RSL CARE SA

ROYAL COMMISSION INTO DEFENCE AND VETERAN SUICIDE SERVICE PROVIDER INPUT

To: Royal Commission into Defence and Veteran Suicide
Department of Veteran Affairs
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EXECUTIVE SUMMARY

1) Veterans are at greater risk of homelessness than are general members of the community.
2) Veterans who are homeless are at greater risk of death by suicide than are other veterans.
3) Some aspects of service life can adversely affect the capacity of a veteran to obtain and maintain suitable housing post-separation.
4) Some aspects of the transition process can increase the likelihood that a veteran will find themselves on the homeless spectrum.
5) Veterans who discharge for medical, administrative and/or discipline reasons are at greater risk of homelessness.
6) Some aspects of the transition process for medical, discipline, and administrative separations from Defence can increase the likelihood that a veteran will find themselves on the homeless spectrum.
7) If a veteran is on the homeless spectrum, it is much more difficult to provide them with the clinical, psychological, and social support they require to address their suicidal ideations.

8) By examining the ‘upstream’ causes of veteran homelessness, potential markers for later suicide attempts may be identifiable and interventions created.

9) During the transition process from defence, veterans who are ‘housing vulnerable’ should be managed separately by specialists to prevent them from becoming actively homeless once they discharge.

10) By preventing or at least reducing occurrences of veteran homelessness, suicide rates may be improved.

11) Veterans should be able to nominate who their primary support person is, and this person should be eligible to receive the support of Open Arms. For homeless veterans this support person is rarely the spouse.

12) Older veterans suicide at rates greater than the normal population, but this cohort is much less visible than occurrences of younger-veteran suicide. More research is required to increase visibility of this group.

13) Older veterans can become isolated from family and friends, usually as a result of complex mental health and substance abuse issues. As a result older veterans can often find themselves on the homelessness spectrum.

14) Older veterans who are socially isolated and on the homeless spectrum have few options available to them to receive care and support, other than through the residential aged care industry.

15) Older veterans enter residential aged care at ages younger than the general population.

16) Older veterans seeking to move into residential aged care can face many barriers that will prevent them from gaining access to a funded place, meaning that many will not be receiving the support they require.

17) Older veterans are more likely to have experienced trauma during their life, and to suffer from other mental health disorders. However with the passing of the WWII population and the increasing number of aged care workers who come from overseas, the aged care industry is rapidly losing its capacity to provide culturally-specific care for veterans.

18) The aged care industry is not trained to provide Trauma Informed Care.

19) The majority of services provide by DVA for veterans do not extend into the residential aged care sector.

BACKGROUND

20) RSL Care SA is a proud not-for-profit (NFP) organisation that has been serving the veteran and broader community of South Australia since 1915.

21) RSL Care SA operates two residential aged care facilities, four retirement living (RL) villages, and a veteran homelessness program. These services are summarised as follows:

   a) Residential aged care - **The War Veterans Home** – 95 licensed beds (Adelaide)

   b) Residential aged care - **Morlancourt** – 61 licensed beds (Adelaide)

   c) Residential aged care – ***Romani*** *- 72 licensed beds, under construction, due for completion in November 2022 (Murray Bridge)*

d) **Andrew Russell Veteran Living (ARVL)**- Homeless veteran program, comprising of the following:

i. 10 x emergency accommodation units (Sturt). In total these units have provided emergency accommodation to 145 homeless veterans.

ii. 16 x affordable housing units in Campbelltown (Adelaide)

iii. 15 x affordable housing units in Wallaroo (regional SA)

iv. 5 x affordable housing units in Angle Park (Adelaide)

v. 3 x affordable housing houses (3 x bedroom) in Angle Park (Adelaide)

vi. 20 x 1-bedroom units (dispersed around Adelaide metro) under an MOU with Westside Housing.

vii. **Total of 69 units**.

e) **Retirement Living** – a total of 229 independent living units, as follows:

– **Hamilton Village**, Adelaide, 31 units

– **Sturt Village**, Adelaide, 36 units

– **War Veterans Home Village**, Adelaide 25 units

– **Waterford Estate**, Murray Bridge, 137 units (with seven new units under construction)

22) While RSL Care SA maintains close ties with RSL SA/NT we are a separate entity entirely, with our own constitution, mission, objects, and with a volunteer skills-based Board.

