Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF NICOLE SADLER

I, Nicole Sadler, Head of Policy and Practice at Phoenix Australia, of Level 3, 161 Barry Street, Carlton in the state of Victoria, say as follows:

Background

1 I am the Head of Policy and Practice at Phoenix Australia (**Phoenix**), the Centre for Posttraumatic Mental Health. I have been at Phoenix since 2017. In this role I am responsible for overseeing the delivery of best practice policy and procedures for organisations in the management of trauma, and the delivery of evidence-based workforce education and training programs.

2 Prior to joining Phoenix Australia, I served in the full-time Army for 23 years as a psychology officer. My last position was as the senior uniformed psychologist in the Australian Defence Force, at the rank of Colonel.

3 I continue to service in the Army Reserves as a Colonel and I was a Defence investigator on the joint Departments of Veterans' Affairs and Defence Transition and Wellbeing Research Programme.

4 I am a registered clinical psychologist and attached to this statement at NS-1 is a copy of my curriculum vitae.

5 My expertise is in military mental health, including in the issues and challenges faced by serving and ex-serving military personnel and their families, and the systems and services to improve and maintain mental health and wellbeing. I also have expertise in working with other organisations at high risk of trauma exposure due to the nature of their work, including police and emergency services, healthcare professionals and community services organisations.

6 I am providing evidence on behalf of my employer, Phoenix Australia.

Defining trauma

7 A trauma is an event that includes either experiencing or witnessing actual or threatened death, injury or sexual violence, such as being in a serious accident, or being involved in a war or a natural disaster or being physically assaulted or sexually abused. Exposure to a trauma may be direct (e.g., directly experienced or witnessed) or indirect (e.g., hearing

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

or reading traumatic materials) and may be experienced as an isolated event (e.g., car accident) or repeatedly (e.g., childhood sexual abuse).[1]

8 Traumatic events are often associated with experiencing strong emotions, such as fear, helplessness or hopelessness, or being overwhelmed. Traumatic events can be unexpected or sudden, but this is not always the case. For example, events that could be traumatic for those in the military or the police are arguably events that are expected and are part of the job, but sometimes it's the nature of the event that can make it potentially traumatic (for example, if a police officer is involved in a fatality that reminds them of their own children).

9 Trauma can also occur from a perceived threat, where someone believes that their life or safety, or the safety of those they care about, is threatened. As an example, if a person is sheltering in their home as a bushfire is approaching, this can be traumatic, even if the bushfire never makes it to them – perhaps the wind changes direction at the last moment – as they perceive that there is a threat to loss of their home and maybe even their life.

10 When traumatic events are repetitive, prolonged and accumulative, they are referred to as complex trauma.

Experiences of potentially traumatic events

11 The experience of a potentially traumatic event is not uncommon in Australia. The most robust national statistics that we have, from the Australian Bureau of Statistics in 2007, suggests that about 75% of the Australian population at some time in their life will experience at least one potentially traumatic event, and 69% of them would have experienced it by the age of 16.[2] We also know that most people exposed to a potentially traumatic event do not go on to develop disorders.[3]

Trauma-impacted groups or cohorts that are more likely to develop mental illness

12 Some events are more likely to be experienced as very traumatic and more likely to result in ongoing difficulties or mental disorders such as posttraumatic stress disorder (**PTSD**). These can include intentional acts of interpersonal violence, such as torture or being physically assaulted, and prolonged or repeated events such as childhood sexual abuse. Intentional interpersonal trauma is more likely to result in a traumatic response than natural events or accidents.[4]

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[1] Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2013).
[2] Australian Bureau of Statistics (2007) Australian National Survey of Mental Health and Wellbeing.
[3] McEvoy, P. M., Grove, R., & Slade, T. (2011). Epidemiology of anxiety disorders in the Australian general population: findings of the 2007 Australian National Survey of Mental Health and Wellbeing. Australian and New Zealand Journal of Psychiatry, 45(11), 957-967.
[4] Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2013).

13 There is also evidence of higher rates of mental disorders and psychological distress in those who have been exposed to repeated traumas due to the nature of their work, including military personnel, police and emergency services personnel.[5]

The potential impact of a traumatic experience on mental health

14 We refer to events as being potentially traumatic as although an individual may be exposed to an event that meets the criteria for a traumatic event, the person may not develop a mental health problem. What may be traumatic for one individual may not be traumatic for another.

15 There are a number of factors that impact whether someone who has experienced a potentially traumatic event (**PTE**) will develop a trauma-related disorder. The three main types of factors are:[6]

(a) Pre-event risk factors may be biological or genetic or other stressors already occurring in their life. If a person has a history of mental health problems and prior trauma, there can be an increased risk of developing a disorder.

(b) Event-specific risk factors such as the degree to which a person was personally impacted or targeted, the degree of horror they were exposed to, the duration of or repetition of the event, and the predictability of the event and the person's perceived level of control over it, and if the person experiences hyper-arousal (a high level of physiological response) or shutdown (dissociation or numbing).

(c) Post-event risk factors include what happens after the event, such as the level of support (practical and emotional) and social connection.

16 The impacts from trauma can range from transitory, sub-syndromal mental health issues such as a person feeling very unsettled, uncertain or unsafe, being angry or experiencing insomnia, to the development of mental disorders, and sometimes these can be chronic.

17 In most cases, psychological distress settles down in the days and weeks following the traumatic event through individuals' using their own coping strategies and support networks.[7]

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[5] Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2013); Van Hooff, M., Lawrence-Wood E., Hodson, S., Sadler, N., et al. (2018). Mental Health Prevalence, Mental Health and Wellbeing Transition Study, the Department of Defence and the Department of Veterans' Affairs, Canberra; Beyond Blue. (2018). Answering the Call National Survey: National Mental Health and Wellbeing Study of Police & Emergency Services.

[6] Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. Psychological bulletin, 129(1), 52; Peleg, T., & Shalev, A. Y. (2006). Longitudinal studies of PTSD: overview of findings and methods. CNS Spectrums, 11, 589-602; Bovin, M. J., & Marx, B. P. (2011). The importance of the peritraumatic experience in defining traumatic stress. Psychological bulletin, 137(1), 47.

[7] Norris FH, Friedman MJ, Watson PJ. 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. Psychiatry-Interpers. Biol. Process. Fal 2002;65(3):240-260

18 Sub-syndromal conditions do not meet the diagnostic criteria for a disorder, but can still impact negatively on someone's ability to get on with their family, social, work and interpersonal responsibilities. People may become angry or irritable, abuse substances, drink too much, or undertake risk taking behaviour (e.g., driving too fast, gambling or even risky sexual behaviours). These may be transitory or they may over time develop into mental disorders.

