales.[6] A 2022 study found that UK veterans are at no greater risk of suicide than the general population. Similar to Australia, younger UK veterans, as well as those who left the armed forces after a short career, were most at risk of suicide.[7] The study recommended focusing on improving and maintaining access to mental health care and social supports for young service leavers, and implementing general suicide prevention measures for all veterans.[8]

United States

20. The US policy and program response to serving and ex-serving member suicide is at least a decade ahead of Australia. Suicide prevention is considered a priority issue in Congress and attracts bipartisan support, reinforced by extensive media interest. This is reflected in the advanced level of collaboration between government departments, and extensive data, research and reporting by government.

21. Policymakers, the US military and researchers have been focused on suicide rates among veterans since the 1980s and 1990s, with the Vietnam veteran suicide rate subject to Centre for Disease Control research[9] and academic review.[10] Following more recent conflicts, including the Gulf War, the United States Air Force established a team to examine suicide rates, leading to the creation of an Air Force Suicide Prevention Program.[11]

22. An outcome report authored in 2001 stated that '[s]ince its creation, suicide rates among Air Force members have fallen to record lows'.[12] More than 20 years ago, the Air Force recognised the distinct risks of suicide among specific cohorts, with the report stating:

> approximately 30 percent of those who [died by] suicide were undergoing disciplinary action (court-martial or administrative non-judicial punishment), or were being investigated for matters that could have resulted in disciplinary action. Mental health intervention during this time is critical.[13]

23. Suicide rates for 'Active Component' service members (those undertaking full-time, active duty) in US military branches gradually increased from 2011 to 2022. Annual reporting by the Department of Defense in 2022 stated that 'the Active Component suicide rate was similar to the suicide rate in the U.S. population, except in 2020 when the Active Component suicide rate was higher'.[14] After 20 years of the 'war on terror', more than four times as many active duty personnel have died by suicide than in post-9/11 war military operations.[15]

24. In 2020, 580 active-duty, reserve and national guard troops died by suicide, an increase from 504 in 2019 and 543 in 2018.[16] Of the 580 troops, about 103 were army national guard members, representing an increase of 35% from 2019, while suicide among active-duty soldiers saw a 20% rise.[17]

25. The Department of Defense established the Suicide Prevention and Response Independent Review Committee[18] to address what has been called a 'suicide crisis' among serving members and veterans.

26. The committee has a broad role in investigating the drivers and risk factors of suicide, including sexual assault, leadership and culture. Its work has a range of implications in the context of collaboration and data, reporting and education for military sexual assault responses.

27. The committee identified that:

> Because military leaders have such a strong influence on the wellbeing of their subordinates, greater care in the promotion and leadership selection process at all levels of the military could create a culture and environment that reduces vulnerability to suicide.[19]

28. The 2023 US reporting indicates the rate of veteran suicides is higher than that of the general population. In 2021, the age- and sex-adjusted suicide rate for veterans[20] was 71.8% higher than for non-veteran adults.[21]

Canada

29. Suicide prevention is a significant public health concern in Canada and is a top priority for the Canadian Armed Forces.[22] Similar to evidence from Australia, the suicide rates among ex-serving members in Canada are higher than for the general population.[23] Over the period 1976 to 2012, male veterans,[24] overall, had a 1.5 times higher risk of dying by suicide than the Canadian male general population.[25]

30. Evidence from Canada and Australia shows that younger veterans were at an increased risk of death by suicide compared to the respective adult populations. In Canada, the suicide rate among male veterans aged under 25 was 242% higher than their counterparts in the general population.[26]

31. The risk of death by suicide among veterans in Canada is higher than for the general population.[27]

32. In Australia and Canada, evidence shows that the rate of suicide among ex-serving women is much higher than for the general female population. In Australia, the rate is 110% higher,[28] while in Canada it is 81% higher.[29]

New Zealand

33. The New Zealand Government does not publish data on veteran suicide.

2.2.3 Common themes

34. In this section, we explore the commonalities identified across the Five Eyes nations and their relevance to the Australian context.

Problematic elements of military culture

35. The armed forces of all Five Eyes countries have had significant problems with 'unacceptable behaviour', a catch-all term that covers bullying, harassment, military institutional violence, military interpersonal violence and military sexual violence. High rates of unacceptable behaviour have been attributed, at least in part, to poor organisational culture.

36. Research commissioned by this Royal Commission found a link between certain elements of military culture and suicide.[30] In Australia and internationally, 'there is emerging evidence that certain military and masculine values and ideologies may have both direct and indirect associations with suicide risk'.[31]

37. An exploratory study of US military recruits found that high levels of hostile and hypermasculine attitudes can contribute to enacting or condoning adverse and hostile behaviours.[32] Another study identified that military training and service promote a set of masculine qualities, including toughness, stoicism, aggressiveness and self-sacrifice, that may contribute to poor mental health and adjustment issues, and act as a barrier to help seeking.[33]

38. The 2019 Wigston review of the UK armed forces found that tackling inappropriate behaviours 'is about the determination of leaders to change the culture; everything else hangs off that'.[34] Wigston found it was 'principally a chain of command issue across the forces – about leadership at every level in the organisation, setting the culture and standards, and ensuring people meet those standards consistently'.[35]

39. The review found that changing embedded norms and behaviours associated with military organisational culture required at least 'a five-to-ten-year programme of concerted activity to make a measurable difference'.[36]

40. In New Zealand, three separate reviews led to the development of Operation Respect in 2016 to prevent inappropriate and harmful behaviour in the New Zealand armed forces.[37] However, in 2020, an independent review of its progress found it had 'lost momentum and needed renewed focus'.[38] The review noted that a 'code of silence' was prevalent and left members feeling unable to raise concerns due to a fear of repercussions.[39] The New Zealand Auditor General is now required to assess the operation's progress every 2 years for 20 years.[40]

41. A consistent experience reported by representatives of the Five Eyes countries is the tension between chain of command reporting and independent oversight of workplace issues such as bullying and harassment. The reliance on the chain of command within military services can be at odds with effective mechanisms for dealing with unacceptable conduct independently and fairly, as discussed in more detail in Chapter 9, Unacceptable behaviour and complaints management.

Sexual misconduct

42. We know from research that military sexual trauma is a potential risk factor for suicidality and suicide in serving and ex-serving men and women.[41]

43. The United States has made significant efforts to reduce the rates of sexual assault within the military, resulting in a 'significant reduction' in prevalence between 2014 and 2018.[42] However, as an independent review stated:

> Devastatingly, these gains did not last, contemporaneous with changes in leadership that quickly undermined efforts to drive down the scourge … In 2018, sexual assault prevalence increased by 44 percent among women (men's prevalence stayed the same).[43]

44. At the direction of President Joe Biden, in 2021, Secretary of Defense Lloyd Austin established the 90-Day Independent Review Commission on Sexual Assault in the Military. As the review states:

> Victims of sexual assault and sexual harassment in the military are all too often doubly betrayed: by the Service member(s) who harmed them, and by the commanders who failed to protect them – or neglected to support them after reporting the harm they experienced.
>
> …
>
> there are aspects of military life that make the experience of sexual assault and the decision to report even more challenging.[44]

45. The review also found that many of the preventative measures taken by military commanders or leaders were too individualistic. This meant that measures tended to be aimed at protecting individuals from sexual assault and/or harassment, rather than addressing the organisational, social and collective norms that enable these forms of sexual violence.[45]

