Introduction

My name is [redacted] Ph.D (C), MSuicidology, BSW (Hons) - I have lived experience mental health system(s) and suicidality and a mother who has lost her son to suicide. For the purposes of this submission, I will primarily be focussing my attention to the mental health of veterans. The reason for this focus is to coincide with the recent release of the Productivity Commission's report - Compensation and Rehabilitation of Veterans that outlines that Department of Veterans Affairs is no longer fit for purpose in supporting the mental health of our veterans; the increased vulnerabilities and stigma attached to help seeking in this population, and the current lack of integrated services in Victoria, that are flexible and can provide alternative choices for veterans who may feel disempowered and stigmatised within the current DVA system.

Suicide rates for the general Australian population are at their highest in ten years (ABS, 2018). Key factors that heighten suicide risk is comorbidity (ABS, 2018). Comorbidities including mental illness, chronic pain, cancer, drug and alcohol misuse are increased in some populations such as the Australian Defence Force (ADF) (DVA, 2017), particularly amongst ex-serving and or transitioned members (DVA, 2017; AIHW, 2018) where over half (55%) had a least one comorbid or co-existing mental disorder (DVA, 2017).

The Mental Health Prevalence report by DVA and Defence, focused on mental disorders among ADF members who had transitioned from regular ADF service between 2010 and 2014. The report also reviewed self-reported mental health status of the transitioned ADF and the 2015 regular ADF. In all the areas of mental health measured the men and women who had transitioned from the ADF had significantly higher rates of mental health issues than those who were currently serving. The Productivity Commission has recently released its report into the Department of Veterans Affairs - Compensation and Rehabilitation for Veterans that states "*despite some recent improvements to the veterans compensation and rehabilitation system, it is not fit for purpose – it requires fundamental reform. It is out of date and it is not working in the best interest of veterans and their families, or the Australian community*". This is particularly disturbing as transitioned members of the ADF who are ex-serving have significantly greater rates of anxiety disorders, affective disorders, alcohol disorders and suicidality compared to both Inactive and Active Reservists indicating poorer mental health outcomes for those who were most disengaged with Defence.

It is widely acknowledged that the DVA is the primary conduit to care and assistance for ex-serving members veterans in Victoria. However, their role in ensuring care and welfare of veterans is contestable. The DVA has its share of systemic issues, such as access to support, administrative burden and lengthy timeframes, fundamentally veterans are dying, that has led to and raised the profile of the DVA and its links to suicide deaths of veterans in the media. Victoria is home to multiple bases and multiple defence members and their families.

A presence of operational defence bases in Victoria is large - see below:

- Albury Wodonga Military Area, Albury-Wodonga: Major training base for Army, including Bandiana and Bonegilla.
- Puckapunyal Military Area, Puckapunyal: The Army's centre for combat and doctrinal development accommodating the School of Armour and School of Artillery.
- HMAS Cerberus, Crib Point: Navy personnel training and development.
- RAAF Base East Sale, East Sale: The Air Force's Central Flying School and Officer Training School.
- Simpson Barracks, Macleod: Army training and Army Reserve base.

Victoria's defence sector is an important part of the State's economy, contributing up to $8 billion annually. The sector employs around 18,500 people and has more than 770 businesses, which make equipment and provide services for defence activities (Victoria State Government, 2019). In Victoria in 2012 the economic cost of suicide (estimated through direct and indirect cost) was estimated at $380 million (KPMG, 2013). Investing early is critical in reducing the social, emotional, psychological and economic burden of suicide.

Mental health of veterans

The ADF recruits more males than females with the average age for enlistment and recruitment being 17-25, 80% being under 230 (ADF, 2015; ABS, 2010, ADF, 2011). This makes this cohort well within the prescribed most vulnerable age group for suicide (Zamorsky, 2011)

Almost three in four Transitioned ADF members are estimated to have met criteria for a mental disorder at some stage in their lifetime that is either, prior to, during or after their military career.

More than 43% of Transitioned ADF members reported accessing DVA-funded treatment through either a DVA White Card (39.4%) or DVA Gold Card (4.2%) (DVA, 2017). This means many more veterans may not be accessing treatment and may fall through the gaps. Only about 30% received assistance in engaging with mental health care. For Transitioned ADF this was most commonly a doctor (either a General Practitioner or Medical Officer), partners or supervisors and, for Regular 2015 ADF, this was most commonly supervisors, General Practitioners or Medical Officers (DVA, 2017) highlighting an opportunity for a systems and integrated approach to mental health care and support for veteran populations.

Over half the Transitioned ADF and around 40% of the 2015 Regular ADF with probable current mental disorder held four or more stigma-related beliefs. However, the vast majority of those with mental health concerns still engaged in care, the primary barrier particularly for those currently serving was the risk of career limitation for those who sought mental health support.

Between 2001-2016 there were approximately 373 suicides (AIHW, 2018). Anecdotally, this number is much much higher with up to 49 veterans recorded as dying by suicide in 2018, and 8 veterans have died with 5 confirmed as suicide since Anzac Day this year. Ex-serving males under 30 are over twice as likely to suicide compared the general population (AIHW, 2018). Ex serving men more broadly have a suicide rate almost 20% higher than males age matched for 2014-2016 (AIHW, 2018). The lack of data across the ADF and DVA in addition to the complex and differing data sets used nationally to capture suicide data, makes it increasingly challenging to obtain accurate and real time data and also demands further action.

Victorians living with mental illness are "just surviving" in a system that depersonalises and denigrates them – not dissimilar to the ADF cultural experiences reported. Both of which lead to heightened states of psychological stress and demand further action. In Victoria a range of hospital and community-based clinical mental health services, and non-clinical services are provided by mental health community support services. These could be used as a platform for a scalable pilot of an integrated service between community, DVA and defence.

This evidence is confronting, particularly confronting is that our young veterans and our Victorians are not experiencing good mental health and are increasingly experiencing high levels of distress, One-in-five Victorians experience mental illness, and out of 72,859 registered clients in Victoria in 2017-18 – how many of those were veterans?