19 Acute stress disorder (**ASD**) is diagnosed if symptoms persist for two days to four weeks after the PTE. Symptoms can include experiencing intrusive memories of the event, distress when reminded of the event, a desire to avoid reminders of the event (including pushing away thoughts and feelings), hyper-arousal impacting the ability to sleep or concentrate, anger and irritability, startle and hypervigilance responses, and emotional withdrawal or flattening. If these symptoms persist for four weeks following exposure to a traumatic event, PTSD can be diagnosed.

20 Mental disorders associated with trauma commonly include PTSD, depression, anxiety, substance use disorder, panic disorder and agoraphobia.

21 When children are exposed to traumas at vulnerable times of their development, it can be associated with developmental delay, physical health problems, interpersonal difficulties, emotional instability, low self-esteem and disordered personality development.[8]

22 Complex trauma is a risk factor in adults for serious mental illness (e.g. schizophrenia, borderline personality disorder), high prevalence disorders such as depression, anxiety, eating disorders and substance abuse and complex PTSD. Complex trauma is also associated with other psychosocial difficulties such as learning problems, social and economic disruption, interpersonal difficulties, criminal behaviour, and chronic physical health problems.

23 Alongside all of these adverse impacts, we can also see posttraumatic growth. Individuals may reflect that even though something terrible occurred, the experience was not necessarily all negative. They may say for example: '*I learnt something about myself that I didn't know, I have some grit or resilience I didn't even know that I had, or I have learnt to appreciate my life and what I have more*'.

Sustained or repeated exposure to traumatic experiences and the development of mental illness

24 Exposure to events that are repetitive, prolonged and accumulative are more likely to result in ongoing difficulties or mental disorders, especially if they include intentional acts

[8] Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2013).

of interpersonal violence (e.g., torture, rape) and/or elements of neglect and an inability to escape (e.g., childhood sexual abuse, domestic violence, concentration camps).[9]

25 In some occupations, such as the police and emergency services, repeated exposure to potentially traumatic events can be an inevitable and unavoidable component of the work. There is evidence of higher rates of mental disorders, self-reported psychological distress and suicidality when compared to the general Australian population. However, there are also some possible protective factors such as the meaning of the job, the training, and an expectation that trauma exposure will be a component of their job. Individuals in these occupations are more likely to experience difficulties where repeated experiences of traumatic incidents result in progressively more severe reactions over time.[10]

26 The other factor we see in the research, particularly in the military sector, but also increasingly in the research being conducted on police and emergency services, is a significant increase in the rates of mental disorder following transition out of uniformed service.[11]

The relationship between unaddressed or untreated significant trauma and mental illness and suicide

27 The risk factors for suicide are complex and multi-faceted (Franklin et al., 2017).

28 Trauma can be associated with the development of mental disorders and many people with mental disorders do not seek or receive appropriate treatment, and even if they do, evidence-based treatments do not work effectively for everyone.[12]

29 One of the strongest established risk factors for completed suicides, and suicidal thoughts and behaviours is the presence of a psychiatric disorder. However, the majority of individuals with a mental disorder do not report suicidal thoughts or behaviours, and conversely, individuals without a disorder can be at risk of suicide.[13]

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[9] Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2013).
[10] Beyond Blue. (2018). Answering the Call National Survey: National Mental Health and Wellbeing Study of Police & Emergency Services.
[11] Van Hooff, M., Lawrence-Wood E., Hodson, S., Sadler, N., et al. (2018). Mental Health Prevalence, Mental Health and Wellbeing Transition Study, the Department of Defence and the Department of Veterans' Affairs, Canberra; Beyond Blue. (2018). Answering the Call National Survey: National Mental Health and Wellbeing Study of Police & Emergency Services.
[12] Forbes D, Van Hooff M, Lawrence-Wood E, Sadler N, Hodson S, Benassi H, Hansen C, Avery J, Varker T, O'Donnell M, Phelps A, Frederickson J, Sharp M, Searle A, McFarlane A, 2018, Pathways to Care, Mental Health and Wellbeing Transition Study, the Department of Defence and the Department of Veterans' Affairs, Canberra.
[13] O'Connor, R. & Nock, M, (2011). *The psychology of suicide*. Lancet Psychiatry, 1, 73-85.

Vicarious or indirect trauma

The meaning of vicarious or indirect trauma

30 Vicarious or indirect trauma can be experienced through being exposed to other people's trauma (written, visual or auditory), for example:

(a) Learning that a close relative or friend was exposed to trauma, especially if it involved violent or accidental death or threatened death.

(b) Police officers who have to review witness statements or look through evidence such as images, soundbites or videos.

(c) Working with people who have been traumatised and reading their statements or hearing their detailed stories, such as asylum seekers.

The impact of vicarious trauma on individuals and communities

31 Similar to direct trauma exposure, vicarious or indirect trauma exposure can result in a range of impacts for individuals and communities. As with other PTEs, the level of impact is influenced by pre-event factors, the nature of the event and post-event factors.

The impact of vicarious trauma on first responders or those working with trauma-impacted individuals and/or communities

32 As noted previously, the impact of vicarious trauma on first responders or those working with trauma-impacted individuals and/or communities will depend on various factors. These may include the duration and intensity of their role (e.g., dealing with highly distressed individuals who has just experienced a trauma, or protracted disaster events), whether they are also a part of that community (e.g., during a bushfire a local volunteer firefighter may personally know people who are impacted), and if they are also concerned about their own safety or safety of family and work colleagues.

The impact of vicarious trauma on the mental health system workforce

33 In relation to the potential impact of vicarious trauma on the mental health workforce, we should consider the entire health and mental health systems, as individuals who are exposed to trauma will present to both of these systems. This can include general practitioners (**GPs**) and their entire healthcare teams – the receptionist, the nurses, the practice managers, people who work in primary health networks, allied health workers, psychologists, occupational therapists, social workers, psychiatrists and pharmacists. All of these professions have the potential to be exposed to indirect or vicarious trauma through their roles.

34 When a community has been impacted by a trauma (e.g., a natural disaster), those working in the health and mental health systems often work and live in these same communities, so they may also be directly impacted by the event.

The meaning of re-traumatisation

35 The term re-traumatisation can be used to refer to when someone has been reminded of a past traumatic event(s) and this has reactivated how that trauma made them feel. The reminders can be conscious or unconscious, and can become generalised rather than specific. It can also be used to refer to when a person is re-experiencing past trauma as though it is occurring again.

36 Re-experiencing is one of the core components of the PTSD diagnosis, and takes many forms including intrusive (unwanted and uninvited) thoughts, images, or sensations related to the trauma, that are triggered by sights, sounds, smells and sensations. When re-experiencing symptoms occur, or when the individual is exposed to other reminders of the event, they are prone to feeling intense emotional and or physiological distress.