Areas of RSL Care SA's interest

23) With respect to the Royal Commission into Defence and Veteran Suicide (RCDVS), this submission is made based on the experiences we have gained operating ARVL, which is RSL Care SA's homeless veteran program explained in paragraph 21.d.

24) In this regard the following areas are of particular interest to RSL Care SA:

a) Veterans who are homeless or on the homeless spectrum.

b) The high rates of suicidal ideation and attempts among homeless veterans.

c) The positive impact that housing can have on a veteran's overall experience of health and wellbeing.

25) These areas of interest will be explored in this submission, in accordance with the RCDVS's authorised lines of inquiry presented by the Governor-General of the Commonwealth of Australia via the Letters Patent, issued 8th July 2021.

ANDREW RUSSELL VETERAN LIVING (ARVL)

26) In late 2016 RSL Care SA commenced operating ARVL in order to support veterans who are homeless or at risk of homelessness.

27) RSL Care SA receives no government funding for ARVL.

28) ARVL's capacity is described in para 21.d of this submission.

29) Of ARVL's 69 units, the 10 at Sturt (para 21.d.i. are exclusively used for short-notice and emergency interventions, primarily for those veterans who are actively homeless. The remaining 58 units are used to provide longer-term affordable housing solutions.

30) The ARVL veteran data provided in subsequent paragraphs in this report relate purely to the veterans who have accessed ARVL's emergency accommodation (that being the 10 units at Sturt), not to those veteran who are residing in our long-term affordable housing accommodation.

AUSTRALIA'S HOUSING CRISIS

31) The pandemic has highlighted the dysfunctional reality of Australia's affordable housing system, as evidenced by CoreLogic's rental review for the June 2021 quarter showing that national rent rates grew by 6.6% in the preceding 12 months. In regional areas rents have risen an average of 17.7%.

32) *Housing stress* is encountered when a low-income tenant faces housing costs that leave them with insufficient income to cover food, clothing and other essentials. The problem of housing stress is defined as being when housing costs are more than 30% of the gross household income. For ARVL, on average our homeless veterans earn $ $690 per week (usually through a DVA pension or government unemployment allowance newstart/jobkeeper), which when combined with government rent assistance ($140 per fortnight) means that on average our ARVL residents could afford to pay $277 per week before being officially under housing stress.

33) CoreLogic's Rental Review for the June 2021 quarter showed that the median rent across Australia is currently $476 per week, $199 per week above the average that an ARVL resident can afford to pay.

34) Veterans who have multiple health conditions are often required to reside in capital cities where many of the necessary mental and social health services are available to them, and in metro areas the average weekly rent is $492 ($215 above the average that an ARVL resident can afford to pay). The median rental prices by capital city are as provided follows (as at June 21):

    a) Adelaide – $430 per week
    b) Melbourne – $444 per week
    c) Perth – $472 per week
    d) Brisbane – $476 per week
    e) Hobart – $499 per week
    f) Darwin – $548 per week
    g) Sydney – $582 per week
    h) Canberra – $620 per week