Suggestions to improve Victorian community understanding of mental illness and reduce stigma and discrimination

In addition to the above outlined information, the mental health consequences of the military have been extensively documented over the past three decades and have informed our current understanding of defence related mental health disorders, especially post-traumatic stress disorder (PTSD) (McFarlane, et al., 2010). An important emerging issue for veterans is their increased risk of poor physical health problems, that can increase mental health problems such as dementia, cancer etc as well as comorbidities such as alcohol or substance misuse, cardiovascular disease and autoimmune disease (McFarlane, et al., 2010). All of these conditions have since been linked to PTSD (McFarlane et al., 2010; Yaffe et al., 2010) and fundamentally require the support of allied or medical and or mental health professions.

A rise in suicide related behaviour and the Australian Defence Force being one of the largest employers in the country (ABS, 2012), it stands to reason that the mental health of serving and post-service ADF members is drawing increased attention of late and is the catalyst for a raft of proposed national mental health strategies and reforms and inquiries to investigate this

Currently, there exists a considerable body of literature that explores post deployed and ex-service members suffering from disordered mental health such as Post-Traumatic Stress Disorder (PTSD) and depression as well as the impacts of workplace, demographics and organisations on mental health on ADF members; however, little is known regarding integrated service delivery models between civilian and defence.

It is important to note that PTSD does not only affect veterans, it is thought that around 12 per cent (Beyond Blue, 2019) of Australians will experience PTSD in their lifetimes it is becoming more and more prevalent in situations where severe trauma is experienced which threatened a person's life or safety or the life or safety of those around them this may include but is certainly not limited to people that have experienced physical or sexual assault, torture, disasters such as bushfires, floods or earthquakes and war. With veterans, PTSD often presents itself as one part of a complex and multifaceted challenge, it is usually coupled with a number of other mental health disorders including anxiety and drug and alcohol problems. As such, taking steps to be proactive and innovative in provision of treatment would likely provide a solid catalyst for change across the system in managing highly complex mental health issues with highly complex vulnerable populations.

It is imperative that as a society we consider the collective impact of mental health and treat these impacts accordingly. This country is experiencing a mental health epidemic, suicide rates continue to rise, the number of people from all cultures and backgrounds experiencing mental health issues continues to rise and it's time to act, but continuing to act in a siloed and disjointed way without acknowledging the complexity of mental health issues, in the context of the specific population and their collective impact will not turn the curve towards an improved and responsive system.

The Victorian Royal Commission into Mental Health is a vehicle to highlight issues in specific vulnerable groups in Victoria, such as veterans of the Australian Defence Force (ADF), especially males aged under 30 and who have transitioned.

The core business of militaries means that there is an inherent requirement to prioritise capability over the welfare of personnel. Within the contemporary ADF setting, competing agendas between capability and welfare creates systemic problems such as stigma and discrimination towards help seeking behaviour that contribute to suicide and poor mental health outcomes (Zamorski, 2015), affecting individuals, communities and organisations in Victoria.

Further, for veterans, the confusion between historical service and contemporary service has led to poorly targeted legislation and support for both serving and ex-serving veterans, this poor legislation support, further exacerbates poor social, psychological and emotional outcomes that often impacts on the families and friend's health and wellbeing also.

It is the day to day effects of working within such regimented systems of power, coupled with unrelenting training regimes, and no foreseeable end in sight, that breaks the psyche and affects a person more than any singular trauma or injury (McFarlane et al., 2010). Therefore, it is here, within a systems perspective that should be the starting point for any Royal Commission into mental health. More so in the context of veteran suicide.

Therefore, understanding the community in which the mental health service support system aims to serve is absolutely critical and clearly lacking in Victoria.

This system is failing veterans who need a specialised, culturally relevant, integrated systems approach to mental health and wellbeing. This approach includes Victoria Health and subsequent mental health agents. Victoria under its current mental health agenda and trials of integrated service delivery, is well placed to trial a scalable initiative, such as a trauma informed integrated framework and piloting an innovative integrated strategy with the ADF and or DVA that could be scaled up to include sexual abuse survivors or modified to address intergenerational trauma that can arise for children living with veterans with PTSD.

Additionally, stigma is a problem for all people living with mental illness and is a wicked problem within the defence population (Gupta, 2013; Zamorski, 2015). If an individual asserts their own agency within the ADF or DVA, that person is labelled the problem, and this happens both directly and indirectly across multiple workplaces in Australia. Practices like this can be stigmatising and disempowering. If they receive care, or raise a complaint, they are labelled the problem, if they remain silent - they may harm themselves or their career (Zamorski, 2015). Fundamentally, the stigma attached to help seeking and receiving care for veterans, heightens the risk of suicide and must be addressed (Zamorski, 2015; Hawthorne, 2013). This has also been the experience of many Victorians who have publicly expressed their distrust and frustration at a fragmented system that denigrates and stigmatises.

Choice is key for veterans, providing a choice of easily accessible and low cost/no cost services that have no attachment to the ADF or DVA needs to be addressed. Current service provision usually requires the individual to go through the ADF or DVA depending on their circumstance. Application processes to access the mental health support they need, can be lengthy and demoralising for individuals, reducing help seeking behaviours. A "record" of mental health problems can also be career ending for veterans, further increasing stigma and heightening the risk of suicide.

A choice of flexible service providers who are not linked to the ADF or DVA, but still provide the same or increased level of support and service is required. An individualised funding package could also be considered as a mechanism for veterans to enhance autonomy and empower individuals to

seek the support they need, when and where they need it. Feeling like they belong, they have purpose, and identity, and feeling heard is integral to maintain health and wellbeing in veteran communities.

To ensure the early identification and effective treatment of mental health disorders in the, general practitioners (GPs) need to be aware that the traditional profile of an Australian veteran has changed, and that more than combat service can give rise to mental health issues.