Preventing or minimising re-traumatisation

37 Reminders of the trauma can be unconscious or unexpected and may be difficult to control or avoid (e.g., certain smells or footage on the TV).

38 Some of the strategies for preventing or minimising the impact of re-experiencing symptoms are to identify with individuals and/or communities potential triggers and when they may be more likely to occur, for example at the anniversary of an event, or if they are exposed to media coverage of a similar event. This should occur alongside more general psycho-education on the impacts of trauma, the common responses to expect, techniques for dealing with any unpleasant or distressing reminders of a trauma, and indications of when professional assistance may be helpful, especially if general functioning and quality of life is being significantly impacted.

Supporting recovery from trauma

Short, medium and long-term recovery needs for people who have experienced trauma

39 In the short-term, recovery needs generally focus on establishing physical and psychological safety. In line with best-practice guidelines, individuals and communities are often supported through the provision of Psychological First Aid (**PFA**).[14] This model aims to support and facilitate the person's own natural coping resources and their own social support mechanisms, and provide a sense of physical and psychological safety

[14] Hobfoll SE, Watson P, Bell CC, et al. Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. (Clinical report). Psychiatry: Interpersonal and Biological Processes. 2007(4):283

and security through a focus on providing nourishment, shelter, means to connect with loved ones, support / strategies to reduce hyper-arousal or distress, information on how to access other necessary supports and services, and information on what to expect following exposure to trauma, including what they can do to support themselves and others, and indicators of when they may benefit from professional assistance. This is the type of intervention or support provided in post-disaster recovery centres.

40 For those who may be feeling very overwhelmed or distressed, they should be identified for an assessment by a mental health professional, as there may be more acute needs that require attention. As previously mentioned, we know that most people recover well from trauma exposure, but there will be a percentage who require additional, professional assistance, and the aim should be to provide early intervention whenever possible.

41 In the medium term and longer-term, we should be monitoring and screening people and identifying those who are not doing so well and providing appropriate evidence-based interventions. These interventions may target subclinical conditions or issues (such as poor sleep, or anger, substance misuse or interpersonal difficulties), or mental conditions (e.g., anxiety, depression, PTSD, substance abuse).[15]

How best practice differs across different cohorts and different types of trauma

42 There are best-practice considerations for different groups and cohorts and for different types of trauma exposures. For example, assessment and treatment needs and options may be different for children, or old people or emergency services personnel. The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2013) provide specific examples on considerations for the assessment and treatment of different populations and cohorts.[16]

The effectiveness of early intervention in preventing and reducing the impact of mental illness

43 Early intervention is important and can assist to mitigate post-event risk factors. Consistent with best-practice, early intervention can be provided by informal support, such as practical and emotional support, facilitating ways of managing distress and accessing social support, and promoting expectations of recovery (such as described through the provision of PFA). Research evidence does not support the use of a single-session, structured, psychological intervention in the acute phase, such as psychological debriefing.[17] It can be helpful to give the person the opportunity to talk about their

[15] Phoenix Australia, 'Recovery after Trauma' <https://phoenixaustralia.org/wp-content/uploads/2015/03/Phoenix-Adults-Guide.pdf> [accessed 18 June 2020].
[16] Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2013).
[17] Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2013).

experiences if they wish to do so, but they should not be compelled to do so. The opportunity to talk should be with someone they feel comfortable with, and when they are ready. A stepped-care model of early intervention should be used, in which the care provided meets the needs of the individual and the care provided at each level is evidence-based.

Psychotherapeutic interventions for treating different types of trauma

44 The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2013) outlines the evidence for psychotherapeutic interventions. These are in the process of being updated, and are aligned with the findings from the International PTSD treatment guidelines.[18] The recommended treatments for adults with ASD or PTSD include: Prolonged Exposure; Cognitive Processing Therapy; Eye Movement Desensitisation and Reprocessing (**EMDR**); and Trauma Focused Cognitive Therapy.

45 These psychological therapies should be delivered by registered health / mental health professionals who have been trained and deemed competent in these therapies. Competence is often determined not only through assessments undertaken during training, but also a process of clinical supervision.

46 Other interventions that are showing promise for adults include guided internet-based trauma-focussed CBT, Present Centred Therapy, Stress Inoculation Training, group-based trauma-focussed CBT and Narrative Exposure Therapy for refugee trauma.

Adopting a 'trauma-informed' approach to mental health services

47 Trauma-informed care is not a specific treatment, but rather an approach to providing services to those who have been impacted by trauma. Trauma-informed care involves an understanding of the impact of trauma and ways to engage with trauma-affected people to minimise the likelihood of worsening the effects of the trauma on that person. Trauma-informed training therefore covers aspects such as: understanding trauma and its impacts; developing skills to work sensitively with individuals impacted by trauma; skills and strategies to assist trauma-affected individuals to manage their behaviours / emotions, to problem solve and build social connections; and self-care. Trauma-informed approaches can be used not only by mental health professionals, but across all sectors providing services to individuals or communities impacted by trauma such as financial, legal, health or community services and first responders.

[18] International Society for Traumatic Stress Studies, 'Posttraumatic Stress Disorder Prevention and Treatment Guidelines' <https://istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_PreventionTreatmentGuidelines_FNL-March-19-2019.pdf.aspx> [accessed 18 June 2020].

48 Effective implementation of trauma-informed care models within organisations includes a whole of organisation policy framework that supports trauma-informed practice, ensuring appropriate training for staff and their supervisors, including opportunities for ongoing training and professional development, opportunities for supervision and reflective practices, actively supporting staff self-care, and setting clear expectations and role boundaries through policies and procedures.[19]

49 As indicated in previous responses, system-wide application of trauma-informed care approaches requires the appropriate policy frameworks and training across sectors that provide services to individuals or communities impacted by trauma such as financial, legal, health or community services and first responders.

Supporting the workforce to deliver specialist trauma-informed care and associated interventions

50 The mental health system is made up of different disciplines that have quite distinct training backgrounds, philosophies and approaches. Even within these disciplines, people come with different ideas and different clinical training. We know that individuals impacted by trauma will often benefit from multi-disciplinary approaches to their case management and treatment. If someone has a serious mental health disorder, they may be supported by a GP, a psychiatrist, psychologist and/or a social worker.

51 To support them to deliver trauma-informed care and evidence-based treatments, and ensure they are able develop a coordinated, holistic approach with clear and shared treatment goals for an individual, they require the correct training and supervision, as well as an understanding of what treatments and services can be delivered by the other service providers.

Challenges in supporting recovery for people who have experienced trauma

52 Key challenges to recovery include:

(a) Many individuals with mental health problems do not access mental health services.