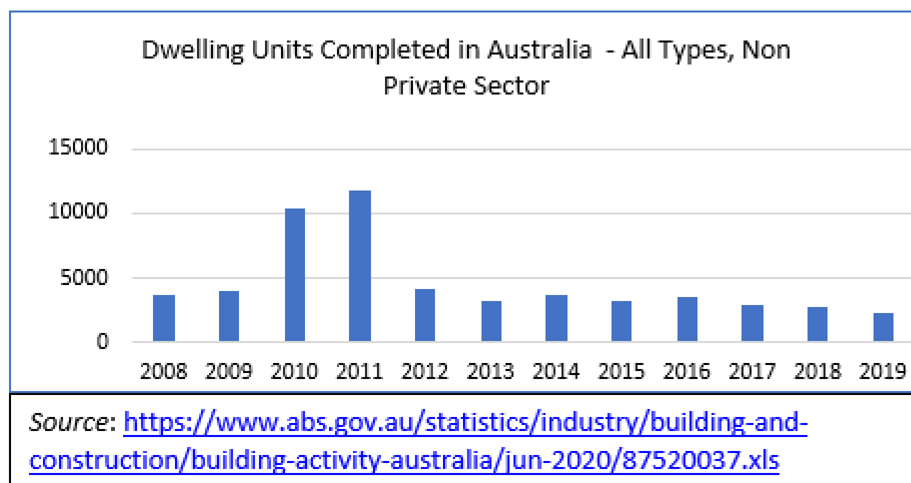
Affordable housing availability for veterans

35) Securing stable and affordable housing is a critical issue for veterans, particularly for those who are vulnerable through poor mental health, physical health, and/or social issues. Unfortunately the nature of Defence service (geographical instability and subsidised housing for current-serving members) can result in situations of reduced homeownership for veterans, making some vulnerable to housing instability post-separation.

36) Having access to suitable affordable housing isn't just a safety net, it is a springboard though which vulnerable veterans can progress from periods of housing-risk to long-term stable renting or homeownership. However, in Australia there has historically been a lag in the establishment of adequate affordable housing stock to meet demand, meaning that each year the relative availability of affordable housing reduces as the population grows. In very real terms, the problem is getting worse each year.

37) According to the Community Housing Industry Association (CHIA), the annual rate of non-private dwelling completions in Australia hovers around 3,000, with the exception of those years immediately after the Global Financial Crisis when the social housing stimulus program had a positive impact.

Figure 1.



Source: https://www.abs.gov.au/statistics/industry/building-and-construction/building-activity-australia/jun-2020/87520037.xls

38) Just to maintain social housing at the current level (4.2% of Australia's total housing, which is already inadequate), CHIA advises that Australia needs to develop around 15,000 homes annually. However as Figure 1 demonstrates, the nation is consistently building less than 4,000.

39) This data demonstrates how veterans are required to compete for an ever-diminishing housing stock, often against members of other vulnerable and special needs groups who will receive higher priority.

COMMON THEMES AND ISSUES AMONG ARVL'S VETERAN POPULATION - LIVED EXPEREINCES OF SUICIDAL BEHAVIOURS

40) Recent Australian research estimates that approximately 5,800 contemporary veterans experience homelessness over a 12-month period in Australia (Hilferty *et al* 2020). This estimate is based on primary data, and it demonstrates that veteran homelessness is a genuine area of concern although arguably it is not an insurmountable problem.

41) The issue of veteran homelessness is of relevance to the RCDVS because the prevalence of mental health concerns is a common theme among veterans who are on the homeless spectrum.

42) A detailed analysis of U.S. veterans (Tsai *et al*, 2018) found that veterans with a history of homelessness attempted suicide in the previous two years at a rate >5.0 times higher compared with veterans without a history of homelessness (6.9% versus 1.2%).

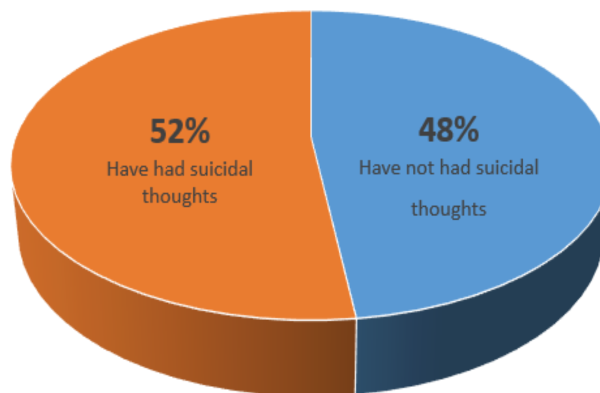
43) Similarly, in their 2015 study McCarthy (*et al*, 2015) found that the frequency of suicide in younger homeless veterans was 2.5 times that of veterans with