What works well and can be done better

A lack of planning and investment has left Victorians with poorer access to mental health services than people in other states, according to the Victorian Auditor General's Office Report. Additionally, increasing public outrage over the treatment of Australian veterans is evident, with many claiming they are left without support for mental health diagnoses such as depression and PTSD expedites the critical need for reform in mental health service and systems in Victoria.

Programs for veterans and males more broadly, that have been evidenced to improve mental health and wellbeing include but not limited to:

- Peer support
- Vet's sheds
- Male mentoring programs
- Retreats – eg. The Banyans Retreat (Queensland)
- Soldier Recovery Centres – expansion of the model for those that have left service.
- Programs that offer a mix of exercise, diet, nutrition and holistic therapies all work well with veterans.

As previously discussed, the obstruction and red tape in accessing services through the ADF and DVA is problematic. Acknowledging the current Productivity Commission recommendations into the DVA the DVA is considered not fit for purpose for addressing the mental health needs of veterans.

Recommendations for what can be done better

- Veterans would benefit from proactive strategies that aim to lessen the burden of mental illness and assist in the transition process.
- An individualised funding package could also be provided to veterans directly instead of the current system through the DVA. From there they can choose who they see and when without fear of discrimination and stigma.
- Reduction of red tape for all persons accessing mental health support with particular focus on veterans accessing DVA support.
- Removing barriers and limitation - the set amount of mental health appointments and services need to be increased or removed, thus allowing people (not just veterans) to manage their own conditions, how they choose, where they choose and how often they choose without limitation.
- A choice of flexible service providers who are not linked to the ADF or DVA, but still provide the same or increased level of support and service is required.
- Victoria under its current mental health agenda and trials of integrated service delivery, is well placed to trial a scalable initiative, such as a trauma informed integrated framework and piloting an innovative integrated strategy with the ADF and or DVA that could be scaled up to include sexual abuse survivors or modified to address intergenerational trauma that can arise for children living with veterans with mental health issues and or disorders such as PTSD.

What makes it hard for people to experience good mental health, and what can be done to improve?

In the context of Victoria veterans:

- Stigma
- Cost to access mental health services
- Distrust in mental health service sector
- Accessibility including inflexible program designs and physical barriers (eg. Veterans may have physical disabilities preventing them from attending appointments)
- Structure (programs can be inflexible and need to be tailored for particular cultural groups)
- Fear (help seeking has historically been career limiting for veterans)
- Limitations of service delivery ie. Set number of appointments allowed under a mental health plan for instance – people have differing needs at different times, therefore flexibility and access needs to be increased.

Improvements:

- Flexible and unlimited options for individuals seeking mental health support, treatment and care.
- Compassionate therapeutic responses by a well-trained (in suicide prevention) mental health workforce
- Whole of systems, whole of community-based approaches
- Place based, community designed approaches
- Follow up care and postvention support for veterans, families, carers and veteran workforce
- Rigorous and robust evaluation of all initiatives
- Funded service agreements embed a suicide prevention impact statement as part of their funding agreement
- Data collection is improved with veteran data collection embedded with current data collection systems.

DVA supports some 316,000 clients, however many individuals, for many reasons including stigma, choose not to use DVA and will go their GP for support or a combination. To ensure the early identification and effective treatment of mental health disorders in the veteran population, general practitioners (GPs) need to be aware that the traditional profile of an Australian veteran has changed, and that more than combat service can give rise to mental health issues.

What are the drivers behind some communities in Victoria experiencing poor mental health outcomes and what needs to be done?

Suicide prevention in Australia is increasing. In Victoria it is acknowledged that suicide rates have reduced from 2016-2017 and is lower than the national average (10.9 and 12.9 respectively) (ABS, 2018). However, mental health service provision, including accessibility, satisfaction and support is dire compared to other states even though it is widely conversed that poor mental health and mental illness can be a contributing factor to suicidality.

Between 2001-2016 there were approximately 373 suicides (AIHW, 2018). Anecdotally, this number is much higher with estimates ranging from 5-8 veterans taking their own lives every week. The lack of data across the ADF and DVA in addition to the complex and differing data sets used nationally to capture suicide data, makes it increasingly challenging to obtain accurate and real time data. This lack of data is a also a key driver for change.

Ex-serving males under 30 are over twice as likely to suicide compared the general population (AIHW, 2018). Ex serving men more broadly have a suicide rate almost 20% higher than males age matched for 2014-2016 (AIHW, 2018).

Ex serving men are more likely to have mental health problems and or disorders and Victoria is home to multiple military bases, defence members and their families.

Acknowledging Objective 2 of Victorian suicide prevention framework 2016-2025 that discusses *groups who are at a higher risk of psychological distress and suicide. Including early responses to concerns among dairy farmers, regional communities, Aboriginal communities, emergency service workers, paramedics, police, at risk occupations (such as construction and trucking) and lesbian, gay, bisexual, transgender and intersex people" (*Victoria, 2019). There is no mention of veteran suicide or veteran mental health and wellbeing. This should also be a driver for change and ensuring policy and legislation is also inclusive of veteran mental health and suicide.

Reiterating again the Productivity Commission into the Department of Veterans Affairs states the DVA is considered not fit for purpose for addressing the mental health needs of veterans. This is a key driver for change and veterans are not receiving the mental health support they desperately need in a timely or appropriate way, this inefficiency is resulting in veterans dying.

What can be done?

Acknowledging veteran mental health and suicide is often considered a "Commonwealth" issue, suicide and mental health issues are a systemic issue and require a whole of government, whole of systems approach if we are to see a reduction.

Suicide prevention activities that integrate health, family, carer, and other social support services lower the risk of suicide. (WHO, 2014).

A number of recommendations are proposed:

DVA is currently not fit for purpose, the mental health system and sector in Victoria needs to increase support to veterans to address the significant gaps in mental health left by the current DVA model. This may include upskilling GPs, allied and medical health practitioners in veteran centric mental health, treatment, assessment and support.

