The Returned & Services League of Australia (RSL) was established in 1916 and is the oldest, largest and most representative ex-service organisation (ESO) in Australia. The RSL is the leading organisation with a firm focus on current serving and ex-serving community welfare.

Firstly, the RSL Victorian Branch would like to take the opportunity to thank the Royal Commission for the opportunity to provide submission to this inquiry into Victoria's mental health system.

As stated, the RSL supports all current and former serving members of the Australian Defence Force (ADF) or of an Allied Defence Force, their spouses, widow or widower, and their dependents. For those entitled, the Department of Veterans Affairs (DVA) provides funding for mental health services; however, others whom we support may not be eligible for entitlement through DVA. Despite whether DVA entitled or not, we know that many from the veteran community require and utilise mental health support and services here in Victoria.

Not all veterans are troubled by their service, with the majority transitioning from the military going on to lead healthy and productive lives together with their families. Unfortunately, for others, transitioning back to civilian life is very difficult. Those most at risk often have mental health conditions that interfere with being able to maintain employment, maintain relationships with family and friends, and/or secure housing.

The March 2019 DVA data in relation to the top 20 accepted disabilities of veterans is telling. Of the 47,121 Vietnam veterans with an 'accepted' disability under DVA, 18,402 (39%) have post-traumatic stress disorder (PTSD) accepted as service related. In reviewing the accepted disabilities of our younger cohort of veterans from East Timor, Solomon Islands, Afghanistan and Iraq, PTSD is the second highest accepted disorder in the top 20. Of the 13,627 of these veterans who have had a claim accepted by DVA, 4,319 (31.6%) have PTSD accepted as service related. The data also shows that depressive disorders, alcohol and drug abuse, anxiety disorders and adjustment disorders are also featuring heavily in our younger veteran cohort. While a high percentage already, the RSL is currently assisting many more from this cohort to complete claims; additionally, research also demonstrates that the trauma of service may not impact until later life. As such, the veteran community is already a significant user of mental health services in all States and Territories and will continue to be so.

Over that past few years, the Commonwealth Government has been increasing the DVA budget in relation to mental health. From increasing eligibility to free counselling via Open Arms (veteran and veterans' families counselling service), extending funding of mental health services to include non-liability mental health coverage, and introducing veteran payments for veterans submitting mental health claims who are unable to work due to a mental health illness. The DVA mental health budget is uncapped, therefore funding is available to assist all veterans needing services. Yet accessing mental health services can still be problematic.

The veterans with significant mental health illness/es whom the RSL support, come to our attention due to relationship breakups (including domestic violence), financial distress, drug or alcohol abuse, suicidal ideations, or homelessness; too often several or all the above at the same time. As such, understanding of what services are best accessed first is often the biggest hurdle to clear. The complexity of issues some individuals present with requires a cohesive and coordinated approach; unfortunately, services that have a wholistic or a wellness approach are more difficult to find.

The RSL will continue to play a role in supporting these veterans. The RSL will advocate in the strongest possible way for ease of access to mental health services that focus on the needs of the person as a whole and provide veteran centric treatments and supports.

In responding to the questions posed by the Royal Commission, the RSL wishes to provide but a few examples by way of explanation.

Question 1: What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Firstly, the RSL would like to share the following excerpt of an email received from a veteran.

> *I recently had a bit of a breakthrough when I swapped the name of my diagnosis from "bipolar disorder" to "cancer." Let's just imagine for a second that last year, I had to go to hospital because I had cancer. Let's say I had 2 rounds of chemotherapy and neither worked. Let's say the doctors tried many different kinds of medications, but couldn't get anything to work on my life-threatening illness until early this year. I think any normal person would feel empathy for me in that situation! People would visit me in hospital, and extend warmth and sympathy towards me had I come down with cancer. However, if I am struck by a very serious episode of bipolar, at least 70% of the people who know me have quite the opposite reaction. Instead of letters of support, I get letters from dear colleagues and friends that say, "I'm not your friend anymore", or "I cannot be your friend anymore" Honestly, it would have been much easier for all parties concerned if I got cancer instead of bipolar disorder because people understand what cancer is. <u>That</u> is the honest truth!*

It is a sad reflection on our society that someone with a mental health diagnosis wishes they had a potentially life-ending disease instead, purely as people understand and empathise with 'cancer'. Everyone knows someone who has been affected by cancer. While people may be afraid of being diagnosed with cancer themselves, they do not shun people with it. In relation to mental health illnesses, there is limited public understanding of the different types of conditions or how the conditions affect people. People are not comfortable with the topic, which is made worse when news stories of bizarre, aggressive behaviour are often explained by, "they have mental health problems".