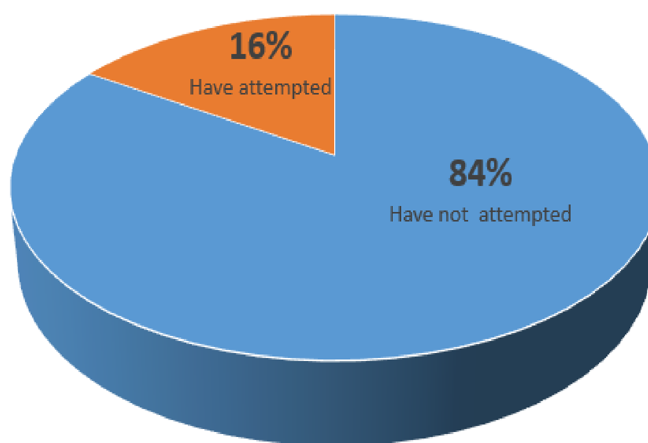
no history of homelessness. In older veterans, the frequency of death by suicide is twice that of veterans with no history of homelessness. This data is consistent with a previous report that found that the suicide rate among veterans with homelessness in the preceding 12 months was 2.3 times higher, with 81.0 suicides per 100,000 as compared to veterans without recent history of homelessness having a rate of 35.8 per 100,000 (Shinka and Byrne 2018).

44) The evidence is clear in this regard, there is a strong association between being homeless and having an increased likelihood of suicidal ideation and suicide attempts.

45) With respect to the veterans accommodated in ARVL's emergency accommodation program (para 21.d.i), these veterans self-reported mental health concerns is shown in Figure 2:

Figure 2: Self-reported ARVL mental health concerns





46) While homelessness is not apparent in all cases of defence and veteran suicide or lived experiences of suicidal behaviours, it can be seen that homeless veterans are a particularly vulnerable and important cohort to

consider when inquiring into the broader issues associated with veteran suicides. On the one hand this realisation highlights a range of challenges for those individuals and organisations who carry responsibilities for reducing veteran suicides, however this knowledge also creates areas of potential opportunities for the establishment of targeted actions and interventions that may help to reduce the nation's veteran suicide rates.

47) Tsai *et al* (2018) observed that although many veterans in America who died by suicide were not actively engaged in the U.S. Department of Veteran Affair (VA) care, other services that support homeless veterans could have provided additional pathways for suicide intervention strategies beyond those that exist within the normal VA care network. Similar opportunities could exist in Australia, whereby veterans who are being managed on the homelessness spectrum but who are not actively engaged with DVA or Open Arms (in our experience some choose not to be), but could be supported by tailored strategies that purposefully extend into the homelessness and affordable housing sectors. This in turn could provide critical pathways for the identification and management of veterans who are vulnerable and have suicidal ideations, but who otherwise might not be connected with veteran support services that are more mainstream.

48) By reducing occurrences of homelessness among Australia's veteran population and by improving accessibility to the relevant wraparound services to penetrate deeper into the homeless veteran community, RSL Care SA suggests that positive inroads can be made to reduce occurrences of veteran suicide.

SUICIDALITY AMONG OLDER HOMELESS VETERANS AND OLDER VETERANS

What is an 'older' homeless person?

49) Studies show that homeless individuals aged 50 and over experience geriatric conditions at rates that are equivalent to those in the general population who are 20 years older (Brown *et al*, 2016) (Shinka and Byrne, 2018). It is therefore useful to consider a threshold of around 50 years of age as being a relevant guide for identifying and categorising exactly what is meant by the term "older homeless person". This compares quite unfavourably with the general community assessment of what an older person might be, which usually applies to people aged 65-years and above.