A consistent lack of evidence also needs to be addressed. A specific focus on longitudinal and intervention specific evidence needs to be prioritised. There is little evidence in Australia that highlights interventions that actually work. Lifespan and systems-based approaches such as Zero Suicide are showing promise, but further evidence is required.

Data - when considering veterans in Australia it is currently unknown how many veterans live in Australia. Therefore, improved data collection is critical. Data collection at key touchpoints, such as hospitals, Centrelink, mental health services, needs improvement. Embedding veteran data in current state and national data systems is crucial. Improved data could provide Victoria and Australia with vital information on where veterans are, how many there are and more specifically how many veteran suicide deaths there are, so we can further investigate and develop programs and initiatives that are efficient and effective in reducing suicide.

In summary, a range of options are outlined below that can address some of the drivers discussed:

- Flexible and unlimited options for individuals seeking mental health support, treatment and care.
- Compassionate therapeutic responses by a well-trained (in suicide prevention) mental health workforce
- Whole of systems, whole of community-based approaches
- Upskilling GPs, allied and medical health practitioners in veteran centric mental health, treatment, assessment and support.

- Place based, community designed approaches
- Follow up care and postvention support for veterans, families, carers and veteran workforce
- Rigorous and robust evaluation of all initiatives
- Funded service agreements embed a suicide prevention impact statement as part of their funding agreement
- Data collection is improved with veteran data collection embedded with current data collection systems.
- Rigorous and robust evaluation needs to be a critical component of any funded initiative and must be costed appropriately.
- Victoria under its current mental health agenda and trials of integrated service delivery, is well placed to trial a scalable initiative, such as a trauma informed integrated framework and piloting an innovative integrated strategy with the ADF and or DVA that could be scaled up to include sexual abuse survivors or modified to address intergenerational trauma that can arise for children living with veterans with mental health issues and or disorders such as PTSD.

What are the needs of family and carers?

Families are a fundamental component of the support system for serving and ex-serving military personnel who have a mental illness or disorder. Families living with a veteran with mental health issues need support and understanding as do carers in the wider population. While the majority of children of military personnel are experiencing healthy and productive lives, research indicates that children of veterans who were deployed are more likely to experience poorer health outcomes (particularly for mental health).[13] This research also revealed that the health outcomes of children of Vietnam War veterans with a diagnosis of PTSD can be especially poor (DVA, 2014).

Caring for a suicidal person places immense psychological, emotional and financial burden on families and carers. Adding to the burden on military transitions (schooling, housing, social networks), familial stress is exacerbated.

People caring for individuals experiencing a suicidal crisis often have limited access to resources and support options specific to their needs that has significant negative impact on the overall health and wellbeing of carers. Well targeted support for carers helps to prevent the breakdown of care situations and ultimately contributes to better care for the individual.

A carer's ability to respond to a suicidal crisis will vary depending on their knowledge and previous experiences, as well as the level of social and personal resources available to them. For Aboriginal and Torres Strait Islander carers the need for support is heightened.

Evidence suggests that the provision of education and support to families and significant others may help to reduce caregiver burden, and also impact positively on the individual at risk of suicide.

Similarly, providing appropriate information and resources to health care providers to better support carers is important given the relationships between issues and challenges that carers and providers typically face when caring for someone who has a history of a suicide attempt.

A range of programs that support families and carers include:

- Peer support and mentoring
- Specialised family therapy
- Psychoeducation
- Telephone support
- Group support (online and or offline)
- Postvention and or aftercare

Defence currently has a range of support mechanisms available for families of Veteran's:

- Kookaburra Kids foundation for children of veterans
- Defence specific spouse support groups
- VVCS
- DVA – At Ease
- Veteran and Family Assistance
- RSL

Most of these programs are offered on a standalone basis. Evidence suggests that programs that are open to the public, flexible, multi-modal, accessible, (eg. combining counselling with online/telephone support) are more effective in attracting and retaining carers (Relationships Australia, 2018).

Despite their role and vulnerability to health consequences, carers often report being unable to access much needed information to help them cope effectively and commonly feel excluded and unsupported by health services, particularly in the military (Berk et al., 2011).

What can be done to retain and better support mental health workforce

- Embed lived experience peer workforce and provide practical and translatable evidence based suicide prevention training training for all mental health workforce staff such as the CASE approach – this includes the ADF and DVA workforce
- Provide flexible, ongoing and assertive follow up care and postvention support for the workforce (including ADF and DVA) who have been exposed to suicidality
- Veteran centric training and support across all allied and mental health professions

What are opportunities for Vic to improve social and economic participation what needs to be done?

Victoria must consider the recommendations throughout this submission and expedite development, implementation and evaluation to improve social and economic participation.

Tell us what areas and reform ideas you would like the RC to prioritise for change?

Reform into Victorian Veteran mental health in Victoria, embedding systems approach, integrated service delivery. Another area that requires priority is data and evaluation. Improved data collection eg. collaborating with other government agencies to expand opportunities for data collection that includes veteran and Australian Defence Force status indicators into current datasets to help us to better understand service use, accessible and where achievable, individual outcomes.

Evaluation of funded initiatives – evaluation needs to be rigorous and robust and built into funding agreements. It is suggested that evaluation funding should be at least 35% of the total funding allocation cost.

What can be done now to prepare for changes to Vic mental health system and support improvements?

Scoping and mapping of current services is essential with a particular focus on vulnerable groups such as veterans.

Evaluation is a tool that can be cost effective if planned and delivered properly. I would suggest that a research agenda and evaluation framework is developed with a specific focus on veteran mental

health and suicide in Victoria. This too can be expanded and adapted to fit for purpose, the broader public arena or targeted for vulnerable populations.