46. In response, the Department of Defense established a 'primary prevention workforce' aimed at minimising incidents of, and ultimately preventing, sexual harassment and sexual assault (including intimate-partner and non-intimate partner violence), family violence (including child abuse and domestic abuse), workplace violence and suicide.[46]

47. Sexual assault in the military has also attracted attention in Canada. In May 2021, the Canadian Government engaged Supreme Court Justice Madame Louise Arbour to conduct a comprehensive external review. The review examined the Department of National Defence and the Canadian Armed Forces policies, procedures, programs, practices and culture in relation to harassment and sexual misconduct.[47]

48. Justice Arbour reported that approximately 500 recommendations on related issues had been directed at the Canadian Armed Forces in many external and internal reviews that had not been implemented, or had been implemented poorly or partially.[48] In findings concerningly similar to our own, Justice Arbour stated:

> the CAF [Canadian Armed Forces] has been unwilling or unable to embrace the intent and vision that came from external sources, choosing the letter over the spirit, often the appearance of implementation over its substance, thereby entrenching their ways of operating. I believe this is a consequence of the insularity within which the CAF has traditionally operated, and its determination to perpetuate its old ways of doing business.[49]

49. Justice Arbour stated the two barriers she believed could hinder her report from creating lasting change:

> The first would be to assume that this is only attributable to a culture of misogyny, and that change will come naturally with time and more enlightened attitudes. The second would be for the CAF to think that it can fix its broken system alone.[50]

50. Justice Arbour recommended establishing an external third-party monitor to oversee the implementation of her report recommendations and to 'challenge the insularity with which senior leadership has, to date, reacted when faced with the recommendations from outsiders'. [51]

51. The Canadian Armed Forces and the Department of National Defence agreed to implement all Justice Arbour's recommendations, which include establishing an external monitor.[52]

52. We have similarly recommended establishing a new entity to provide the external scrutiny and oversight we believe is critical to reduce the risk and prevalence of suicide among the Defence and veteran community. As outlined in Part 8 of this report, we envisage the new entity would ensure an evidence-based approach to system reform to enhance health and wellbeing outcomes. See Chapter 30, Beyond the Royal Commission, for further details.

Oversight of military justice systems – considerations for the Inspector-General of the Australian Defence Force

53. The Inspector-General of the Australian Defence Force (IGADF) plays an essential oversight role in the military justice system of the ADF. The role of the Inspector-General is to investigate and expose any failure of military justice and, thus, to act as an 'independent umpire'.

54. All Five Eyes governments have established independent bodies or positions to oversee their Defence departments and hold military leaders to account. The roles and functions of inspector general positions in the other Five Eyes countries are notably broader than that of the IGADF.

55. This is relevant to our terms of reference as engagement with the military justice system has emerged as a risk factor in suicide and suicidality, and the IGADF is also responsible for investigating the deaths of serving members, including suspected suicide. This is covered in more detail in Chapter 12, Role and functions of the Inspector-General of the ADF.

56. The United States has a variety of oversight bodies, including the Army Inspector General and the Department of Defense Office of Inspector General.[53] The Army Inspector General is said to have been established in 1777 and is described as a personal staff officer of the commander who provides a sounding board for sensitive issues.[54] It is a military position reached by military rank. Army inspectors general have functions to conduct inspections at the direction of a commander, provide assistance and receive complaints, teach and train, and to carry out investigations when directed by the commander.[55] Being a position within the Army, it is not independent.

57. Both the Department of Defense and the Department of Veterans Affairs have inspectors general, which are statutory positions appointed by the President with Senate endorsement. The inspectors general have audit, evaluation and investigation units that focus on systemic, rather than individual, issues. They report publicly, provide an annual report to Congress and maintain a compendium of recommendations. The status of implementation is reported annually to their respective secretaries and the positions are independent of their departments and Congress.

58. In the United Kingdom, military oversight centres on the Service Complaints Ombudsman for the Armed Forces. A person may not be appointed as the Ombudsman if they are a member of the regular or reserve forces, or employed in the UK civil service.[56] The Service Complaints Ombudsman is a military-specific body with independent and impartial oversight of the services complaints system.[57]

59. The UK Service Complaints Ombudsman is responsible for determining appeals related to complaints made to the Service Central Admissibility Team. Complainants are members who feel wronged in any service matter.[58] The Service Complaints Ombudsman can, on application, conduct investigations into:

- service complaints (after they have been finally determined)
- allegations of maladministration in connection with handling a service complaint
- allegations of undue delay in the handling of service complaints.[59]

60. The Ombudsman has the power to make findings and recommendations.[60]

61. The Ombudsman is a statutory position and is appointed by the King on the recommendation of the Secretary of State.[61] To be eligible for appointment, a person must not be a member of the regular or reserve forces, or employed in the civil service of the state, although it appears a person is not precluded from being appointed if they served in the military.[62]

62. In New Zealand, a focus on external oversight to enhance accountability followed the Inquiry into Operation Burnham. The inquiry investigated allegations of wrongdoing on the part of New Zealand Defence Force (NZDF) personnel in Afghanistan, including the NZDF's treatment of civilians and an associated alleged cover-up.[63]

63. The inquiry reported that:

> Over a number of years, NZDF personnel failed to provide full and accurate information to ministers and the public, and failed to adequately scrutinise or respond to the information available to them. Their actions prevented civilian control and ministerial accountability from operating effectively, and have diminished public confidence in [the] NZDF as an institution. Clearly, some form of increased oversight is needed to ensure this does not happen again.[64]

64. In 2023, legislation was passed to create the role of Inspector-General of Defence in New Zealand.[65] The statute does not impose any eligibility criteria (beyond obtaining a security clearance) on who may fulfil the role. It simply provides that the Governor-General make the appointment on the recommendation of the House of Representatives.[66] The inquiry that recommended the creation of the office of the Inspector-General noted that '[t]he Inspector-General need not be a person with a military background, but he or she would need to have access to investigators/advisers with significant military expertise'.[67]

65. Canada established the National Defence and the Canadian Armed Forces Ombudsmen in 1998 to ensure the 'fair treatment of concerns raised by Canadian Armed Forces members, departmental employees and their families'.[68]

66. In her report in 2022, Justice Arbour noted the importance of the Canadian Armed Forces oversight, stating:

> I see a dire need for outside input to truly transform the insular culture entrenched in the CAF [Canadian Armed Forces]. Alerted for years to the prevalence of sexual misconduct, the CAF has demonstrated an unwillingness or inability to change.
>
> …
>
> I believe that true change must come not only from external oversight but also from external input into the various mechanisms used by the CAF to tackle sexual misconduct in 'real-time' as it occurs. [69]

67. As of May 2024, the third report by an external monitor examining the implementation of Justice Arbour's recommendations acknowledged progress to date, which has included an increase in members of the chain of command seeking assistance with managing complaints.[70] However, the report also stated that:

> there is a lot more that needs to be achieved, including ensuring that policies and procedures and accountability mechanisms are lined up such that the organization's reaction to sexual misconduct, when it does occur, is coherent from beginning to end.[71]

Key insights

68. It is apparent that there are no single, consistent or accepted criteria for analogous or similar roles to the IGADF in other jurisdictions.

69. Australia's history of reviews includes many instances where the implementation of recommendations failed to achieve the intended outcomes, outlined in Chapter 11, Governance and accountability in Defence. We are concerned that, even with strong support from the government of the day, Australia will continue to replicate the overseas experience without a fully independent oversight entity. Reform recommendations may sit idle due to institutional inertia and a return to business as usual.