50) In their study, Brown *et al (2016)* found that a group of homeless people with a median age of just 58 years had more trouble bathing, dressing and eating than 80-year-olds who had housing. Homeless elderly faced more difficulties using transportation, taking their medications, managing money, applying for benefits, arranging a job interview and finding a lawyer. They had higher rates of cognitive and visual impairment and urinary incontinence, and they were more prone to falls and to be depressed. About 40 percent of homeless adults reported difficulty with one or more activities of daily living, while a third reported having fallen in the past six months. About a quarter had cognitive impairment, 45 percent had vision impairment and 48 percent had urinary incontinence

What is an 'older' homeless veteran?

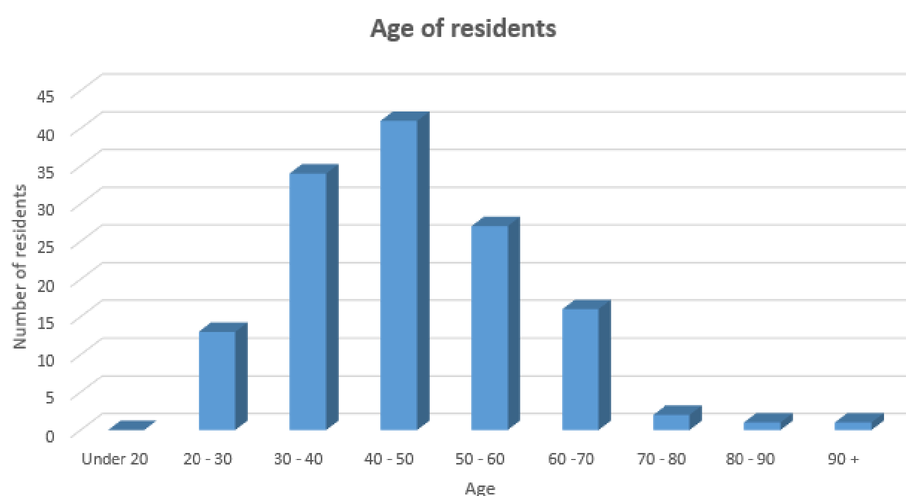
51) Sadly we don't know much about Australia's older veteran homeless population, when we should. Australian research reveals that very little is known about the extent of homelessness amongst older Australian veterans

(Hilferty *et al,* 2020), which signals a potential need and direction for future research.

52) While there is a general lack of data available to describe the rates of homelessness amongst Australia's older homeless veteran population, evidence from the U.S. found that in 2009 those aged 51 and above comprised about 47% of all veterans who used emergency shelter over the course of a year, however by 2016 this percentage had grown to 59.1% (Shinka and Byrne, 2018).

53) InFigure 3 it can be seen that the issue of older veteran homelessness is not confined to America, with the following age brackets noted in ARVL's emergency accommodation:

Figure 3: ARVL - Age demographics of residents



54) Of the ARVL residents, 48 (34%) have been older than 50 years of age, with the oldest ARVL resident being 92 years.

55) When comparing the over 50s veteran group to the younger veterans accessing ARVL, the following is worth noting:

a) A larger percentage are male (92% compared with 88%)

b) The Jamie Larcombe Centre (JLC) is still the predominant referral pathway; however, unlike the younger veterans less older veterans come from the prison system or from visible recovery. See Figure 11 on page 20 for a complete summary of the referral pathways to ARVL.

c) A greater number of older residents are not able to move from ARVL's crisis accommodation into a private rental (they cannot maintain private rental accommodation), and therefore they remain with ARVL's affordable housing or move into RSL Care SA's residential care services. Without these services they would have remained in a situation of being actively homeless.

d) A higher number of older-veteran referrals come from generic homelessness agencies (such as Hutt street Centre, homelessness connect, etc), whereas younger veterans are more likely to self-refer.

e) Fewer over 50's indicated a history of substance use (23% of over 50's compared with 61% of under 50's), had suicidal thoughts in the past 12 months (35% of over 50's compared with 53% of under 50's), or report having actually attempted suicide in the past 12 months (4% of over 50's compared with 19% of under 50's).