(b) Even if they access care, they will not necessarily receive evidence-based treatment from a trained professional, or stay in treatment long enough to get the full benefit of treatment.

(c) Even the most effective treatments do not work effectively for everyone.

[19] Hobfoll SE, Watson P, Bell CC, et al. Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. (Clinical report). Psychiatry: Interpersonal and Biological Processes. 2007(4):283.

Settings that should be considered for the delivery of trauma-informed care, treatment and support beyond mental health services

53 Any service that works with or provides services to trauma affected population.

Phoenix Australia's training program: its objectives, who accesses them, and measuring translation into practice

54 The trauma-informed care (**TIC**) provided by Phoenix Australia is evidence-informed, and designed to teach participants the key aspects of TIC, including how to safely talk about trauma, simple strategies to teach clients and individuals to help them deal with their distress, how to foster independence and recovery, and encouraging connection with others. They are also taught how to apply these skills in their own work setting, and techniques for self-care. The course can be delivered in face-to-face, online and blended formats and it is the equivalent of one day of training. Training is delivered by a senior mental health expert.

55 Training is attended by a broad range of practitioners and frontline workers from a range of professional backgrounds who work in community-based services, including youth, family, homeless, aged, welfare, alcohol and substance, mental health, and disability, as well as emergency service, financial and judiciary sectors. Each course includes opportunities for skills practice and feedback, and is evaluated through satisfaction surveys. Depending on the needs of client group, translation into practice may be facilitated through follow-up group supervision sessions.[20]

Supporting workforces to manage vicarious trauma and supporting people in times of crisis

56 Phoenix Australia has developed a Trauma Management Framework for working with organisations who are exposed to trauma, vicarious trauma, or support individuals who have been impacted by trauma. The framework is evidence-informed and based not only on the research, but also on our extensive experience with working with organisations, who due to the nature of their work, are likely to be exposed to trauma. The framework takes a whole-of-organisation and whole-of-career approach and considers the impact of not only trauma exposure, but also the impact of other occupational and organisational stressors, such as shift work, bullying, perception of leadership, whether they think their work conditions are fair etc. Some of the key considerations to supporting mental health and wellbeing include:

(a) having a strategic approach, supported by policies and procedures;

[20] See Phoenix Australia, 'Training Programs' <https://www.phoenixaustralia.org/for-practitioners/training-programs/ > [accessed 18 June 2020].

(b) the role of organisational culture;

(c) the role of leaders at all levels;

(d) building psychological readiness through training;

(e) systems for monitoring the wellbeing of the workforce;

(f) a stepped-care approach, with access to different levels of intervention;

(g) the role of families; and

(h) evaluation and continuous improvement.

Nature and impact of trauma following emergencies and disasters

The unique experience of trauma for people who have experienced emergencies or disasters

57 Emergencies and natural disasters can impact multiple aspects of the individual's life or the community, such as mental health, physical health, community/social, educational and economic aspects, and these impacts can last for many years. Support for communities should therefore address and coordinate across all of these different aspects. The aim should also be to bolster and support community recovery through their own resources (e.g., supporting GP practices and local mental health providers to undertake trauma-related assessments and evidence-based interventions, rather than 'flying-in' temporary mental health assets for a short period of time) and prioritising the re-establishment of places for community gatherings.[21]

58 Any response community should be coordinated and multi-faceted, and aim to ensure:

(a) the right support is being provided to meet the different needs of community members;

(b) lessons are learnt from previous disaster responses;

(c) best-practice is adopted based on what is known nationally and internationally;

(d) coordination occurs quickly;

(e) the right training and information is provided to frontline responders; and

(f) information is disseminated to the right people about what is working and what is not working.

[21] The University of Melbourne, 'Beyond Bushfires: Community Resilience and Recovery' <https://www.unimelb.edu.au/cdmps/research/research-projects/beyond-bushfires> [accessed 18 June 2020].

59 Additional information on the impact of vicarious trauma on first responders is provided in our fact sheet on emergency services personnel.[22]

Supporting recovery from trauma following emergencies and disasters

60 Considerations include:

(a) bolstering and supporting local resources – for a community to deal with the ongoing impacts of trauma and disasters, it is critically important that the focus is on ensuring the local leaders and service providers have the necessary skills, training and resources;

(b) responses facilitate cross-agency coordination to maximise outcomes and minimise duplication of effort;

(c) the community is actively involved in coming up with, prioritising and implementing solutions;

(d) communities are encouraged to prioritise the re-establishment of community services, which includes places to gather, socialise and worship; and

(e) re-establishing routine and normalcy of activities e.g., opening schools and businesses as quickly as possible to promote a sense of safety and calm.[23]

sign here ►

print name Nicole Sadler

date 19 June 2020

[22]Phoenix Australia, 'Trauma and the emergency services' <https://www.phoenixaustralia.org/wp-content/uploads/2016/03/Phoenix-EmergencyServices-Personnel.pdf> [accessed 18 June 2020].

[23] Hobfoll SE, Watson P, Bell CC, et al. Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. (Clinical report). Psychiatry: Interpersonal and Biological Processes. 2007(4):283.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NS-1

This is the attachment marked 'NS-1' referred to in the witness statement of Nicole Sadler dated 19 June 2020.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

CURRICULUM VITAE

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EDUCATION:

Master of Psychology (Clinical), Charles Sturt University, 2005

Bachelor of Arts (Honours), Australian National University, 1992

Current:

Candidature Doctor of Philosophy, University of Adelaide, commenced February 2017 – examining suicidality in serving and ex-serving Australian Defence Force personnel.

Other:

Graduate Diploma of Management in Defence Studies, Australian Command and Staff College, 2004

EMPLOYMENT HISTORY:

November 2019 to current: Head Policy and Practice Portfolio, Phoenix Australia – Centre for Posttraumatic Mental Health.

April 2019 to November 2019: Head Policy and Service Development, Phoenix Australia – Centre for Posttraumatic Mental Health.

July 2017 to March 2019: Director, Military and High Risk Organisations, Phoenix Australia – Centre for Posttraumatic Mental Health.

July 2017 to current: Senior Psychologist (Colonel), Australian Army Reserves, Army Headquarters, Australian Defence Force, Canberra / Defence Investigator Transition and Wellbeing Research Programme, Joint Health Command.

January 2017 to July 2017: Director Special Projects Mental Health (Colonel), Joint Health Command, Australian Defence Force, Canberra.

August 2012 to January 2017: Director Strategic and Operational Mental Health (Colonel), Joint Health Command / Head of Corps, Australian Army Psychology Corps, Canberra.