2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
[redacted]

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Introduction My name is [redacted] Ph.D (C), MSuicidology, BSW (Hons) - I have lived experience mental health system(s) and suicidality and a mother who has lost her son to suicide. For the purposes of this submission, I will primarily be focussing my attention to the mental health of veterans. The reason for this focus is to coincide with the recent release of the Productivity Commission's report - Compensation and Rehabilitation of Veterans that outlines that Department of Veterans Affairs is no longer fit for purpose in supporting the mental health of our veterans; the increased vulnerabilities and stigma attached to help seeking in this population, and the current lack of integrated services in Victoria, that are flexible and can provide alternative choices for veterans who may feel disempowered and stigmatised within the current DVA system. Suicide rates for the general Australian population are at their highest in ten years (ABS, 2018). Key factors that heighten suicide risk is comorbidity (ABS, 2018). Comorbidities including mental illness, chronic pain, cancer, drug and alcohol misuse are increased in some populations such as the Australian Defence Force (ADF) (DVA, 2017), particularly amongst ex-serving and or transitioned members (DVA, 2017; AIHW, 2018) where over half (55%) had a least one comorbid or co-existing mental disorder (DVA, 2017). The Mental Health Prevalence report by DVA and Defence, focused on mental disorders among ADF members who had transitioned from regular ADF service between 2010 and 2014. The report also reviewed self-reported mental health status of the transitioned ADF and the 2015 regular ADF. In all the areas of mental health measured the men and women who had transitioned from the ADF had significantly higher rates of mental health issues than those who were currently serving. The Productivity Commission has recently released its report into the Department of Veterans Affairs - Compensation and Rehabilitation for Veterans that states despite some recent improvements to the veterans compensation and rehabilitation system, it is not fit for purpose ? it requires fundamental reform. It is out of date and it is not working in the best interest of veterans and their families, or the Australian community. This is particularly disturbing as transitioned members of the ADF who are ex-serving have significantly greater rates of anxiety disorders, affective disorders, alcohol disorders and suicidality compared to both Inactive and Active Reservists indicating poorer mental health outcomes for those who were most disengaged with Defence. It is widely acknowledged that the DVA is the primary conduit to care and assistance for ex-serving members veterans in Victoria. However, their role in ensuring care and welfare of veterans is contestable. The DVA has its share of systemic issues, such as access to support, administrative burden and lengthy timeframes, fundamentally veterans are dying, that has led to and raised the profile of the DVA and its links to suicide deaths of veterans in the media. Victoria is home to multiple bases and multiple defence members and their families. A presence of operational defence bases in Victoria is large - see below: Albury Wodonga Military Area, Albury-Wodonga: Major training base for Army, including Bandiana and Bonegilla. Puckapunyal Military Area, Puckapunyal: The Army's centre for combat and doctrinal development accommodating the School of Armour and School of Artillery. HMAS Cerberus, Crib

Point: Navy personnel training and development. RAAF Base East Sale, East Sale: The Air Force's Central Flying School and Officer Training School. Simpson Barracks, Macleod: Army training and Army Reserve base. Victoria's defence sector is an important part of the State's economy, contributing up to $8 billion annually. The sector employs around 18,500 people and has more than 770 businesses, which make equipment and provide services for defence activities (Victoria State Government, 2019). In Victoria in 2012 the economic cost of suicide (estimated through direct and indirect cost) was estimated at $380 million (KPMG, 2013). Investing early is critical in reducing the social, emotional, psychological and economic burden of suicide. Mental health of veterans The ADF recruits more males than females with the average age for enlistment and recruitment being 17-25, 80% being under 230 (ADF, 2015; ABS, 2010, ADF, 2011). This makes this cohort well within the prescribed most vulnerable age group for suicide (Zamorsky, 2011) Almost three in four Transitioned ADF members are estimated to have met criteria for a mental disorder at some stage in their lifetime that is either, prior to, during or after their military career. More than 43% of Transitioned ADF members reported accessing DVA-funded treatment through either a DVA White Card (39.4%) or DVA Gold Card (4.2%) (DVA, 2017). This means many more veterans may not be accessing treatment and may fall through the gaps. Only about 30% received assistance in engaging with mental health care. For Transitioned ADF this was most commonly a doctor (either a General Practitioner or Medical Officer), partners or supervisors and, for Regular 2015 ADF, this was most commonly supervisors, General Practitioners or Medical Officers (DVA, 2017) highlighting an opportunity for a systems and integrated approach to mental health care and support for veteran populations. Over half the Transitioned ADF and around 40% of the 2015 Regular ADF with probable current mental disorder held four or more stigma-related beliefs. However, the vast majority of those with mental health concerns still engaged in care, the primary barrier particularly for those currently serving was the risk of career limitation for those who sought mental health support. Between 2001-2016 there were approximately 373 suicides (AIHW, 2018). Anecdotally, this number is much much higher with up to 49 veterans recorded as dying by suicide in 2018, and 8 veterans have died with 5 confirmed as suicide since Anzac Day this year. Ex-serving males under 30 are over twice as likely to suicide compared the general population (AIHW, 2018). Ex serving men more broadly have a suicide rate almost 20% higher than males age matched for 2014-2016 (AIHW, 2018). The lack of data across the ADF and DVA in addition to the complex and differing data sets used nationally to capture suicide data, makes it increasingly challenging to obtain accurate and real time data and also demands further action. Victorians living with mental illness are just surviving in a system that depersonalises and denigrates them ? not dissimilar to the ADF cultural experiences reported. Both of which lead to heightened states of psychological stress and demand further action. In Victoria a range of hospital and community-based clinical mental health services, and non-clinical services are provided by mental health community support services. These could be used as a platform for a scalable pilot of an integrated service between community, DVA and defence. This evidence is confronting, particularly confronting is that our young veterans and our Victorians are not experiencing good mental health and are increasingly experiencing high levels of distress, One-in-five Victorians experience mental illness, and out of 72,859 registered clients in Victoria in 2017-18 ? how many of those were veterans? Suggestions to improve Victorian community understanding of mental illness and reduce stigma and discrimination In addition to the above outlined information, the mental health consequences of the military have been extensively documented over the past three decades and have informed our current understanding of defence related mental health disorders, especially post-traumatic stress disorder (PTSD) (McFarlane, et al., 2010). An important emerging issue for veterans is their increased risk of poor physical health problems, that can increase mental health problems such as dementia, cancer etc as well as