The veteran community is involved in a great deal of education around mental health disorders. For those working or volunteering in ex-service organisations, there is no stigma attached to a mental health diagnosis, we listen, we support - no judgement.

A possible suggestion is to make mental health conditions more public, in a positive way. In recent times the Victorian government has made an excellent start on highlighting issues such as domestic violence, and more recently elder abuse. Advertisements such as the 'call it out' campaign has put the focus on challenging the types of behaviours that society should not allow to continue. Why can't it be highlighted that the majority of people with mental health conditions lead very normal lives, with the odd medical intervention required, the same as people do for their physical ailments. As the veteran

questioned, everyone understands and sympathises with someone with cancer, why not someone with a mental health illness?

Question 2: What is already working and what can be done better to prevent mental illness and to support people to get early treatment and support?

Victoria has some excellent mental health services, including drug and alcohol services. In addition, telephone and on-line support systems are numerous and provide access to counselling or support when needed most. Veterans are also fortunate to have the Open Arms counselling service providing timely, as well as ongoing, mental health support 24 hours a day. So, there is much that is working well. However, we know it takes a lot for someone to reach out and seek assistance; unfortunately, if the services aren't available when needed, or the person is turned away, they do not readily come back. Services need to be receptive when people do seek assistance.

From the RSL perspective, a challenge we face in Victoria is accessing inpatient psychiatric services, or more specifically, veteran-focused inpatient psychiatric services. This is a noted barrier when trying to prevent further decline in mental health and in getting veterans to access treatment and support early.

To successfully use any program/service, firstly people need to be aware of it, and secondly, they must be comfortable to use it. Unfortunately trust in civilian programs can often be problematic in the veteran community; this is not just in relation to the younger veterans but is something that has been, and still is seen in all veteran age groups and cohorts.

The Psychological Trauma Recovery Service (PTRS) unit at the Heidelberg Repatriation Hospital-Austin Health, still referred to and known as 'Ward 17' by the veteran community, is where all veterans expect to go for inpatient treatment. As 'Ward 17' has treated veterans for decades, there is a trust in the service. Part of the trust also revolves around staff being knowledgeable of veteran trauma, thus veterans are more willing to discuss all the issues currently being faced. There is also a comfort in knowing that others in the unit have a shared experience. By bringing back the military family camaraderie, it creates a supportive environment. Veterans speak so positively of the support elicited from having other veterans with similar problems around them when facing some very 'dark' days.

The PTRS unit is a 20-bed unit that provides treatment and support predominantly to veterans and first responders. The RSL is conscious of the trauma faced by our first responders (professions often favoured by ex-service persons) and understand their need for excellent trauma recovery services the same as veterans. Unfortunately, this leads to a large waiting list. As the PTRS unit is the only psychiatric inpatient facility that veterans want (and expect) to go to, this can create problems with accessing services. Veterans who have had admissions to public hospital facilities (other than Austin Health) report frustration of being admitted with people they cannot relate to, i.e. no shared experience. The PTRS unit needs to be expanded to help meet demand. To reduce the waiting times for veterans to receive treatment there needs to be an increase in bed capacity.

As the title suggests, the PTRS unit is a trauma recovery service; it is not an acute, crisis responsive service. However, in the veteran community, this is not fully understood nor is it accepted. As previously stated, due to the history of the Repatriation Hospital and the veteran psychiatric services that have been provided over the many decades at the hospital, this is where veterans still wish to be

treated. While the RSL is advocating for increased inpatient capacity at the PTRS unit, what is really required is for the unit to be expanded to deliver acute psychiatric services as it did in the initial post-Vietnam era. By expanding the treatment services to include acute and post-acute, it would decrease the confusion of where to seek admission. The treatment flows from crisis to wellness, no need to change hospitals or psychiatric professionals.