January 2010 to August 2012: Commanding Officer (Lieutenant Colonel), 1st Psychology Unit, Australian Defence Force, Sydney.

January 2007 to December 2009: Staff Officer Grade One (Lieutenant Colonel), Workforce Strategy, Personnel-Branch Army Headquarters, Australian Defence Force, Canberra.

January 2006 to December 2006: Senior Psychologist, Royal Military College-Duntroon (Major), Australian Defence Force, Canberra.

January 2005 to December 2005: Senior Psychologist (Major), 1st Health Support Battalion, Holsworthy, Australian Defence Force, Sydney.

January 2004 to December 2004: Full-time student (Major), Australian Command and Staff College, Australian Defence Force, Canberra.

January 2003 to December 2003: Staff Officer Grade Two (Major), Strategic Human Resources, Personnel-Branch Army Headquarters, Australian Defence Force, Canberra.

January 2001 to December 2002: Staff Officer Grade Two (Major), Mental Health, Directorate of Mental Health, Australian Defence Force, Canberra.

August 1999 – December 2000: Staff Officer Grade Two (Major), Directorate of Psychology, Australian Defence Force, Canberra.

January 1998 – August 1999: Staff Officer Grade Three (Captain), Directorate of Psychology, Australian Defence Force, Canberra.

March 1995 – December 1997: Intern Psychologist (Lieutenant) / Student Counsellor (Captain), Army Logistics Training Centre, Australian Defence Force, Albury-Wodonga.

January 1994 – March 1995: Intern Psychologist (Lieutenant), 14 Psychology Unit, Australian Defence Force, Adelaide.

January 1993 – December 1993: Graduate Administrative Assistant, Graduate Development Program, Department of Defence, Canberra.

PROFESSIONAL MEMBERSHIPS: Registered Psychologist with a practice endorsement in clinical psychology – Australian Health Practitioner Regulation Agency.

APPOINTMENTS: OzHelp Foundation Board Member – April 2020 – current

AWARDS: Member of the Order of Australia (AM) – Queen's Birthday Honours 2018

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PUBLICATIONS (Reverse Chronological Order):

Sadler, N., Forbes, D., O'Donnell, ML. (in press – May 2020). Mental health, well-being and suicidality following separation from the military: Advancing research and practice. Psychiatry: Interpersonal and Biological Processes.

Cowlishaw, S., Little, J., Sbisa, A., McFarlane, A. C., Van Hooff, M., Lawrence-Wood, E., O'Donnell, M., Hinton, M., **Sadler, N.,** Savic, A., Forbes, D., & Metcalf, O. (2020). Prevalence and implications of gambling problems among firefighters. *Addictive Behaviors, 105*(106326). doi: 10.1016/j.addbeh.2020.106326

Hansen, C., McFarlane, A., Iannosa, M., **Sadler, N.**, Benassi, H., Lawrence-Wood, E., Hodson, S., Searle, A. & Van Hooff, M. (2020), Psychosocial factors associated with psychological distress and functional difficulties in recently transitioned and current serving regular Australian Defence Force members. *Psychiatry Research.* 286. doi: 10.1016/j.psychres.2020.112860

Sadler, N. (2019, November 21). Veterans have poorer mental health than Australians overall. We could be serving them better. *The Conversation.* Retrieved from https://theconversation.com/veterans-have-poorer-mental-health-than-australians-overall-we-could-be-serving-them-better-119525

Forbes, D., Pedlar, D., Adler, A.B., Bennett, C., Bryant, R.A., Busuttil, W., Cooper, J., Creamer, M.C., Fear, N.T., Greenberg, N., Heber, A., Hinton, M., Hopwood, M., Jetly, R., Lawrence-Wood, E., McFarlane, A.C., Metcalf, O., O'Donnell, M.L., Phelps, A., Richardson, J.D., **Sadler, N**., Schnurr, P.P., Sharp, M--L., Thompson, J.M., Ursano, R.J., Van Hooff, M., Wade, D. & Wessely, S. (2019). Treatment of military-related posttraumatic stress disorder: Challenges, innovations, and the way forward. *International Review of Psychiatry*. 1-16. doi: 10.1080/09540261.2019.1595545

Cooper, J. & **Sadler, N**. (2019). Trauma-informed mental health care for Australian Defence Force personnel and veterans. In Benjamin, R. Haliburn, J. & King, S. *Humanising Mental health Care in Australia: A guide to trauma-informed approaches*, Routledge, Australia

Tuppin, K., Sinclair, L. & **Sadler, N**. (2017). The Three Pillars of Australian Army Psychology: To serve with a strong foundation. In S. Bowles, & P.T. Bartone (Eds). *Handbook of Military Psychology.* USA: Springer Publishing Co.

Gisler, K. & **Sadler, N.** (2000). Suicide in the ADF 1985-2000. *Australian Military Medicine*. 9(3), 138-142.

PEER REVIEWED CONFERENCE PRESENTATIONS / ABSTRACTS (Reverse Chronological Order)

Dell, L., Casetta, C., Cowlishaw, S., Fredrickson, J., **Sadler, N.,** Crane, M., Lewis, V., O'Donnell, M., Terhaag, S., & Forbes, D. *A longitudinal study evaluating resilience: Patterns and predictors of resilience in the early years of the military career*. 35th Meeting of the International Society for Traumatic Stress Studies, Boston, USA, 15 November 2019.

Sadler, N (2019). *Longitudinal Course of Suicidal ideation, plans and attempts in current and ex-serving Australian Defence Force (ADF) members*. 2019 AMMA Annual Conference, Canberra 5 October 2019.

Forbes, D., **Sadler, N.,** *Pathways to Care in Transitioned ADF Members & Regular ADF Members in 2015: Results from Pathways to Care Report. 2*018 AMMA Annual Conference - Armistice to Afghanistan-Evolution of Military Healthcare, Canberra, Friday 12 October 2018

Van Hooff, M., Lawrence-Wood, E., Forbes, D., McFarlane, A., **Sadler, N.,** Benassi, H., Hodson, S., & Hansen, C. (2017). The Transition and Wellbeing Research Programme: Pre-release update. *Journal of Military and Veteran's Health*. 25(4): 76.

Lawrence-Wood, E., **Sadler, N.** & Benassi, H. (2016). Exploring the impact of deployment to a combat zone: The Impact of Combat Study. *Journal of Military and Veteran's Health*. 24(4): 22.

Lawrence-Wood, E. & **Sadler, N**. (2016). Understanding the Impact of Exposure to a Combat Zone – Research Update. Presentation for the Australian Psychological Society Congress, 14th-16th September, Melbourne, Australia.