comorbidities such as alcohol or substance misuse, cardiovascular disease and autoimmune disease (McFarlane, et al., 2010). All of these conditions have since been linked to PTSD (McFarlane et al., 2010; Yaffe et al., 2010) and fundamentally require the support of allied or medical and or mental health professions. A rise in suicide related behaviour and the Australian Defence Force being one of the largest employers in the country (ABS, 2012), it stands to reason that the mental health of serving and post-service ADF members is drawing increased attention of late and is the catalyst for a raft of proposed national mental health strategies and reforms and inquiries to investigate this. Currently, there exists a considerable body of literature that explores post deployed and ex-service members suffering from disordered mental health such as Post-Traumatic Stress Disorder (PTSD) and depression as well as the impacts of workplace, demographics and organisations on mental health on ADF members; however, little is known regarding integrated service delivery models between civilian and defence. It is important to note that PTSD does not only affect veterans, it is thought that around 12 per cent (Beyond Blue, 2019) of Australians will experience PTSD in their lifetimes it is becoming more and more prevalent in situations where severe trauma is experienced which threatened a person's life or safety or the life or safety of those around them this may include but is certainly not limited to people that have experienced physical or sexual assault, torture, disasters such as bushfires, floods or earthquakes and war. With veterans, PTSD often presents itself as one part of a complex and multifaceted challenge, it is usually coupled with a number of other mental health disorders including anxiety and drug and alcohol problems. As such, taking steps to be proactive and innovative in provision of treatment would likely provide a solid catalyst for change across the system in managing highly complex mental health issues with highly complex vulnerable populations. It is imperative that as a society we consider the collective impact of mental health and treat these impacts accordingly. This country is experiencing a mental health epidemic, suicide rates continue to rise, the number of people from all cultures and backgrounds experiencing mental health issues continues to rise and it's time to act, but continuing to act in a siloed and disjointed way without acknowledging the complexity of mental health issues, in the context of the specific population and their collective impact will not turn the curve towards an improved and responsive system. The Victorian Royal Commission into Mental Health is a vehicle to highlight issues in specific vulnerable groups in Victoria, such as veterans of the Australian Defence Force (ADF), especially males aged under 30 and who have transitioned. ? The core business of the military means that there is an inherent requirement to prioritise capability over the welfare of personnel. Within the contemporary ADF setting, competing agendas between capability and welfare creates systemic problems such as stigma and discrimination towards help seeking behaviour that contribute to suicide and poor mental health outcomes (Zamorski, 2015), affecting individuals, communities and organisations in Victoria. Further, for veterans, the confusion between historical service and contemporary service has led to poorly targeted legislation and support for both serving and ex-serving veterans, this poor legislation support, further exacerbates poor social, psychological and emotional outcomes that often impacts on the families and friend's health and wellbeing also. It is the day to day effects of working within such regimented systems of power, coupled with unrelenting training regimes, and no foreseeable end in sight, that breaks the psyche and affects a person more than any singular trauma or injury (McFarlane et al., 2010). Therefore, it is here, within a systems perspective that should be the starting point for any Royal Commission into mental health. More so in the context of veteran suicide. Therefore, understanding the community in which the mental health service support system aims to serve is absolutely critical and clearly lacking in Victoria. This system is failing veterans who need a specialised, culturally relevant, integrated systems approach to mental health and wellbeing. This approach includes Victoria Health and subsequent mental health agents. Victoria under its current mental health agenda and trials of

integrated service delivery, is well placed to trial a scalable initiative, such as a trauma informed integrated framework and piloting an innovative integrated strategy with the ADF and or DVA that could be scaled up to include sexual abuse survivors or modified to address intergenerational trauma that can arise for children living with veterans with PTSD. Additionally, stigma is a problem for all people living with mental illness and is a wicked problem within the defence population (Gupta, 2013; Zamorski, 2015). If an individual asserts their own agency within the ADF or DVA, that person is labelled the problem, and this happens both directly and indirectly across multiple workplaces in Australia. Practices like this can be stigmatising and disempowering. If they receive care, or raise a complaint, they are labelled the problem, if they remain silent - they may harm themselves or their career (Zamorski, 2015). Fundamentally, the stigma attached to help seeking and receiving care for veterans, heightens the risk of suicide and must be addressed (Zamorski, 2015; Hawthorne, 2013). This has also been the experience of many Victorians who have publicly expressed their distrust and frustration at a fragmented system that denigrates and stigmatises. Choice is key for veterans, providing a choice of easily accessible and low cost/no cost services that have no attachment to the ADF or DVA needs to be addressed. Current service provision usually requires the individual to go through the ADF or DVA depending on their circumstance. Application processes to access the mental health support they need, can be lengthy and demoralising for individuals, reducing help seeking behaviours. A ""record"" of mental health problems can also be career ending for veterans, further increasing stigma and heightening the risk of suicide. "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