70. A combination of sustained momentum and an appetite for change is essential and will be enabled through strong oversight and accountability mechanisms. Establishing an independent, new entity is the most effective way to ensure our recommendations will be implemented, evaluated and refined consistently over time. Part 8 of this report provides further detail.

71. A further key lesson from our Five Eyes partners was the importance of seeking and considering external input when developing and implementing policy. There would be significant benefit in Defence and DVA meaningfully engaging with external experts to inform approaches to health and wellbeing. This is further discussed in Chapter 15, Promoting health and wellbeing among ADF members.

2.2.4 Lessons from program and policy approaches

72. We found a number of culture and leadership practices and programs in the Five Eyes countries that could be useful within the Australian military.

Military culture, staffing and leadership

73. In Canada, New Zealand and the United States, we saw a focus on improving the culture and quality of military leadership by integrating emotional intelligence and critical thinking into leadership and command assessment programs. This marks a shift away from more traditional power-over leadership styles that may inadvertently encourage or tolerate unacceptable behaviour, towards leadership styles that incorporate more flexibility, openness to listening, and nuanced thinking.

74. In Canada, the Canadian Armed Forces established a Chief of Professional Conduct and Culture to drive culture change. The chief leads an agency that supports professional conduct and fosters an inclusive culture.[72]

75. In New Zealand, a new leadership development framework takes a deliberate step away from authoritarian leadership styles towards emotional intelligence and strategic thinking skills.[73] Elements of the framework include ‘thinking smart’, ‘influencing others’, ‘building teams’, ‘developing positive culture’, ‘living the ethos and values’, and ‘mission focus’.[74]

Box 2.1 The United States Commander Assessment Program

The United States Commander Assessment Program is a relatively new system with a more holistic way of selecting commanders. It gives the US Army greater insight into officers' knowledge, skills and behaviours, to improve the selection of commanders for promotion.

The program includes a 360-degree feedback assessment, physical exam, IQ testing, psychosocial assessment and a scenario-based leadership style assessment. Participants must successfully complete the comprehensive assessment program before they can take up a command position.

Participants receive direct feedback about areas they need to address before they can assume a command position. If necessary, they initially take a staff position to develop their skills further.

Following several cycles of implementation, the Army has:

> observed a ~30% change between those who would have been placed into command under the legacy system, and those who were appointed by virtue of their performance on the BCAP [Battalion Commander Assessment Program].[75]

Those who fail the first time can work on skills that need strengthening before applying for another command position in the future. '[O]f the candidates who receive news that they are not yet certified and choose to recompete, about 75% of the time they earn certification the next season.'[76]

Health care

76. In the US, suicide prevention is indicated as the highest priority for Veterans Affairs. The National Strategy for Preventing Veteran Suicide 2018–2028 offers a comprehensive public health approach combining community-based suicide prevention strategies and clinically based interventions. The strategy focuses on supporting those veterans and families who do not directly connect with Veterans Affairs through a multidisciplinary approach to service engagement.[77]

77. The US system follows a whole-health model that aims to reduce reliance on prescription medications and promote accessible alternative therapies, such as acupuncture, yoga and meditation. Veterans' personal healthcare plans support them to focus on their healthcare priorities and allow them to access virtual health care to ensure accessibility for all veterans.[78]

78. In addition, in 2017, the US Veterans Health Administration rolled out the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment (REACH VET) program nationally to enhance clinical approaches for suicide risk assessment.[79] The program uses 'a suicide prediction model to identify patients at statistically elevated risk of suicide … to contact and engage veterans who might benefit from enhanced care'.[80]

79. Researchers assessed the program's outcomes with respect to healthcare use, safety planning, treatment engagement, suicide attempts and mortality outcomes. The authors found that inclusion in the REACH VET program was associated with a 5% reduction in documented suicide attempts.[81] The researchers stated that:

> Several factors likely contributed to successful implementation of REACH VET. Suicide prevention is a top priority among senior VHA leaders. Consistent senior leadership engagement was evidenced by regular briefings between VHA national suicide prevention program staff and the Under Secretary for Health, as well as Congressional leaders.[82]

80. Despite its limitations, the findings suggest that REACH VET shows promise as an intervention to enhance veteran care and that further program research would be beneficial.

81. In the United Kingdom, Operation Courage is a National Health Service initiative 'designed to help serving personnel due to leave the military, reservists, armed forces veterans and their families'.[83] This specialist initiative offers a range of supports, including identifying early signs of mental health concerns and trauma. It is staffed by professionals who have experience in working with, or for, the military.[84]

82. Further, the Veteran Friendly Practice Accreditation Programme facilitates a program that helps general practitioners expand their understanding of, and deliver holistic care when managing, veterans' physical and mental health. The Royal College of General Practitioners accredits the general practitioners. Accredited practices must have a clinical lead for veterans and ask patients about military service.[85]

83. The University of Chester independently evaluated the accreditation program in August 2022. It found that 77% of survey respondents felt they had a better understanding of veterans' needs.[86] Eighty-four per cent of accredited GP practices felt they had a better understanding of veterans' experiences since becoming accredited.[87] Ninety-nine per cent of the practices said they would recommend seeking accreditation.[88]

84. The Canadian approach to defence and veteran suicide prevention has developed within the government's overarching defence policy, titled 'Strong, Secure, Engaged'. In relation to health, the policy states the 'one size fits all' approach will be replaced with services that are more 'people-centred, compassionate, dependable and comprehensive'.[89]

85. This new approach to care, titled 'Total Health and Wellness', encapsulates the fundamental areas for the wellbeing of members, veterans and their families. This includes psychological wellbeing in the workplace; the physical work environment; and personal health, including physical, mental, spiritual and familial aspects.[90]

86. The strategy has key initiatives to support health and resilience, including promoting a culture of healthy behaviour and supporting military families. It also focuses on providing high-quality health care that meets or exceeds Canadian standards, both in garrison and during military operations.[91]

Transition programs

87. A common experience across military institutions is the tension between maintaining operational capability and preparing people to exit the military. All Five Eyes countries are working to improve their transition processes, usually via a structured framework to assess a member's readiness to leave service. Countries commonly focus on employment post-discharge in their transition programs.

88. Canada is working to improve the transition and discharge process through a Canadian Armed Forces transition group whose role is:

> to provide education and training on what transition comprises, to ensure that CAF members begin to think about transition early in their careers, thereby improving transition readiness, and to deliver services, based on recognized domains of well-being.[92]

89. Discharging Canadian members are encouraged to lodge their claims with Veterans Affairs Canada early to ensure all benefits are in place before discharge. If they are not in place, discharge may be delayed.

90. Although roughly similar in size, the Canadian Armed Forces has 32 transition centres nationwide, compared to Australia's 15.[93] Core services include vocational transition support and administrative assistance to families who have lost a loved one in service.[94]

91. The US Transition Assistance Program is set out in legislation and starts one year before discharge. It involves initial individual counselling, several training sessions and a mandatory Capstone component where a commander certifies a service member's readiness for transition.[95]

92. Transition support includes the US Veterans Affairs Solid Start program, established in 2019, where an active outreach to veterans is conducted at 90, 180 and 365 days after discharge.[96] Under the program, veterans receive three phone calls and email contact during their first year after finishing military service. Program representatives provide information about specific benefits based on their needs and interests.[97]

93. Together, these programs deliver 2 years of support, including transition readiness modules and a standardised medical template that simplifies the claims process.