Fikretoglu, D., Zamorski, M., Adler, A. & **Sadler, N**. (2015). Resilience training to minimise the adverse consequences of trauma exposure in military personnel. Presentation for the International Society for Traumatic Stress Studies Conference, November, New Orleans, USA.

Lawrence-Wood, E. & **Sadler, N.** (2015). Understanding the Impact of Exposure to a Combat Zone. *Journal of Military and Veteran's Health*. 23(4): 77.

Sadler, N. & Morton, D. (2015). ADF Mental Health and Wellbeing Strategy 2016-2020: where we have come from and where we are going. *Journal of Military and Veteran's Health.* 23(4): 9.

Sadler, N., Wade, D., Hodson, S. & Burns, J. (2015). Building Mental Fitness – High Resilience. *Journal of Military and Veteran's Health*. 23 (4): 17.

McFarlane, AC., Van Hooff, M., Hodson, S., **Sadler, N**., Benassi, H., Forbes, D., Bryant, R., Sim, M., Kelsall, H., Rosenfeld, J. & Burns, J. (2015). The Impact of Combat Study: Investigating the longitudinal trajectory of mental, physical, biological and neurocognitive profile in ADF personnel deployed to a combat zone. *Journal of Military and Veteran's Health*. 23 (1): 53.

Van Hooff, M., McFarlane, AC., Hodson, S., **Sadler, N**., Benassi, H., Forbes, D., Bryant, R., Sim, M., Kelsall, H., Rosenfeld, J. & Burns, J. (2015). The Health and Wellbeing Study: Investigating the mental, physical, and social health of serving and ex-serving Australian Defence Force (ADF) personnel. *Journal of Military and Veteran's Health*, 23 (1): 52.

Sadler, N. & McDonald, A. (2015). Participation in The Technical Cooperation Program (TTCP) HUM Technical Panel 13: Psychological Health and Operational Effectiveness: Perspectives and Learnings from Australia and New Zealand*. Journal of Military and Veteran's Health*. 23 (1): 63.

Sadler, N., Hodson, S. & Deans, C. (2014). Impact of Military Service**:** Strategies and tools to assist the military and veteran community. Workshop, 49th Australian Psychological Society Annual Conference, 30th September – 3rd October, Hobart, Australia.

Hodson, S., **Sadler, N.** & Nursey, J. (2014). Working Together To Improve Veteran Mental Health and Psychological Wellbeing. Professional Practice Forum, 49th Australian Psychological Society Annual Conference, 30th September – 3rd October, Hobart, Australia.

Hodson, S., **Sadler, N.** & Weiland, P. (2014). Building resilience within organisations with high risk occupations. Clinical tutorial, Australasian Conference on Traumatic Stress, 11th-13th September, Melbourne, Australia.

Forbes, D., Hoge, C., **Sadler, N.** & Hodson, S. (2014). Panel discussion: Mental Health and the Military. Australasian Conference on Traumatic Stress, 11th-13th September, Melbourne, Australia.

Benassi, H. & **Sadler, N.** (2013). Mental Health Screening in the ADF: Are we getting it right? *Journal of Military and Veteran's Health*. 21 (4): 21.

Sadler, N. & Daniels, J. (2013). Defence and Department of Veterans' Affairs Symposium: Challenges and strategies for meeting the mental health needs of contemporary veterans. Presentation for the 22nd Annual Australian Military Medicine Association Conference, 31st October-3rd November, Adelaide, Australia.

Heffernan, K. & **Sadler, N.** (2011). Critical Incident Mental Health Screening Responses on ADF Operations: Key challenges and lessons learnt. *Journal of Military and Veteran's Health.* 20(1): 77.

Heffernan, K., Kaine, A. & **Sadler. N.** (2011). Key Operational Mental Health Themes from the Middle East Area of Operations. *Journal of Military and Veteran's Health.* 20(1): 63.

Hodson, S. & **Sadler, N.** (2011). Critical Incident Mental Health Support: 10 years of experience. Presentation for the Asia-Pacific Military Medicine Conference, 2nd – 6th May, Sydney, Australia.

Sadler, N. (2006). Screening for Psychological Changes Throughout A Military Deployment: Australian Defence Force Personnel In The 2003 Gulf War. *Journal of Military and Veteran's Health*. 15(2): 14.

Bennett, N. & **Sadler, N.** (2006). Psychological Support To Deployed Forces: A Review Of Intervention During Operation Sumatra Assist. *Journal of Military and Veteran's Health*. 15(2): 18.

CONFERENCE AND WORKSHOP PRESENTATIONS (Reverse Chronological Order):

Sadler, N. & Forbes, D. (2020). *Stigma and help-seeking in emergency services agencies.* Emergency Services Foundation, 23 April 2020, live webinar.

Sadler, N. (2020). Tips for working with bushfire impacted individuals. TAL Risk Academy, 26 February 2020, live webinar.

Sadler, N. (2020). *Working with bushfire impacted individuals and communities.* National Bushfire Response Agency, 7 February 2020, Canberra.

Sadler, N. (2019). Resilience: What is it and how do we get it? Restructuring and resilience forum, Bevington Group, 22 October 2019, Melbourne

Sanders, K., McFarlane, A., & **Sadler, N**. (2019). *Mental health in first responders: what you need to know.* The Australian and New Zealand Society of Occupational Medicine Annual Scientific Meeting 2019, Adelaide, 29 October 2019.

Sadler, N. & Sanders, K. (2019). Security and Health Executive Leadership Institute – 2019 course. Mental Health in first responders and the community, 2 October 2019, Sydney

Sadler, N. (2019). Mental health and member safety. Life Saving Victoria Conference. 15 September 2019, Melbourne.

Sadler, N. (2019). Best practice approaches to mental health and wellbeing in high risk organisations. Presentation to the Australasian Council of Women and Policing Conference, 3 September, Canberra, Australia.

Sadler, N. (2019). Mental health and wellbeing in high-risk organisations: challenges and opportunities**.** Presentation to the Australian and New Zealand Policing Advisory Agency Conference 2019, 18 July, Melbourne, Australia.

Sadler, N. (2019). PTSD in contemporary veterans. Presentation to the Royal United Services Institute – Victoria, 27 June, Melbourne, Australia.

Sadler, N., Parker, P., Heffernan, K & Lane, D. (2019). Live webinar for Veteran and Military stream, *'Making Sense of Veteran Mental Health Presentations'.* Panel discussion. Mental Health Professionals Network Online Conference, 28 May 2019

Sadler, N. (2019). Trauma informed practice in the workplace. Presentation to the Interdepartmental Forum of Workplace Mental Health (IFMH) trauma presentation 20th March, Canberra, Australia.

Sadler, N. & Parker, P (2019). Current, new and innovative evidence-based treatments for veterans. Presentation to the *Breaking down the barriers,* Veteran Mental Health Symposium, 15th March, Sydney, Australia.