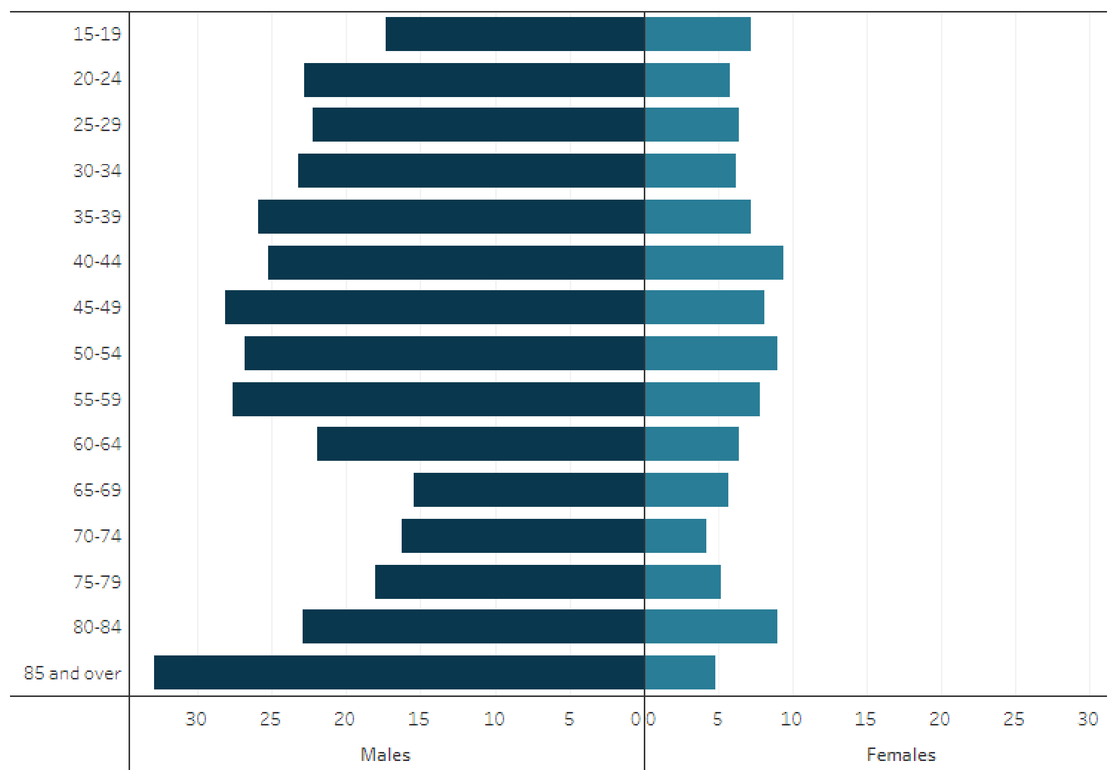
56) Researchers from the U.S. did not find any difference in geriatric conditions between homeless people who camped on the streets, cycled between shelters and hotels, stayed part time with family and friends or had recently lost their rental housing. This is of relevance to ARVL's older veterans, given that many existed on the homeless spectrum without necessarily camping on the streets, but from a health and wellbeing perspective they still seemed to have aged in advance of their years.

What is older person suicide?

57) Historically, the rate of suicide has been highest in the elderly, and suicide attempts among older persons are more likely to be lethal than among younger age groups. This may be attributed to declines in physical condition, making survival less likely, social isolation reducing the probability of successful rescue, and suicide attempts that are more carefully planned (Shinka *et al,* 2012).

58) Crestani *et al* (2017) also found that rates of suicide increase with age and reach their highest levels in the oldest age groupings and are sufficiently large for them to constitute a public health concern. The Australian Institute of Health and Welfare (AIHW) report similar findings, stating that while males aged 85+ only accounted for 2.7% of the total male deaths by suicide, they had the highest age-specific rates (32.9 per 100,000 population). The age-specific rate for females aged 80–84 was 9.0 per 100,000 population—the second highest age-specific suicide rate behind those aged 40–44 and equal with females aged 50–54. This indicates that deaths by suicide have a significant impact on these older age population, and age is a risk factor for suicide.