94. Veterans Affairs monitors Solid Start's performance by tracking calls answered and cross-referencing those veterans who were contacted against services accessed. In 2021, representatives successfully contacted approximately 71% of eligible veterans. Analysis showed that veterans who had spoken to a Solid Start representative accessed benefits more than those who had not.[98]

95. Members are given a visual journey map to help them plan their next steps. A skill bridge program provides members with a pre-discharge employment opportunity, and Veterans Affairs employment counsellors at each base meet with transitioning members 6 months prior to discharge. There are also programs to support spouses in finding employment.

Key insights

96. After considering the approaches of other Five Eyes countries, it is clear there is much we can learn to improve the ADF's level of transition support. We particularly urge further consideration of the US model's intensive monitoring, discharge preparation and follow-up. We believe the lessons of its Five Eyes counterparts can assist the ADF in delivering a best-practice transition process, further discussed in Chapter 23, Transition from military to civilian life.

Respect and recognition following discharge

97. Acknowledging a member's contribution to service before their discharge is the right thing to do in the context of the actual and potential sacrifices service men and women made.

98. In Australia, the Defence Veterans' Covenant respects and recognises the unique nature of military service and the contribution of veterans and their families.[99] Through the covenant, ex-serving members can apply for a Veteran Card, which provides discounts on the cost of government and civilian services. They may also apply for a lapel pin and an oath that formally recognise service.[100] By using the card and the pin, veterans may be recognised when not in uniform or wearing their medals, allowing the Australian community to show them and their families respect.

99. Other Five Eyes countries acknowledge service in various ways, usually via a covenant that pledges to honour, recognise and support veterans. In our view, the UK system represents best practice. Not only does it acknowledge members' contributions and service, but it also ensures that government institutions are held accountable for what they provide to ex-serving members and their families.

100. The UK Armed Forces Covenant has a clear and powerful goal. It stipulates that serving and ex-serving UK Armed Forces members and their families should be treated fairly and respectfully.[101] It states that they should not suffer disadvantage due to their service and that they may be given special consideration in certain circumstances (particularly, wounded and bereaved veterans and their families).

101. The UK covenant establishes a host of services within government agencies to cater for veterans' needs. These include a Veterans' Mental Health Network, Armed Forces Liaison Officers in Wales, and clinical leads in each National Health Service Trust. It has enabled local authorities to run Armed Forces Partnership Committees. An Armed Forces Covenant Trust Fund also provides grants supporting the aims of the Armed Forces Covenant.

Veterans' Affairs practices

102. The veterans' claims system in Australia is complex and has, at times, been perceived as adversarial. Visiting the other Five Eyes countries and discussing their systems and processes provided much insight into how Australia could improve veterans' affairs administration.

103. We have seen how representation is important in establishing a system that veterans and their families trust. In the United States, veterans make up one-third of the Department of Veterans Affairs workforce. Similarly, in New Zealand, veterans are an important part of the Veterans' Affairs workforce. This promotes a culture of understanding, supporting and believing veterans' experiences.

104. We also saw the importance of support for veterans navigating the claims and complaints system. In Canada, the Bureau of Pensions Advocates is an organisation of lawyers within Veterans Affairs Canada that provides free legal advice and representation to serving members and veterans who have received a disability benefits decision.[102] The bureau provides free, independent legal assistance to veterans in about 98% of Veterans Review and Appeal Board proceedings.[103] If a member or veteran disagrees with a Veterans Affairs Canada decision, they can choose to review or appeal it. The bureau will review the file and may recommend a departmental review or board hearing.[104]

Support for families

105. Partners and families of serving members are often integral to service life. They provide practical, emotional, wellbeing and logistical support and, as such, are part of ensuring military readiness and capability, assisting in the transition to civilian life and supporting their loved one post-service.

106. We found that the other Five Eyes countries acknowledge that military families should be equipped with the requisite tools and support to assist their service people or veteran family members. In particular, they focus on the role of families during transition, because they quickly notice any decline in mental health and support help seeking.

107. In the United Kingdom, the Minister of Defence's duty of care was extended to explicitly include military families. This followed the *Living in our Shoes: Understanding the Needs of UK Armed Forces Families* report (2020) and the *UK Armed Forces Families Strategy 2022–2032*.[105] Families are seen as a potential influencer of a UK Armed Forces member's decision to discharge, whether that be to stay in service or to leave it.

108. New Zealand has a confidential support line for serving and ex-serving members and their families, and provides access to six confidential support sessions.[106] Postings to different locations are not as frequent in the New Zealand Defence Force as they are in the ADF, and while unaccompanied postings are available, the NZDF aims for at least two consecutive postings in a row for members with families.

109. In the United States there is a concerted focus on families. A soldier's readiness is assessed as being a function of a 'golden triangle' of three elements: the soldier's family and next of kin, the soldier's friends, and the soldier's leader.[107]

110. The Military Family Readiness System is a network of programs and services operated by the US Defense Department and other federal, state and community-based agencies and organisations.[108] Its aim is to promote military families' wellbeing by offering programs and services that enhance family readiness, resilience and quality of life. It includes:

    - Military OneSource, a one-stop gateway to a wide range of programs and services
    - Military and Family Readiness centres, which help members and families adapt to the military lifestyle
    - Military and Family Life Counsellors, who provide non-medical, confidential counselling
    - the Family Advocacy Program, which prevents and responds to child abuse and neglect, and domestic violence
    - the Exceptional Family Member Program, which supports families with medical/educational special needs through case management
    - the Spouse Education and Career Opportunity Program, which offers career coaches, grants, scholarships and fellowships.[109]

111. The United States also has the statutorily independent Military Family Readiness Council to focus the Department of Defense on family issues. The council provides direct feedback to the Secretary of Defense and congressional defense committees on military family readiness, including an annual report. It includes an assessment of the adequacy and effectiveness of the Department of Defense's military family readiness programs and activities in meeting military families' needs and requirements.[110]

Collecting, analysing and reporting suicide data

112. The capacity of each Five Eyes country to collaborate in the collection, analysis and reporting of suicide data is at different stages of development.

113. The United States has allocated substantial resources to obtain and report on military suicide and related data. Each year, the Department of Defense publishes suicide counts and rates across its armed forces, including risk and contextual factors for deaths by suicide and suicide attempts.[111] Data collection for suicide reporting is extensive, including over 500 data items. When authorised, it also captures information from family, friends and colleagues.[112]

114. This has allowed US policymakers and defence chiefs to significantly expand their evidence base on defence and veteran suicide and suicidality, which informs policies and programs.

115. The United States also has a collaboration office that oversees decision-making and data across the Department of Defense and Department of Veterans Affairs.[113] The two departments also implement a Joint Strategic Plan, and a Joint Executive Committee meets quarterly, co-chaired by the Department of Defense Under Secretary and the Veterans Affairs Deputy Secretary.[114] The committee reports annually to the secretaries and the Congress.[115]

116. The departments share members' data in real time throughout their service. Serving members are required to share their data, while dependants can opt in or out. Veterans can authorise the sharing of records when they make a claim to Veterans Affairs.

117. In the United States, survey data on unacceptable behaviour is also collected. Yearly on-site evaluations use survey data to identify 20 military sites as low- or high-risk locations.[116] This is used to provide insights into risk and protective factors, and improve efforts to reduce sexual assault, harassment and suicide within the military.[117]

118. The US experience points to the fundamental importance of collecting high-quality data and undertaking research that can guide responses to member and veteran suicide and provide evidence of the success or otherwise of those responses. The importance of data collection and analysis is discussed in detail in Chapter 29, Use of data and research by Defence and DVA.

Box 2.2 Army STARRS

In the United States, Army STARRS (Army Study to Assess Risk and Resilience in Service members) was established to study risk and resilience among service members. Sponsored by the National Institute of Mental Health and Army, it has defined major predictors of suicide risk in the active duty army.