Sadler, N. (2019). Developing and delivering graded exposure training to enhance resilience. Presentation to the Mental Health Strategies for First Responders conference, 7th March, Melbourne, Australia.

Sadler, N. (2019). Transition from the military. Department of Veterans' Affairs and Mental Health Practitioner Network webinar, 13th March, Canberra, Australia.

Sadler, N. (2018). Suicidality: considerations for individuals and organisations. Converge International Annual Conference, 3rd December, Melbourne, Australia.

Sadler, N. (2018). Suicide prevention. Department of Veterans' Affairs and Mental Health Practitioner Network webinar, March, Sydney, Australia.

Sadler, N. (2017). Military Mental Health Landscape. Presentation for the Military Mental Health Match, International Initiative for Mental Health Leadership, 27th-28th February, Sydney, Australia.

Sadler, N. (2016). Resilience in the Australian Defence Force. Presentation for the Australian Human Resources Institute, ACT Conference, 19th October, Canberra, Australia.

Sadler, N. & Mack, L. (2016). Suicide prevention measures for serving and ex-serving ADF personnel. Presentation for the Australian Advisory Group for Suicide Prevention Arrangements, 26th October, Sydney, Australia.

Sadler, N. & Casetta, C. (2016). The Longitudinal ADF Study Evaluating Resilience (LASER-Resilience). Presentation for the Prime Ministerial Advisory Council on Veterans' Mental Health meeting, 2nd March, Canberra, Australia.

Sadler, N. (2015). Mental Health Programs in the Australian Defence Force. Presentation for the National Mental Health Commission meeting, 12th August, Canberra, Australia.

Sadler, N. (2015). ADF Mental Health Strategy. Presentation for the Moral Injury Conference, Australian Centre for the Study of Armed Conflict and Society, 19th February, Canberra, Australia.

TECHNICAL REPORTS / INTERNAL TO DEFENCE DOCUMENTS (Reverse Chronological Order)

I have authored or co-authored a range of technical and policy reports for Phoenix Australia and Defence and internal to Defence documents including:

Heffernan, K., Deans, C, Howard, A., McGregor, K., McKay, G., **Sadler, N**., & Nursey, J. (2020). *Best practice framework for volunteering in support of veterans and veterans' families' wellbeing.* Melbourne: Phoenix Australia-Centre for Posttraumatic Mental Health.

Savic, A., Pedder, D.J., Bowd, C., Crozier, T., & **Sadler, N**. (2019). *Victoria State Emergency Service: Review of critical incident mental health framework.* Melbourne: Phoenix Australia – Centre for Posttraumatic Mental Health.

Crozier, T. & **Sadler, N.** (2019). *Review of guidelines and handbook for managing exposure to objectionable material report for the Office of National Intelligence*. Melbourne: Phoenix Australia – Centre for Posttraumatic Mental Health.

Deans, C.L., Heffernan, K.M., Savic, A., Pedder, D.J., & **Sadler, N.L.** (2019). *New South Wales Police Force Mental Health & Wellbeing Review.* Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne.

Lethbridge, R., & **Sadler, N.** (2019). *CFA Mental Health and Wellbeing Services Report: Career Firefighters.* Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne.

Cowlishaw, S., Pedder, D. J., Ye, L., Freijah, I., & **Sadler, N**. (2019). *Ambulance Victoria Psychosocial Health & Wellbeing Survey: Summary Report.* Report prepared for Ambulance Victoria. Melbourne: Phoenix Australia Centre for Posttraumatic Mental Health.

Heffernan, K., Crozier, T., Nursey., J., Pacella, B., Freijah., I, Johnson., L., Little, J., Humphries, M., Stone, C., & **Sadler., N (**2019). *The Office of the Director of Public Prosecutions, Western Australia: Report on the review of mental health related workplace risks and best practice recommendations.* Melbourne: Phoenix Australia – Centre for Posttraumatic Mental Health.

Varker, T., Kartal, D., Metcalf, O., Gong, J., Khatri, J**., Sadler, N**. & O'Donnell, M. (2019). *Current research in suicide prevention: A continuum framework of prevention and treatment for suicidality.* Report prepared for the Department of Veterans' Affairs. Phoenix Australia Centre for Posttraumatic Mental Health.

Dell, L., Fredrickson, J., Cowlishaw, S., **Sadler, N**., Crane, L., Lewis, V., O'Donnell, M., Terhaag, S., Cole, R., and Forbes, D. (2019) *LASER-Resilience Report Patterns and Predictors of Wellbeing.* Report prepared for the Australian Government Department of Defence. Phoenix Australia: Melbourne.

Burns, J., Van Hooff, M., Lawrence-Wood, E., Benassi, H., **Sadler, N.**, Hodson, S., Hansen, C., Avery, J., Searle, A., Iannos, M., Abraham, M., Baur, J., & McFarlane, A. (2019). *Technology Use and Wellbeing Report, Mental Health and Wellbeing Transition Study.* Canberra: the Department of Defence and the Department of Veterans' Affairs.

Lawrence-Wood, E., McFarlane, A., Lawrence, A., **Sadler, N.**, Hodson, S., Benassi, H., Bryant, R., Korgaonkar, M., Rosenfeld, J., Sim, M., Kelsall, H., Abraham, M., Baur, J., Howell, S., Hansen, C., Iannos, M., Searle, A., & Van Hooff, M. (2019). *Impact of Combat Report*, Impact of Combat Study. Canberra: Department of Defence and Department of Veterans' Affairs.

Bryant, R., Lawrence-Wood, E., Baur, J., McFarlane, A., Hodson, S., **Sadler, N.**, Benassi, H., Howell, S., Abraham, M., Iannos, M., Hansen, C., Searle, A., & Van Hooff, M. (2019). *Mental Health Changes Over Time: a Longitudinal Perspective: Mental Health and Wellbeing Transition Study.* Canberra: Department of Defence and Department of Veterans' Affairs.

Kelsall, H., Sim, M., Van Hooff, M., Lawrence-Wood, E., Benassi, H., **Sadler, N.**, Hodson, S., Hansen, C., Avery, J., Searle, A., Ighani, H., Iannos, M., Abraham, M., Baur, J., Saccone, E., & McFarlane, A. (2018). *Physical Health Status Report, Mental Health and Wellbeing Transition Study.* Canberra: the Department of Defence and the Department of Veterans' Affairs.

Forbes, D., Van Hooff, M., Lawrence-Wood, E., **Sadler, N.**, Hodson, S., Benassi, H., Hansen, C., Avery, J., Vaker, T., O'Donnell, A., Phelps, A., Frederickson, J., Sharp, M., Searle, A., & McFarlane, A. (2018). *Pathways to Care, Mental Health and Wellbeing Transition Study.* Department of Defence and the Department of Veterans' Affairs, Canberra.