"Choice is key for veterans, providing a choice of easily accessible and low cost/no cost services that have no attachment to the ADF or DVA works well and needs to be addressed in Victoria. Current service provision usually requires the individual to go through the ADF or DVA depending on their circumstance. Application processes to access the mental health support they need, can be lengthy and demoralising for individuals, reducing help seeking behaviours. A ""record"" of mental health problems can also be career ending for veterans, further increasing stigma and heightening the risk of suicide. A choice of flexible service providers who are not linked to the ADF or DVA, but still provide the same or increased level of support and service is required. An individualised funding package could also be considered as a mechanism for veterans to enhance autonomy and empower individuals to A lack of planning and investment has left Victorians with poorer access to mental health services than people in other states, according to the Victorian Auditor General's Office Report. Additionally, increasing public outrage over the treatment of Australian veterans is evident, with many claiming they are left without support for mental health diagnoses such as depression and PTSD expedites the critical need for reform in mental health service and systems in Victoria. Programs for veterans and males more broadly, that have been evidenced to improve mental health and wellbeing include but not limited to: Peer support Vet's sheds Male mentoring programs Retreats ? eg. The Banyans Retreat (Queensland) Soldier Recovery Centres ? expansion of the model for those that have left service. Programs that offer a mix of exercise, diet, nutrition and holistic therapies all work well with veterans. As previously discussed, the obstruction and red tape in accessing services through the ADF and DVA is problematic. Acknowledging the current Productivity Commission recommendations into the DVA the DVA is considered not fit for purpose for addressing the mental health needs of veterans. Recommendations for what can be done better: Veterans would benefit from proactive strategies that aim to lessen the burden of mental illness and assist in the transition process. An individualised funding package could also be provided to veterans directly instead of the current

system through the DVA. From there they can choose who they see and when without fear of discrimination and stigma. Reduction of red tape for all persons accessing mental health support with particular focus on veterans accessing DVA support. Removing barriers and limitation - the set amount of mental health appointments and services need to be increased or removed, thus allowing people (not just veterans) to manage their own conditions, how they choose, where they choose and how often they choose without limitation. A choice of flexible service providers who are not linked to the ADF or DVA, but still provide the same or increased level of support and service is required. Victoria under its current mental health agenda and trials of integrated service delivery, is well placed to trial a scalable initiative, such as a trauma informed integrated framework and piloting an innovative integrated strategy with the ADF and or DVA that could be scaled up to include sexual abuse survivors or modified to address intergenerational trauma that can arise for children living with veterans with mental health issues and or disorders such as PTSD. "

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What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

"In the context of Victoria veterans what makes it hard for people to experience good mental health is: Stigma Cost to access mental health services Distrust in mental health service sector Accessibility including inflexible program designs and physical barriers (eg. Veterans may have physical disabilities preventing them from attending appointments) Structure (programs can be inflexible and need to be tailored for particular cultural groups) Fear (help seeking has historically been career limiting for veterans) Limitations of service delivery ie. Set number of appointments allowed under a mental health plan for instance ? people have differing needs at different times, therefore flexibility and access needs to be increased. Lack of connection to family, friends, colleagues etc. Financial stressors (leaving the ADF and not being able to find suitable employment) Relational stressors - family breakdown Drug and alcohol misuse is more prevalent in veteran populations Improvements: Flexible and unlimited options for individuals seeking mental health support, treatment and care. Compassionate therapeutic responses by a well-trained (in suicide prevention) mental health workforce Whole of systems, whole of community-based approaches Place based, community designed approaches/responses Follow up care and postvention support for veterans, families, carers and veteran workforce Rigorous and robust evaluation of all initiatives Funded service agreements embed a suicide prevention impact statement as part of their funding agreement Data collection is improved with veteran data collection embedded with current data collection systems. DVA currently supports some 316,000 clients, however many individuals, for many reasons including stigma, choose not to use DVA and will go their GP for support or a combination. To ensure the early identification and effective treatment of mental health disorders in the veteran population, general practitioners (GPs) need to be aware that the traditional profile of an Australian veteran has changed, and that more than combat service can give rise to mental health issues. "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"Suicide prevention in Australia is increasing. In Victoria it is acknowledged that suicide rates have reduced from 2016-2017 and is lower than the national average (10.9 and 12.9 respectively) (ABS, 2018). However, mental health service provision, including accessibility, satisfaction and support is dire compared to other states even though it is widely conversed that poor mental health and mental illness can be a contributing factor to suicidality. Between 2001-2016 there were approximately 373 suicides (AIHW, 2018). Anecdotally, this number is much higher with estimates ranging from 5-8 veterans taking their own lives every week. The lack of data across the ADF and DVA in addition to the complex and differing data sets used nationally to capture suicide data, makes it increasingly challenging to obtain accurate and real time data. This lack of data is a also a key driver for change. Ex-serving males under 30 are over twice as likely to suicide compared the general population (AIHW, 2018). Ex serving men more broadly have a suicide rate almost 20% higher than males age matched for 2014-2016 (AIHW, 2018). Ex serving men are