Army STARRS and STARRS-Longitudinal Study is the largest and most comprehensive research project of mental health, risk and resilience among US military personnel ever conducted. The project was originally conducted from 2009 to 2015 and has been extended into longitudinal research as STARRS-LS (2015–2020) and STARRS-LS (2020–2025).[118]

The project is designed to investigate the risk and protective factors for suicide, suicide-related behaviour and other mental/behavioural health issues in Army soldiers. It initially used information from 37 Army and Department of Defense data sources, involving over a billion records associated with more than 1.6 million soldiers on active duty from 2004 to 2009. From this data, the research team created a series of enormous databases that allowed them to investigate a diverse combination of factors. These included demographic, psychological, biological, neurological, behavioural and social domains, with the goal of generating actionable findings for the Army.[119]

The project was designed using an adaptive approach, allowing it to evolve as new information became available. The research team shared preliminary findings with senior Army leadership as they became available, so the Army could apply them to its health promotion, risk reduction and suicide prevention efforts.

Annexure 2.1 Details of country visits

United Kingdom (25 August to 10 September 2022)

119. Commissioners met more than 70 government officials and representatives from mental health and veterans' organisations. They hosted several roundtables attended by a range of participants. Commissioners visited Merville Barracks in Essex to view the Personnel Recovery Centre, Army Hive Information Service and Military Corrective Training Centre.

Table A1 List of participants at our UK meetings

Sector	Meeting participant
Government	• UK Minister for Veterans: ◦ Office of Veterans Affairs Strategy Research and Data Policy, Programmes and Engagement ◦ LGBT+ Veteran Review Project Lead, Cabinet Office • Ministry of Defence – UK Armed Forces Units: ◦ Chief of Defence Force and Senior Enlisted Advisor to the Chiefs of Staff ◦ Chief of Defence People ◦ Armed Forces Covenant Team ◦ Armed Forces People Policy and Defence People Team ◦ Armed Forces Families & Safeguarding ◦ Armed Forces Family Policies Team ◦ Armed Forces Diversity and Inclusion Team ◦ Wigston Review Implementation Team ◦ UK Surgeon General ◦ Defence Inquests Unit ◦ Discipline and Conduct, Diversity & Inclusion Directorate ◦ Merville Barracks, Colchester, Essex: Personnel Recovery Centre, Army Hive Information Service and the Military Corrective Training Centre • Office for National Statistics • Armed Forces Covenant Fund Trust Service

Sector	Meeting participant
Academics	• Institute of Psychiatry, Psychology and Neuroscience, King's College London • Academic Department Military Mental Health, King's College London • Veterans & Families Institute for Military Social Research and Centre for Military Women's Research, Anglia Ruskin University • Swansea University • Families Policy, Newcastle University • Department of Violence Prevention, Trauma and Criminology, University of Worcester • Queens University, Belfast, Northern Ireland • Westminster Centre for Research in Veterans, University of Chester
Oversight	• Independent Veterans Advisor and Vice Chair of the Veterans Advisory Board • Commissioners – Wales, Scotland and Northern Ireland • Service Complaints Ombudsman • Representative from the Veterans Transition Review
Charities	• Confederation of Service Charities • Forward Assist • Help for Heroes • Ripple Pond • Forces in Mind Trust • Soldiers and Sailors Families' Association • Families Federation • Royal British Legion
Health and mental health	• National Health Service: Op Courage • Armed Forces Health Strategy and Partnerships – National Health Service • Veterans Trauma Network • Consultant Psychiatrist and Director of Research and Training • Armed Forces Clinical Reference Group (National Health Service) • National Director of Health & Justice, National Health Service England

Canada (10 to 26 September 2022)

120. Commissioners met more than 60 government officials as well as representatives from mental health and veterans' organisations.

Table A2 List of participants at our Canada meetings

Sector	Meeting participant
Government	• Office of Veterans Affairs: ◦ Director General Health Professionals and Chief Medical Officer ◦ Bureau of Pensions Advocates Team ◦ Chief Psychiatrist • Canadian Armed Forces/Department of National Defence: ◦ Parliamentary Secretary to the Minister of National Defence ◦ Military Personnel Command ◦ Mental Health Department ◦ Surgeon General to the Canadian Armed Forces ◦ Chaplain General ◦ Transition Group ◦ Chief Professional Conduct and Culture ◦ Canadian Forces Morale and Welfare Services ◦ Military Personnel Research and Analysis ◦ Judge Advocate General ◦ Modernisation Division ◦ Military Justice Division and Prosecutions
Academics	• MacDonald Franklin Operational Stress Injury Research Centre
Oversight	• Authors and contributors to the *Report of the Independent External Comprehensive Review of the Department of National Defence and the Canadian Armed Forces* (Arbour report) • Office of the National Defence and Canadian Armed Forces Ombudsman • Office of the Ombudsman for Veterans • Office of the Military Police Complaints Commission
Charities	• Atlas Institute for Veterans and Families • Royal Canadian Legion
Health and mental health	• Mental Health Commission Canada

New Zealand (19 to 24 February 2023)

121. Commissioners met 45 government officials and representatives from mental health and veterans' organisations across New Zealand. They took part in four roundtables and canvassed a range of military issues.

Table A3 List of participants at our New Zealand meetings

Sector	Meeting participant
Government	• Office of Veterans' Affairs: ◦ Veterans' Entitlements Appeal Board ◦ Clinical Advisor to Veterans' Affairs • New Zealand Defence Force: ◦ Chief of Defence Force ◦ Defence Legal Service ◦ Integrated Wellness ◦ Surgeon-General of the New Zealand Defence Force ◦ Diversity and Inclusion Team ◦ Recruitment Unit ◦ Defence Psychology ◦ Suicide Prevention Office, Ministry of Health ◦ Department of Corrections NZ ◦ Accident Compensation Commission
Academics	• Department of Preventive and Social Medicine, University of Otago • Toi Ohomai, Te Pūkenga (New Zealand Institute of Skills and Technology)
Oversight	• Authors and contributors to the Inquiry into Operation Burnham
Charities	• Soldiers, Sailors, Airmen's Association New Zealand • The Lion Academy

United States (2 to 18 June 2023)

122. Commissioners met more than 75 government officials and representatives from mental health and veterans' organisations. They took part in 11 roundtables covering a range of military issues. Commissioners visited the Pentagon, the Federal Bureau of Investigation headquarters and the Walter Reed Army Medical Center.