Van Hooff, M., Lawrence-Wood, E., Hodson, S., **Sadler, N.**, Benassi, H., Hansen, C., Grace, B., Avery, J., Searle, A., Iannos, M., Abraham, M., Baur, J. & McFarlane, A. (2018). *Mental Health Prevalence, Mental Health and Wellbeing Transition Study.* Department of Defence and the Department of Veterans' Affairs, Canberra.

Van Hooff, M., Forbes, D., Lawrence-Wood, E., Hodson, S., **Sadler, N.**, Benassi, H., Hansen, C., Grace, B., Avery, J., Searle, A., Iannos, M., Abraham, M., Baur, J., Vaker, T., O'Donnell, A., Phelps, A., Frederickson, J., Sharp, M & McFarlane, A. (2018). *Mental Health Prevalence and Pathways to Care Summary Report, Mental Health and Wellbeing Transition Study.* Department of Defence and the Department of Veterans' Affairs, Canberra.

Sadler, N. & Varker, T. (2018). Queensland Police Service Mental Health Screening Advice. Phoenix Australia – Centre for Posttraumatic Mental Health.

Wade, D., McGregor, K., Cash, R., Cooper. J., Couineau, A., Phelps, A., Crozier, T., **Sadler, N**. (2018). Review of Queensland workers' compensation scheme for emergency service workers with psychological injuries. Final report. Phoenix Australia – Centre for Posttraumatic Mental Health.

Baker, D., Rice, S., **Sadler, N.,** Cooper, J. & Wade, D. (2017). The Next Post: Young people transitioning from military service and their mental health. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health.

Phelps, A., Varker, T., Dennison, M., Nursey, J., Cooper, J., **Sadler, N.,** Howard, A., Wade, D. & Forbes, D. (2017). AFP Structural Review, Reform and Policy Development on Mental Health: Final Report. Phoenix Australia Centre for Posttraumatic Mental Health Technical Report.

Couineau, A., **Sadler,** N., Terhaag, S. & Nursey, J. (2017). Review of Trauma Support for Victoria Police Special Operations Group. Phoenix Australia Centre for Posttraumatic Mental Health Technical Report.

Sadler, N. (2016). ADF Mental Health and Wellbeing Strategy 2017-2021 Concept Paper. Internal Department of Defence paper.

Henderson, K., Richardson, F. & **Sadler. N.** (2016). Background paper for the Inaugural ADF Resilience Forum, 20 April 2016. Internal Department of Defence paper.

Sadler, N. (2015) Background paper for the Military and Veteran Mental Health Symposium, 14 November 2015, Sydney.

Sadler, N. (2014). Maximising the Army Uniformed Psychology Capability. Submission to the Army Institutional Lessons Learnt. Internal Department of Defence Technical Report.

Sadler, N. & Turner, K. (2012). 2012-2015 ADF Mental Health Prevalence and Wellbeing Action Plan. Department of Defence.

Burns, T. & **Sadler, N.** (2012) Brief for Commanding Officer Mentoring Task Force – 5: Mitigating Green-on-Blue Threat Through Interpersonal Relationships. Internal Department of Defence Technical Report.

Kaine, K. & **Sadler, N.** (2012). Key Findings of Return to Australia Psychological Screens Mentoring Task Force – 4. Internal Department of Defence Technical Report.

Burns, T. & **Sadler, N.** (2012). Comparative Data Report – Key Return to Australia Psychological Screen Findings Mentoring and Reconstruction Task Force (MRTF) – 1, MRTF-2, Mentoring Task Force (MTF -1) and MTF-2. Internal Department of Defence Technical Report.

Said, D., Burns, T. & **Sadler, N.** (2012). Key Findings of Return to Australia Psychological Screens Mentoring Task Force – 3. Internal Department of Defence Technical Report.

Sadler, N. & Stephens, M. (2012) Impact of Length of Deployment of Mental Health of Australian Defence Force Personnel. Internal Department of Defence Technical Report.

Sadler, N. (2011). Females and Army Culture Issues. Internal Department of Defence technical paper commissioned by Commander Forces Command.

Sadler, N. (2011). Operational Mental Health Support: Trends from Psychological Screening. Report for Chiefs of Service Committee. Internal Department of Defence Technical Report.

Sadler, N. (2010). Operational Mental Health Support: Trends from Psychological Screening. Report for Chief of Army's Senior Advisory Committee. Internal Department of Defence Technical Report

Sadler, N. (2010). Psychology Support to Engineers on Operations. Internal Department of Defence Technical Report.

Levey, M., Cohn, A. & **Sadler, N.** (2010). Army's Psychology Capability. Internal Department of Defence Technical Report.

Sadler, N. (2009). Army Recruitment and Retention of Women Strategy. Internal Department of Defence Technical Report.

Di Savia, L. & **Sadler, N.** (2009). Environmental Scan of Army Work-Life Balance. Internal Department of Defence Technical Report.

Sadler, N. (2009). Army People Plan 2009-2018. Department of Defence.

Sadler, N. (2006). Findings of the PULSE Climate Survey – Headquarters Royal Military College. Internal Department of Defence Technical Report.

Sadler, N. (2005). Findings of the PULSE Climate Survey – 1st Health Support Battalion. Internal Department of Defence Technical Report.

Sadler. N. & Bennett, N. (2005). Key Findings of Return to Australia Psychological Screens Operation Sumatra Assist. Internal Department of Defence Technical Report.

Sadler, N. (2005). Screening for psychological changes throughout a military deployment: Australian Defence Force personnel in the 2003 Gulf War. Internal Department of Defence Technical Report.

Cotton, A., Dines, A., Trevillian, L. & **Sadler, N.** (2001). ADF Mental Health Strategy – Concept Paper. Internal Department of Defence Technical Report.

TRAINING WORKSHOPS

I have organised and facilitated numerous mental health workshops and forums including in the areas of:

- Trauma Informed Care
- Graded exposure training for the viewing of objectionable materials
- Psychological First Aid
- Understanding the veteran experience for mental health professionals
- Resilience building
- Vicarious Trauma

TRAINING VIDEOS (Reverse Chronological Order):

I have been the producer / project manager for the following mental health awareness videos:

Let's Talk. (2016). Australian Defence Force Annual Mental Health Day video.

Take Action. (2015). Australian Defence Force Annual Mental Health Day video.

Staying Connected. (2014). Australian Defence Force Annual Mental Health Day video.

Fighting Fit. (2013). Australian Defence Force Annual Mental Health Day video.