If this cannot be achieved by Austin Health, a private hospital may be able to provide another answer. As DVA fund treatment in public or private hospitals, a private psychiatric clinic could establish itself as providing specialist veteran services; a unit for veterans, dedicated to the treatment of veterans. A unit where veterans can receive treatment in an atmosphere where they are comfortable, surrounded by others from the military family.

Question 3: What is already working well and what can be done better to prevent suicide?

In relation to suicide prevention, DVA funds training for paid staff and volunteers working in the veteran community. We take this training very seriously so we can 'pick up' on veterans with suicidal ideation and help them to access urgent assistance and support. We know it's not perfect as there are still far too many veteran suicides, but we are all working hard to find ways to prevent as many as possible.

However, it does not assist when mental health professionals disregard people with suicidal ideations. We wish to give the Royal Commission the following example of service failure:

A veteran well known to the RSL Vic Branch made contact following an attempted suicide overnight. The veteran advised that he had attempted to 'end it all' with drugs; fortunately, he was unsuccessful as he had become severely ill during initial dosing. While the veteran has a history of drug abuse, he stated that he had been clean for close on five months and that he had purchased the drugs to 'kill himself' not to get high.

Needing medical assistance/safety for the veteran (effects post drugs), the veteran was escorted to the emergency department of a [redacted] public hospital – the experience here was very different to what was expected. While the triage nurse, the admission clerk and the medical intern who looked after the veteran cannot be faulted, the psychiatric registrar did not help the situation.

It is understood that persons affected by drugs can be a risk to staff; however, this veteran was becoming quite drowsy and was quite calm, there had been no displays of anger or aggression of any kind noted. Around 40 minutes after arriving at the hospital, the psychiatric registrar stated (to the RSL staff members who had escorted the veteran):

- 'He has chronic mental health problems, so he doesn't need admission'
- 'He has a DVA card, so he can get into any service he wants – doesn't need to be here'
- 'You can organize somewhere for him to go' (*thought DVA & RSL were the same)*
- 'He has a psychiatrist, so he needs to go back and see him today' (*NB: the veteran's psychiatrist was four hours' drive away in regional Victoria, more by train which was the mode of transport used by this veteran)*

Following attempts to further discuss concerns about the veteran's (still current) suicidal ideations, the psychiatric registrar stated:

- 'If he suicides, it's on my head not yours'

At this point the psychiatric registrar stated that the veteran would not be admitted and was to leave the hospital. He was discharged with three (3) diazepam tablets and no follow up. It was left to the RSL to make sure the veteran was kept safe that night!

While the veteran appeared calmer the following morning (Friday), he stated that thoughts of 'just ending it' had not gone away – he was still far from well. Enlisting the support of the counsellors from [redacted] who also agreed the veteran was suicidal, the veteran was escorted to the emergency department of another [redacted] public hospital. [redacted] had been able to arrange admission to the PTRS unit at the Heidelberg Repatriation Hospital-Austin Health for the following Tuesday, and this information was reported to the hospital. While initially informed by the hospital that the veteran would be admitted, the veteran was then told he would not be. Following a great level of advocacy from both [redacted] and the RSL the veteran was kept overnight but was then discharged the following day with a packet of diazepam; again, no follow up was organised. The veteran took all the tablets! Fortunately, he made a phone call to say good-bye to his family, which set off a chain of events starting with the ambulance being called and the veteran being taken back to the hospital.

The veteran was transferred to the PTRS unit at the Heidelberg Repatriation Hospital-Austin Health, as scheduled the following Tuesday, having never passed further than the emergency department of the hospital.

There was a total lack of empathy shown to this veteran by the psychiatric medical staff at both hospitals. To have a Doctor say 'if he suicides, it's on my head' is totally unacceptable. Would the treatment (by the doctors) be different if the veteran had tried to commit suicide by means other than drugs, ie was he just seen as a 'junkie'?

RSL Advocates, support staff and volunteers all want to have faith that the system will look after and treat veterans when they are in need, even more so when they are in crisis. However, the current system prevents us comprehending how to navigate the many obstacles facing veterans when they are desperately seeking help or needing admission to a mental health facility.