Table A4 List of participants at our US meetings

Sector	Meeting participant
Government	• Veterans Affairs: ◦ Veterans' health, services and supports ◦ Veterans' affairs, compensation and pensions ◦ Office of Mental Health and Suicide Prevention ◦ Pension and Fiduciary Service ◦ Office for the Veterans Experience ◦ Data Management and Analytics ◦ Program Evaluation and Resource Center and Center for Innovation to Implementation ◦ Deputy Inspector General ◦ Collaboration Service • Department of Defense: ◦ Director and Deputy Director ◦ Military Community and Family Policy Team ◦ Suicide Prevention Program, Army, Navy and Airforce ◦ Air Force's Integrated Resilience Office ◦ Suicide Prevention Program, Coast Guard ◦ Office of Force Resiliency ◦ Sexual Assault Prevention and Response Office ◦ Department of Defense Office of Inspector General ◦ Military Community Support Programs ◦ Office of Military Family Readiness Policy ◦ Federal Electronic Health Record Modernization Office ◦ Defense Healthcare Management Systems

Sector	Meeting participant
Government	◦ Defense Human Resource Activity ◦ Defense Manpower Center ◦ Enterprise Intelligence & Data Solutions ◦ Military Personnel Programs Branch ◦ Customer Relationship Management ◦ Psychological Health Performance & Analytics ◦ Office of National Programs
Academics	• Research Transition Office, Walter Reed Army Research Institute • Center for Military Psychiatry and Neuroscience • Center for the Study of Traumatic Stress, Uniformed Services University
Oversight	• Independent Review Commission on Military Sexual Assault • Diversity and Inclusion for the Chief of Naval Operations
Health and mental health	• Walter Reed Medical Center and National Intrepid Center of Excellence • National Institute of Mental Health • Mental Health Services, Epidemiology, and Economics • Substance Abuse and Mental Health Services Administration • Federal Bureau of Investigations Wellbeing and Resiliency Program
Other	• The RAND Corporation

Endnotes

1 Child Rights International Network, *The Pressure Cooker: Child recruitment and suicide in the British armed forces*, August 2023, p 16 (Exhibit G-01.018, DVS.2222.0001.0001).
2 Australian Institute of Health Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, p 4 (Exhibit K-01.123, DVS.2222.0001.3284).
3 Australian Institute of Health Welfare, *Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021*, p 11 (Exhibit K-01.123, DVS.2222.0001.3284).
4 UK Ministry of Defence, *Suicides in the UK regular armed forces: Annual summary and trends over time, 1 January 1984 to 31 December 2022*, March 2023, p 1.
5 UK Ministry of Defence, *Suicides in the UK regular armed forces: Annual summary and trends over time, 1 January 1984 to 31 December 2022*, March 2023, p 1.
6 UK Government, *Veteran suicide figures to be recorded for the first time*, media release, 22 September 2021.
7 C Rodway and others, 'Suicide after leaving the UK Armed Forces 1996–2018: A cohort study', *PLOS Medicine*, vol 20, 8, 2023.
8 C Rodway and others, 'Suicide after leaving the UK Armed Forces 1996–2018: A cohort study', *PLOS Medicine,* vol 208, 8, 2023.
9 US Centre for Disease Control and Prevention, 'Current Trends Postservice Mortality Among Vietnam Veterans', webpage, last updated 2 May 2001, www.cdc.gov/mmwr/preview/mmwrhtml/00000865.htm, viewed 22 April 2024.
10 TA Bullman and others, 'The Risk of Suicide among Wounded Vietnam Veterans', *American Journal of Public Health*, vol 86, 5, 1996.
11 US Airforce, *The Airforce Suicide Prevention Program, A description of program initiatives and outcomes*, April 2001.
12 US Airforce, *The Airforce Suicide Prevention Program, A description of program initiatives and outcomes*, April 2001, p 3.
13 US Airforce, *The Airforce Suicide Prevention Program, A description of program initiatives and outcomes*, April 2001, p 26.
14 US Department of Defense, *Annual Report on Suicide in the Military Calendar Year 2022*, p 9.
15 TH Suitt, *High Suicide Rates among United States Service Members and Veterans of the Post 9/11 Wars*, Watson Institute Brown University, June 2021, p 1.
16 US Department of Defense, Under Secretary of Defense for Personnel and Readiness, *Annual Suicide Report, Calendar Year 2020*, September 2021, p 15 (Exhibit B-01.030, STU.0006.0001.3477).
17 Stars and Stripes, 'Military suicide rates rise again in 2020 and Defense officials don't know why', webpage, last updated 30 September 2021, www.stripes.com/theaters/us/2021-09-30/military-suicides-increase-annual-pentagon-report-3080336.html, viewed 23 April 2024.
18 US Department of Defense, 'DOD Names Lead for Suicide Prevention and Response Independent Review Committee', webpage, last updated 17 May 2022, www.defense.gov/News/News-Stories/Article/Article/3034968/dod-names-lead-for-suicide-prevention-and-response-independent-review-committee/, viewed 23 April 2024.
19 US Department of Defense, Suicide Prevention and Response Independent Review Committee, *Preventing Suicide in the U.S. Military: Recommendations from the Suicide Prevention and Response Independent Review Committee*, p 35 (Exhibit F-04.080, DVS.1111.0001.3130).
20 In this report, 'Veterans are identified as persons who served on federal active duty, other than for training, and were not currently serving at the time of their death'. US Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Repor*t *Methods Summary*, 2023, p 3.
21 US Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Repor*t, 2023, p 16.
22 Government of Canada, D Boulos, *2021 Report on Suicide Mortality in the Canadian Armed Forces (1995 to 2020),* 2021, p i. (STU.0000.0004.0393).
23 Phoenix Australia, *Defence Force and Veteran suicides: Literature review*, July 2020, p 17 (Exhibit 08-06.17, Hearing Block 1, EXP.0001.0015.0004).

24 In this report, 'veterans' encompassed 'Regular Force and Class C Reservist Veterans who released from the CAF [Canadian Armed Forces] between 1976 and 2012'. Exhibit 17-03.026, Hearing Block 3, 2017, *Veteran Suicide Mortality Study 1976 to 2012,* Veterans Affairs Canada, 2021 (EXP.0003.0010.0119 at 0124).
25 Exhibit 17-03.026, Hearing Block 3, 2017, *Veteran Suicide Mortality Study 1976 to 2012,* Veterans Affairs Canada, 2021 (EXP.0003.0010.0119 at 0123).
26 Phoenix Australia, *Defence Force and Veteran suicides: Literature revie*w, July 2020, p 18 (Exhibit 08-06.17, Hearing Block 1, EXP.0001.0015.0004).
27 Phoenix Australia, *Defence Force and Veteran suicides, Literature review*, July 2020, p 15 (Exhibit 08-06.17, Hearing Block 1, EXP.0001.0015.0004).
28 Australian Institute of Health and Welfare, *Final report to the Independent Review of Past Defence and Veteran Suicides*, September 2021, p 4 (Exhibit 01-01.014, Hearing Block 1, INQ.0000.0001.1353).
29 Phoenix Australia, *Defence Force and Veteran Suicides: Literature review,* July 2020, p 18 (Exhibit 08-06.17, Hearing Block 1, EXP.0001.0015.0004).
30 T Varker and others, *ADF members and ex-members suicide literature review: An update,* commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, p 8 (Exhibit L-01.026, DVS.2222.0001.0531).
31 T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide*,* October 2023, p 53 (Exhibit L-01.026, DVS.2222.0001.0593).
32 T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023*,* p 55 (Exhibit L-01.026, DVS.2222.0001.0531).
33 T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide*,* October 2023*,* p 55 (Exhibit L-01.026, DVS.2222.0001.0531).
34 UK Ministry of Defence, *Report on Inappropriate Behaviours*, July 2019, p 4.
35 UK Ministry of Defence, *Report on Inappropriate Behaviours*, July 2019, p 4.
36 UK Ministry of Defence, *Report on Inappropriate Behaviours*, July 2019, p 5.
37 New Zealand Controller and Auditor General, *New Zealand Defence Force: Resetting efforts to reduce harmful behaviour*, March 2023, p 3.
38 New Zealand Controller and Auditor General, *New Zealand Defence Force: Resetting efforts to reduce harmful behaviour*, March 2023, p 3.
39 New Zealand Controller and Auditor General, *New Zealand Defence Force: Resetting efforts to reduce harmful behaviour*, March 2023, p 11.
40 New Zealand Controller and Auditor General, *New Zealand Defence Force: Resetting efforts to reduce harmful behaviour*, March 2023, p 11.
41 T Varker and others, *ADF members and ex-members suicide literature review: An update,* commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, p 41 (Exhibit L-01.026, DVS.2222.0001.0531).
42 Independent Review Commission on Sexual Assault in the Military*, Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military – Equipping the Force and Empowering Prevention: Recommendations to Prevent Sexual Harassment and Sexual Assault in the U.S. Military*, July 2021, p 12 (Exhibit F-04.079, DVS.1111.0001.2831).
43 Independent Review Commission on Sexual Assault in the Military*, Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military – Equipping the Force and Empowering Prevention: Recommendations to Prevent Sexual Harassment and Sexual Assault in the U.S. Military*, July 2021, p 12 (Exhibit F-04.079, DVS.1111.0001.2831).
44 Independent Review Commission on Sexual Assault in the Military*, Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military – Equipping the Force and Empowering Prevention: Recommendations to Prevent Sexual Harassment and Sexual Assault in the U.S. Military*, July 2021, p 10 (Exhibit F-04.079, DVS.1111.0001.2831).
45 Independent Review Commission on Sexual Assault in the Military, *Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military*, July 2021, p 27 (Exhibit F-04.079, DVS.1111.0001.2831).