more likely to have mental health problems and or disorders and Victoria is home to multiple military bases, defence members and their families. Acknowledging Objective 2 of Victorian suicide prevention framework 2016-2025 that discusses groups who are at a higher risk of psychological distress and suicide. Including early responses to concerns among dairy farmers, regional communities, Aboriginal communities, emergency service workers, paramedics, police, at risk occupations (such as construction and trucking) and lesbian, gay, bisexual, transgender and intersex people (Victoria, 2019). There is no mention of veteran suicide or veteran mental health and wellbeing. This should also be a driver for change and ensuring policy and legislation is also inclusive of veteran mental health and suicide. Reiterating again the Productivity Commission into the Department of Veterans Affairs states the DVA is considered not fit for purpose for addressing the mental health needs of veterans. This is a key driver for change and veterans are not receiving the mental health support they desperately need in a timely or appropriate way, this inefficiency is resulting in veterans dying. What can be done? Acknowledging veteran mental health and suicide is often considered a Commonwealth issue, suicide and mental health issues are a systemic issue and require a whole of government, whole of systems approach if we are to see a reduction. Suicide prevention activities that integrate health, family, carer, and other social support services lower the risk of suicide. (WHO, 2014). A number of recommendations are proposed: DVA is currently not fit for purpose, the mental health system and sector in Victoria needs to increase support to veterans to address the significant gaps in mental health left by the current DVA model. This may include upskilling GPs, allied and medical health practitioners in veteran centric mental health, treatment, assessment and support. A consistent lack of evidence also needs to be addressed. A specific focus on longitudinal and intervention specific evidence needs to be prioritised. There is little evidence in Australia that highlights interventions that actually work. Lifespan and systems-based approaches such as Zero Suicide are showing promise, but further evidence is required. Data - when considering veterans in Australia it is currently unknown how many veterans live in Australia. Therefore, improved data collection is critical. Data collection at key touchpoints, such as hospitals, Centrelink, mental health services, needs improvement. Embedding veteran data in current state and national data systems is crucial. Improved data could provide Victoria and Australia with vital information on where veterans are, how many there are and more specifically how many veteran suicide deaths there are, so we can further investigate and develop programs and initiatives that are efficient and effective in reducing suicide. In summary, a range of options are outlined below that can address some of the drivers discussed: Flexible and unlimited options for individuals seeking mental health support, treatment and care. Compassionate therapeutic responses by a well-trained (in suicide prevention) mental health workforce Whole of systems, whole of community-based approaches Upskilling GPs, allied and medical health practitioners in veteran centric mental health, treatment, assessment and support. Place based, community designed approaches Follow up care and postvention support for veterans, families, carers and veteran workforce Rigorous and robust evaluation of all initiatives Funded service agreements embed a suicide prevention impact statement as part of their funding agreement Data collection is improved with veteran data collection embedded with current data collection systems. Rigorous and robust evaluation needs to be a critical component of any funded initiative and must be costed appropriately. Victoria under its current mental health agenda and trials of integrated service delivery, is well placed to trial a scalable initiative, such as a trauma informed integrated framework and piloting an innovative integrated strategy with the ADF and or DVA that could be scaled up to include sexual abuse survivors or modified to address intergenerational trauma that can arise for children living with veterans with mental health issues and or disorders such as PTSD. "

What are the needs of family members and carers and what can be done better to support them?

"Families are a fundamental component of the support system for serving and ex-serving military personnel who have a mental illness or disorder. Families living with a veteran with mental health issues need support and understanding as do carers in the wider population. While the majority of children of military personnel are experiencing healthy and productive lives, research indicates that children of veterans who were deployed are more likely to experience poorer health outcomes (particularly for mental health).13 This research also revealed that the health outcomes of children of Vietnam War veterans with a diagnosis of PTSD can be especially poor (DVA, 2014). Caring for a suicidal person places immense psychological, emotional and financial burden on families and carers. Adding to the burden on military transitions (schooling, housing, social networks), familial stress is exacerbated. People caring for individuals experiencing a suicidal crisis often have limited access to resources and support options specific to their needs that has significant negative impact on the overall health and wellbeing of carers. Well targeted support for carers helps to prevent the breakdown of care situations and ultimately contributes to better care for the individual. A carer's ability to respond to a suicidal crisis will vary depending on their knowledge and previous experiences, as well as the level of social and personal resources available to them. For Aboriginal and Torres Strait Islander carers the need for support is heightened. Evidence suggests that the provision of education and support to families and significant others may help to reduce caregiver burden, and also impact positively on the individual at risk of suicide. Similarly, providing appropriate information and resources to health care providers to better support carers is important given the relationships between issues and challenges that carers and providers typically face when caring for someone who has a history of a suicide attempt. A range of programs that support families and carers include: Peer support and mentoring Specialised family therapy Psychoeducation Telephone support Group support (online and or offline) Postvention and or aftercare Defence currently has a range of support mechanisms available for families of Veteran's: Kookaburra Kids foundation for children of veterans Defence specific spouse support groups VVCS DVA ? At Ease Veteran and Family Assistance RSL Most of these programs are offered on a standalone basis. Evidence suggests that programs that are open to the public, flexible, multi-modal, accessible, (eg. combining counselling with online/telephone support) are more effective in attracting and retaining carers (Relationships Australia, 2018). Despite their role and vulnerability to health consequences, carers often report being unable to access much needed information to help them cope effectively and commonly feel excluded and unsupported by health services, particularly in the military (Berk et al., 2011). "

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

"A number of approaches can be done to attract, retain and better support the mental health workforce including peer support workers including but not limited to: Embed lived experience peer workforce and provide practical and translatable evidence based suicide prevention training training for all mental health workforce staff such as the CASE approach ? this includes the ADF and DVA workforce Provide flexible, ongoing and assertive follow up care and postvention support for the workforce (including ADF and DVA) who have been exposed to suicidality Veteran centric training and support across all allied and mental health professions "

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise

these opportunities?
"Victoria must consider the recommendations throughout this submission and expedite development, implementation and evaluation to improve social and economic participation."

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"In addition to the previously documented recommendations - I would like to see reform into Victorian Veteran mental health in Victoria, embedding systems approach, integrated service delivery. Another area that requires priority is data and evaluation. Improved data collection eg. collaborating with other government agencies to expand opportunities for data collection that includes veteran and Australian Defence Force status indicators into current datasets to help us to better understand service use, accessible and where achievable, individual outcomes. Evaluation of funded initiatives ? evaluation needs to be rigorous and robust and built into funding agreements. It is suggested that evaluation funding should be at least 35% of the total funding allocation cost. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Scoping and mapping of current services is essential with a particular focus on vulnerable groups such as veterans. Evaluation is a tool that can be cost effective if planned and delivered properly. I would suggest that a research agenda and evaluation framework is developed with a specific focus on veteran mental health and suicide in Victoria. This too can be expanded and adapted to fit for purpose, the broader public arena or targeted for vulnerable populations. "

Is there anything else you would like to share with the Royal Commission?
"A number of recommendations have been provided for consideration. Although this submission has a primary focus on veteran communities, the recommendations could be expanded to address mental health in other vulnerable communities also. The issues that occur with veterans are systemic, therefore a whole of systems, whole of community, system approach is required. Fundamentally, suicide is everyones business, but everyones business is not the same, Victoria is in a strong position to enhance leadership in mental health and wellbeing and suicide prevention in veteran communities that other states can learn from. Thank you"