From a national perspective, the federal government continues to announce increased funds for mental health in each year's budget yet waiting lists for services are still a reality. In relation to services for veterans, the DVA budget now has uncapped funds for mental health treatments and supports. Additionally, the introduction of DVA's non-liability mental health cover allows veterans to seek mental health treatment as soon as they need it, without needing to first prove that the condition is service related. As such, there is an assumption made by the general health care system that all veterans have easy access to services, and that they receive the right support. Unfortunately, on the ground it is not

the case, veterans have as many problems accessing services, particularly in-patient services, as everyone else.

The example above demonstrates that despite the veteran presenting with suicidal ideation, it was not taken seriously by the system. There were many things that could have been done better by both hospitals in this case. With the exception of one registrar suggesting the veteran go back to see his own psychiatrist, there was no other follow up support discussed or offered.

What could have been done better: even if persons presenting with suicidal ideations are not to be admitted, where there have been recent thoughts of suicide there should be immediate follow up support organised prior to the person being discharged from hospital, particularly when discharging from emergency departments.

Question 5: What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Geographical location does make a difference:

Those in rural or remote areas have less access to specialist services than people in metropolitan areas. A known fact that we all accept and search for ways to improve. Yet it is no longer just those in rural and remote areas finding service provision difficult. Housing affordability is a main driver for people to move to areas outside major metropolitan locations, yet the further we expand geographically around our large cities, the less infrastructure is in place and the fewer services are available. The veteran community is further impacted in non-metropolitan locations as not all health providers, including mental health specialists, will accept the DVA payment schedule. This has resulted in specialists refusing to take veterans as clients unless they agree to (privately) pay an additional fee.

The RSL firmly believes that there should be no out of pocket costs for people to access necessary professional supports for mental wellness, whether funding is provided by DVA or Medicare rebates.

In exploring ways to overcome geographical service provision, Telehealth has been an ongoing suggestion. However, there needs to be further development and expansion of this type of service for it to be beneficial.

Another avenue the RSL would promote is greater use of technology. Use of online information, interactive services, and social media have become the norm in society, particularly for younger generations. The use of apps is now commonplace. Many of the veterans the RSL support are now utilising smart devices to monitor and improve their sleep patterns. The data can be easily downloaded and shown to the medical or mental health practitioners to demonstrate, with accuracy, how they are sleeping. The RSL recently received a request from a psychiatric unit to fund the purchase of a Garmin watch for a veteran. While initially considered a strange request, the veteran (suffering PTSD) is now able to monitor his heart rate. Where his heart rate starts to increase, the veteran utilises the strategies taught to decrease his heart rate, thus non-escalation of his disorder.

A recently released report from the Transition and Well-being Research Programme, commissioned by DVA and Defence, is the *Technology Use and Well-being Report*. The study investigated use of the

internet and emerging technology by persons who had transitioned from the ADF compared to use by persons still in the ADF in 2015.

> *Overall use of internet was high, with more than 95% of the Transitioned ADF and Regular ADF using 1-2 hours a day. Around 20% of both the Transitioned and Regular ADF reported that going online when going through a difficult time made them feel better. Among the Transitioned ADF, those with a probable disorder were more likely to spend more time on the internet and to use the internet after 11pm. Both the Transitioned ADF and Regular ADF with a probable disorder reported that it was easier to be themselves online and that they talked about different things online, they went online more often when going through a difficult time, and going online made them feel better.*
>
> *Half of the Transitioned ADF and Regular ADF reported using new and emerging technologies, with 80% using apps and a third using wearable devices.... A quarter of the Transitioned ADF and Regular ADF used them to 'improve sleep'..... Among those who reported using new or emerging technology, around 20% of Transitioned ADF and almost 10% of Regular ADF met the criteria for a probable disorder. Transitioned ADF were more likely to use new and emerging technology to improve their mood.*

The use of apps and technology could be better utilised to assist those with mental health conditions monitor their well-being. However, there are cost implications to the system. For veterans with DVA entitlement this is an area the RSL will explore further with DVA. For the general public, it needs to be recognized that the benefits in preventing mental health deterioration would well out-weigh any costs.

Cost implications:

Costs of services and supports, including technology, do have an impact on what is able to be accessed, thus do have impact on communities. While veterans entitled to a DVA health treatment card, including non-liability health cover, can have mental health services fully funded by DVA (public or private services), others from both the veteran community and the general community are not so lucky.