46 Independent Review Commission on Sexual Assault in the Military, *Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military*, July 2021, p 21 (Exhibit F-04.079, DVS.1111.0001.2831).
47 L Arbour, *Report of the Independent External Comprehensive Review of the Department of National Defence and the Canadian Armed Forces*, Canada Department of National Defence, 2022, p 319 (Exhibit 58-01.11, Hearing Block 8, DVS.0008.0003.0001).
48 L Arbour, *Report of the Independent External Comprehensive Review of the Department of National Defence and the Canadian Armed Forces*, Canada Department of National Defence, 2022, p 12 (Exhibit 58-01.111, Hearing Block 8, DVS.0008.0003.0001).
49 L Arbour, *Report of the Independent External Comprehensive Review of the Department of National Defence and the Canadian Armed Forces*, Canada Department of National Defence, 2022, p 12 (Exhibit 58-01.111, Hearing Block 8, DVS.0008.0003.0001).
50 L Arbour, *Report of the Independent External Comprehensive Review of the Department of National Defence and the Canadian Armed Forces*, Canada Department of National Defence, 2022, p 308 (Exhibit 58-01.111, Hearing Block 8, DVS.0008.0003.0001).
51 L Arbour, *Report of the Independent External Comprehensive Review of the Department of National Defence and the Canadian Armed Forces*, Canada Department of National Defence, 2022, p 304 (Exhibit 58-01.111, Hearing Block 8, DVS.0008.0003.0001).
52 Canada Department of National Defence, *Independent External Comprehensive Review of the Department of National Defence and the Canadian Armed Forces – Final Report and Next Steps*, media release, 1 June 2022.
53 Department of the Army Inspector General, 'Army Inspector General PSA', webpage, last updated 25 January 2022, www.ig.army.mil/, viewed October 2023; Department of Defense Office of Inspector General, 'About DoD Office of Inspector-General', webpage, www.dodig.mil/About/, viewed July 2023.
54 Department of the Army Inspector General, 'What is an Inspector General?', webpage, www.ig.army.mil/FAQ/Whats-an-IG/, viewed October 2023; Department of the Army Inspector General, 'History of the Army Inspector General', webpage, www.ig.army.mil/About/History/, viewed October 2023.
55 Department of the Army Inspector General, 'What is an Inspector General?', webpage, www.ig.army.mil/FAQ/Whats-an-IG/, viewed October 2023.
56 Armed Forces (Service Complaints and Financial Assistance) Act 2015 (UK) s 356B (3)(a)(b).
57 Service Complaints Ombudsman for the Armed Forces, *Who is the Service Complaints Ombudsman?* fact sheet.
58 Armed Forces Act 2006 (UK) s 340A(3); The Armed Forces (Service Complaints) Regulations 2015 r 7.
59 Armed Forces Act 2006 (UK) s 340H.
60 Armed Forces Act 2006 (UK) s 340M(1).
61 Armed Forces Act 2006 (UK) s 365B (inserted by Armed Forces (Services Complaints and Financial Assistance) Act 2015 (UK) s 1).
62 Armed Forces Act *2006* (UK) s 365B(2)–(3).
63 New Zealand, Inquiry into Operation Burnham, *Report of the Government Inquiry into Operation Burnham and related matters*, July 2020, p 8.
64 New Zealand, Inquiry into Operation Burnham, *Report of the Government Inquiry into Operation Burnham and related matters*, July 2020, p 368.
65 Inspector-General of Defence Act 2023 (NZ).
66 Inspector-General of Defence Act 2023 (NZ) s 7.
67 The Hon Andrew Little and the Hon David Parker, *Inspector-General of Defence to be established*, media release, 19 July 2023.
68 Government of Canada, 'DND/CAF Ombudsman Office Information', webpage, last updated 30 May 2024, www.canada.ca/en/ombudsman-national-defence-forces/information-about-office.html, viewed 21 June 2024.
69 L Arbour, *Report of the Independent External Comprehensive Review of the Department of National Defence and the Canadian Armed Forces*, 2022, p 274 (Exhibit 58-01.111, Hearing Block 8, DVS.0008.0003.0001).
70 J Therrien, External Monitor Report, *Third Status Report – May 8, 2024*, p 7.
71 J Therrien, External Monitor Report, *Third Status Report – May 8, 2024*, p 15.

72 Department of National Defence, 'Defence Team Conduct and Culture Consultation Summary Report', webpage, last updated 21 November 2022, www.canada.ca/en/department-national-defence/services/conduct-and-culture/join-the-discussion-defence-team-conduct-and-culture-consultation/defence-team-conduct-and-culture-consultation-summary-report.html, viewed 21 June 2024.
73 M Meehan and D Neill, 'The New Zealand Defence Force: an adaptable organization requiring adaptable leaders', in D Lindsay and D Woychesin (eds), *Adaptive leadership in the military context: international perspectives,* Canadian Defence Academy Press, 2014, p 111.
74 M Meehan and D Neill, 'The New Zealand Defence Force: an adaptable organization requiring adaptable leaders', in D Lindsay and D Woychesin (eds), *Adaptive leadership in the military context: international perspectives*, Canadian Defence Academy Press, 2014, p 113.
75 The Cove, *'What the Australian Army can learn from the US Army Battalion Commander Assessment Program', webpage, last updated 19 December 2022*, www.cove.army.gov.au/article/what-army-can-learn-from-us-army-battalion-commander, viewed 23 April 2024.
76 US Defense Visual Information Distribution Service, 'Army Command Assessment Program "Turning Heads" in Fourth Year of Leadership Assessments', webpage, last updated 17 October 2023, www.dvidshub.net/news/455951/army-command-assessment-program-turning-heads-fourth-year-leadership-assessments, viewed 23 April 2024.
77 US Department of Veterans Affairs, National Strategy for Preventing Veteran Suicide (va.gov), 2018–2028, p 8.
78 US Department of Veterans Affairs, National Strategy for Preventing Veteran Suicide (va.gov), 2018–2028, p 26.
79 American Psychiatric Association, *The Veterans Health Administration REACH VET Program: Suicide Predictive Modeling in Practice, 2023*, doi.org/10.1176/appi.ps.202100629.
80 American Psychiatric Association, *The Veterans Health Administration REACH VET Program: Suicide Predictive Modeling in Practice, 2023*, p 206.
81 American Psychiatric Association, *The Veterans Health Administration REACH VET Program: Suicide Predictive Modeling in Practice, 2023,* p 206.
82 American Psychiatric Association, *The Veterans Health Administration REACH VET Program: Suicide Predictive Modeling in Practice, 2023*.
83 National Health Service, United Kingdom, *Mental health support for veterans, service leaders and reservists*, webpage, last updated 24 August 2021, www.nhs.uk/nhs-services/armed-forces-community/mental-health/veterans-reservists, viewed 1 July 2024.
84 National Health Service, United Kingdom, *Mental health support for veterans, service leaders and reservists*, webpage, last updated 24 August 2021, www.nhs.uk/nhs-services/armed-forces-community/mental-health/veterans-reservists, viewed 1 July 2024.
85 University of Chester, Westminster Centre for Research in Veterans, *An Evaluation Of The Veteran Friendly GP Practice Accreditation Programme,* 2021, p 7.
86 University of Chester, Westminster Centre for Research in Veterans, *An Evaluation Of The Veteran Friendly GP Practice Accreditation Programme*, 2021, p 16.
87 University of Chester, Westminster Centre for Research in Veterans, *An Evaluation Of The Veteran Friendly GP Practice Accreditation Programme*, 2021, p 16.
88 University of Chester, Westminster Centre for Research in Veterans, *An Evaluation Of The Veteran Friendly GP Practice Accreditation Programme*, 2021, p 18.
89 Canada Department of National Defence, *Strong, Secure, Engaged: Canada's Defence Policy*, 2017, p 25.
90 Canada Department of National Defence, *Strong, Secure, Engaged: Canada's Defence Policy*, 2017, p 25.
91 Canada, Department of National Defence, *Strong, Secure, Engaged: Canada's Defence Policy*, 2017, p 25.
92 Canadian Armed Forces Transition Group, *My Transition Guide: Transitioning from Military to Civilian Life*, 2nd edition, 2020, p 7 (Exhibit 101-03.047, Hearing Block 12, STU.0000.0004.0001).
93 Canadian Armed Forces Transition Group, *My Transition Guide: Transitioning from Military to Civilian Life*, 2nd edition, 2020, p 7 (Exhibit 101-03.047, Hearing Block 12, STU.0000.0004.0001).
94 Canadian Armed Forces Transition Group, *My Transition Guide: Transitioning from Military to Civilian Life*, 2nd edition, 2020, p 110 (Exhibit 101-03.047, Hearing Block 12, STU.0000.0004.0001).

95 US Department of Defense, 'DoDTAP Transition Assistance Program, 'Transition Components', webpage, www.dodtap.mil/dodtap/app/transition/gps, viewed 24 May 2024
96 US Department of Veterans Affairs, 'VA Solid Start', webpage, last updated 10 April 2020, www.benefits.va.gov/transition/solid-start.asp, viewed 11 April 2024.
97 US Department of Veterans Affairs, 'VA Solid Start', webpage, last updated 10 April 2020, www.benefits.va.gov/transition/solid-start.asp, viewed 11 April 2024.
98 US Government Accountability Office, *VA Could Enhance Outreach for Its Solid Start Program by Increasing Collaboration with Veterans Organizations*, *Highlights of GAO-23-105699*, a report to congressional requesters, January 2023 (Exhibit F-05.029, DVS.1111.0001.1028).
99 Department of Veterans' Affairs, 'Australian Defence Veterans' Covenant', webpage, last updated 1 July 2024, www.dva.gov.au/recognition/veterans-covenant, viewed 7 August 2024 (Exhibit 31-01.026, Hearing Block 4, EXP.0004.0020.0021).
100 Department of Veterans' Affairs, 'Australian Defence Veterans' Covenant', webpage, last updated 1 July 2024, www.dva.gov.au/recognition/veterans-covenant, viewed 7 August 2024 (Exhibit 31-01.026, Hearing Block 4, EXP.0004.0020.0021).
101 UK Government, 'About the Covenant - Armed Forces Covenant', webpage, www.armedforcescovenant.gov.uk/about-the-covenant/, viewed 18 June 2024.
102 Department of Veterans' Affairs, *Veterans' Advocacy and Support Services Scoping Study*, December 2018, p 11 (Exhibit 27-02.011, Hearing Block 4, ONC.0001.0017.0315).
103 Department of Veterans' Affairs, *Veterans' Advocacy and Support Services Scoping Study*, December 2018, p 67 (Exhibit 27-02.011, Hearing Block 4, ONC.0001.0017.0315).
104 Department of Veterans' Affairs, *Veterans' Advocacy and Support Services Scoping Study*, December 2018, p 74 (Exhibit 27-02.011, Hearing Block 4, ONC.0001.0017.0315).
105 A Selous and others, *Living in our Shoes, Understanding the needs of UK Armed Forces Families*, UK Ministry of Defence, June 2020 (Exhibit 68-02.021, Hearing Block 10, DVS.0010.0001.0367); UK Ministry of Defence, *UK Armed Forces Families Strategy 2022–32*, January 2022.
106 New Zealand Defence Force, Defence Health Hub, 'NZDF4U Wellbeing Support', webpage, www.health.nzdf.mil.nz/support-providers/nzdf-community-wellbeing-support/nzdf4u-wellbeing-support, viewed 21 June 2024.
107 Department of Defense, Walter Reed Army Institute of Research, Army Public Health Center, *Optimizing Golden Triangle Calls: A Quick Guide for Leaders*, guide, 2021.
108 Military One Source, 'Military Family Readiness System', webpage, last updated 28 May 2024, www.militaryonesource.mil/parenting/family-life/military-family-readiness-system, viewed 21 June 2024.
109 Military One Source, 'Military Family Readiness System', webpage, last updated 28 May 2024, www.militaryonesource.mil/parenting/family-life/military-family-readiness-system, viewed 21 June 2024.
110 Department of Defense Military Family Readiness Council, Office of the Law Revision Counsel, United States Code, 10 USC 1781a.
111 US Department of Defense, *Calendar Year 2019 Annual Report, Department of Defence Suicide Event Report*, March 2021, pp 1, 66–67 (Exhibit B-01.029, STU.0006.0001.3363).
112 US Department of Defense, *Calendar Year 2019 Annual Report, Department of Defence Suicide Event Report*, March 2021, pp 1, 66–67 (Exhibit B-01.029, STU.0006.0001.3363).
113 US Department of Veterans Affairs and Department of Defense, *Joint Strategic Plan Fiscal Years 2022-2027*, November 2021.
114 US Department of Defense, 'VA-DoD Joint Executive Committee', PowerPoint Presentation (defense.gov).
115 US Department of Defense, 'VA-DoD Joint Executive Committee', PowerPoint Presentation (defense.gov).
116 US Department of Defense, *2021 On-Site Installation Evaluation Summary*, March 2022, p 4 (Exhibit K-01.097, DVS.2222.0001.1531).
117 US Department of Defense, *2021 On-Site Installation Evaluation Summary*, March 2022, p 4 (Exhibit K-01.097, DVS.2222.0001.1531).
118 R Ursano and others, 'The Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) & The Study to Assess Risk and Resilience in Servicemembers – Longitudinal Study (STARRS-LS)', *Center for the Study of Traumatic Stress,* vol 8, 1, 2024, p 1.
119 R Ursano and others, 'The Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) & The Study to Assess Risk and Resilience in Servicemembers – Longitudinal Study (STARRS-LS)', *Center for the Study of Traumatic Stress*, vol 8, 1, 2024, p 3.

Royal Commission
into Defence and Veteran Suicide