The RSL received a recent request from an occupational rehabilitation provider to assist with funding an inpatient stay at a private mental health clinic. The veteran was not eligible for DVA funding for treatment and had no private health insurance. According to the rehabilitation provider, a two-week stay in the private clinic was the preferred option for treatment, as opposed to going via an emergency department to access services for a few days under the public sector. The quote was for a minimum of $40,000 for a two-week admission. Certainly, this type of cost could never be afforded by the majority of people in the general population. DVA entitled veterans are also fortunate to be able to use private residential drug and rehabilitation services without cost to themselves; unfortunately, again these private residential facilities are far too costly for most people to afford. They are certainly well out of reach for anyone in receipt of Newstart allowance or disability support pension.

While most people who are homeless would not be trying to self-fund mental health treatment, it is not beyond scope that others may put up the funds for a loved one/friend to undergo treatment. Unfortunately, private inpatient mental health clinics will not accept anyone without an address. While it is understandable that the clinics do not wish to become homelessness services, for people to re-stabilize their mental health conditions they often need inpatient services, and all too often, private

clinics are the only ones with immediate vacancies. Even with DVA funding for service provision and the RSL guaranteeing to assist with post discharge accommodation, veterans have been denied admission to inpatient services due to their 'homeless' status.

While the RSL cannot solve the cost implications for the general public, we can assist our community. For individuals from the veteran community who may not be eligible for DVA entitlement/funding of services, for example Allied veterans or family members of veterans, the RSL can assist with ensuring that services can be afforded, particularly where access to services is deemed urgent. The RSL can also assist with the funding of technology components deemed beneficial to the monitoring and controlling of symptoms or ongoing wellness. But if we do not know when individuals from the veteran community need assistance, we cannot support them. The RSL has an excellent relationship with the PTRS unit, as such a two-way referral system is well established. While the RSL has good relationships with some private providers, it is of concern that some veterans may not be aware of extra support they could receive from ESOs.

The justice system now asks the question, 'have you served with the ADF?' – it is a simple question that has enabled the justice system to identify veterans. By identifying them, the justice system is able to tap into the ESOs for support when the individual is coming up for parole. A similar question should be part of the entry form in all health settings, particularly emergency departments, but should also identify family members of a veteran. While many veterans may hold gold or white DVA health cards, it should not be assumed that they all do. Protocols could be established to connect persons identified from the veteran community with DVA, with Open Arms, or with ESO services.

Question 6: What are the needs of family members and carers and what can be done better to support them?

The effects of a mental health disability can have far reaching impact on the life of an individual and his/her family. Partners and/or caregivers of veterans who suffered PTSD have been shown to have higher levels of depression, anxiety, hostility, obsessive compulsive symptoms, and physical complaints.

A recent call for RSL assistance was from a 65-year-old wife, and full time carer, of her husband. Her husband, a veteran, has multiple physical and mental health co-morbidities; the wife is currently suffering severe depression. In searching for mental health supports for herself, she made a phone call to My Aged Care, who referred her to the NDIS; of course, the NDIS referred her back to My Aged Care. Two separate systems, but no support offered to her from either. While the veteran receives assistance via aged care services, the system is so focused on the veteran and his needs, the system did not identify or address her needs as a caregiver, nor did it refer her to mental health services. Health provision services are still working in silos.

Mental health disorders can be extremely disabling, affecting an individual's well-being on every level; for the wife in this example, her depression is so severe it has further impacted on her ability to socialize, communicate with family, to care for her husband and to care for herself. As the system failed to recognize her needs, the RSL is assisting the wife to access community mental health services, and providing some companionship visiting to check on her well-being.

As the different health systems still operate in silos, all too often it is being left to community groups, such as the RSL and other mainstream community organisations, to pick up and assist individuals who fall through the gaps between the systems, particularly carers. There must be integration of the different health care systems. Furthermore, for many carers, the ability to attend appointments for themselves is very limited. Services need to be made available to reach out to the carer in their own environment. As a nation we rely on unpaid carers, there must be improved support services available to them.

Question 9: Thinking about what Victoria's mental health system should look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

As a result of funding boundaries, health, mental health, disability and aged care all operate in silos, an issue that is often talked about but not addressed. The ability for these different health systems to operate less as standalone systems and more as an integrated whole of health approach has now become a priority. Likewise, mental health services need a more wholistic approach and focus.

Back in June 2009, the National Health and Hospitals Reform Commission Report stated that it was imperative for people living with mental illness to be supported across the whole spectrum of health and social support services, including employment support and assisted housing, as without these supports being provided in an holistic way, 'people with severe mental illness can experience a downwards spiral that impairs their ability to live a normal life.' (*National Health and Hospitals Reform Commission Report: A healthier future for all Australians, final report June 2009, pg 106*).

The need for mental health programs to have an holistic approach has not changed since 2009, nor has it already been addressed in all but a few individual programs.

The same process needs to be followed as is completed for any illness: assessment of all needs, followed by treatment/support to meet those needs, followed by ongoing review to ensure the treatment and support provided has been appropriate and successful. Going back to the cancer analogy, when diagnosed with cancer the medical professionals discuss and provide treatment options, from recommended treatment through to any/all alternatives; referrals are also made to numerous other health professionals to support treatment regimens and symptom management. Preferred treatment is then given, with the individual being fully supported by a much wider health team. The assessment and treatment for someone with cancer takes multiple months, with follow ups for years. The same pattern of assessment, treatment/support and long-term follow-up also exists in other physical disease processes, such as arthritis, motor neurone disease, diabetes, etc., to name but a few. So why should someone with a mental health illness be treated any different?

The need for a more holistic approach is inarguable. Psychiatric treatment, whether provided as an inpatient or an out-patient basis, will not be effective unless areas such as financial hardship, drug and alcohol use, housing, employment, and support networks have also been addressed.

The RSL is very aware that financial debt often plays a significant role in a decline in mental health. The RSL has developed good working relationships with a number of mental health providers and associated program providers, including PTRS, Open Arms, and occupational rehabilitation services, to ensure providers are not hesitant in contacting us when assistance is required. Where the worry of debt is

impeding the veteran's treatment, the RSL can provide financial support which enables the veteran to then focus on his/her program to improvement. While the RSL can support the veteran community with this area, financial counselling should be readily available in all mental health treatment units; assistance with debt management is one less stressor to recovery.

Drug addictions and/or alcohol abuse is a difficult area. While services are available, understanding where to start can be confusing. Even more so where the individual does not necessarily wish to give up the drug of choice. A dilemma noted by the RSL is getting veterans to access specialist addiction services rather than just inpatient psychiatric services. Potentially this is a health issue that requires more focus and information on how to go about successful treatment.

Housing considerations must also be of high importance. The RSL is keenly aware that there are homeless veterans. While no-one can provide exact numbers, it does not negate the problem. The RSL is fortunate to be involved in the Veterans Transitional Housing units in Richmond. While it has provided a stopgap for some homeless or at risk of homelessness veterans, it is far from being the solution to all. The RSL's experience in this program has demonstrated the significant mental health support that is required to be provided for homeless individuals; certainly a 'safe' roof over their head is only a small component of the battle forward. As such, while an increase in affordable housing is needed in Victoria, programs to support persons needing housing assistance must be available, accessible and utilised.

Employment opportunities are another vital component to recovery. A job can improve self-worth, as well as providing a steady income. For veterans, there is a strong need for employment to be more than just something that pays the bills. Veterans proudly served their country, as such they often seek employment that is meaningful and beneficial to society. The RSL acknowledges the Victorian Government's 'employing veterans in the Victorian Public Sector' program and the success of this initiative. Unfortunately for some veterans with mental health illnesses, rejoining the workforce is not yet an option or may never be an option. Programs to assist individuals regain self-worth and feel productive are of vital importance to improving mental health.

All too often the only treatment or support being provided to a veteran with a mental health illness are some tablets and a three-monthly follow up with a psychiatrist. There are individuals who change medication regimes, including change of medication, alone; no-one around to ensure there are no adverse effects. By providing wholistic care and treatment, a support team approach ensures this does not occur. Ongoing and embracing support would play a pivotal role in recovery and maintaining optimal mental health wellness. The importance of reconnection with family and friends or social groups is another area not considered as part of treatment provision yet is fundamental to a person with mental health conditions improving their quality of life.