Figure 4: *Age specific suicide rate by sex and age – 2018 (source: AIHW:* https://www.aihw.gov.au/reports/australias-health/suicide-and-intentional-self-harm)



59) Homeless older veterans are at greater risk of suicidal ideation and attempts than is the general ex-service population. As a result, it is suggested that Australia's population of older homeless veterans should be specifically researched as a cohort, because by better understanding this vulnerable group we can create additional opportunities for targeted interventions that may reduce occurrences of veteran suicide in this population.

60) However suicidal ideation for the elderly is not restricted to the homeless, and RSL Care SA feels that the issue of older person suicide is a largely hidden concern for our veteran population generally. Certainly in our experience we have been required to manage several suicide attempts and numerous cases of suicidal ideation amongst older veterans in our residential aged care facilities, usually without the same access to specialised mental health support and counselling services that would be available if these residents were from younger cohorts residing in the community. Importantly, these instances of suicidal ideation were not related to a desire for a medically assisted death due to ailing health, but rather were directly related to issues of mental health and depression.

61) There are potentially three main issues for the RCDVS to consider regarding older veteran suicide, being:

   a) **Issue 1: Visibility**. Older veterans and particularly those in residential aged care are largely invisible to organisations such as DVA and Open Arms.

      Also, some aspects of suicidal ideation in the elderly may be incorrectly attributed to a desire for the veteran to be supported to have a medically assisted death, which is a different issue entirely. More research is required into older veteran suicide, and as part of this there needs to be an improved capacity for DVA to capture data concerning older person suicides and suicidal ideation.

   b) **Issue 2: Access to suitable services**. Most aged care services lack the specialised skills needed to adequately manage veteran issues, and most veteran-specific services do not enter residential aged care. This needs to improve.

   c) **Issue 3: Funding.** At just $7.37 per day, the *Veterans Supplement* for aged care is grossly inadequate. Furthermore, this funding is largely inaccessible to the aged care sector, meaning that many veterans who are otherwise eligible (for what is an unnecessarily limited eligibility) do not receive it. The funding needs to be increase to at least $15 per day, and its eligibility criteria and approval process needs to be improved to increase penetration into the industry.

62) These issues are explored further in this following section on older veterans in residential aged care.

COMMON ISSUES AND BARRIERS FACED BY OLDER VETERANS ACCESSING AGED CARE SERVICES

Inadequate homeless services

63) Unfortunately many emergency accommodation solutions simply do not cater for frail older persons, and they lack support options such as personal care attendants, ramps in place of stairs, grab bars in the bathroom, adequate

physical security to ensure their safety, and specialist geriatric health professionals.

64) For older veterans who are on the homeless spectrum, the traditional pathways for providing health and wellbeing services may need to be adapted to better meet their needs. This includes the services provided by DVA's Veteran Home Care, which is an excellent service, but it generally relies on the care recipient having a stable housing solution to be effective.

65) The lack of specialised housing services for older homeless veterans is problematic, and in many cases the only viable option available to meet their care needs is for them to move in a federally funded residential aged care service. However there are a range of factors that can adversely impact a veteran's ability to gain access to residential aged care accommodation, creating barriers for some of our nation's most vulnerable veterans. Reducing these barriers should be an area of attention for the RCDVS, because having suitable access to residential aged care services is a critical aspect of health and wellbeing for older veterans.

66) Factors to consider when assessing common barriers to residential aged care for vulnerable older veterans are explained in the following section.

Federally funded aged care services

67) Many of the care needs for veterans in aged care generally align with that of the broader population, however there are certainly a number of specific differences and challenges faced by veterans and by the *Approved Providers* of residential aged care services who are responsible for delivering their care. These issues include:

68) **Younger Age.** In our experience veterans generally enter our service younger and stay in the aged care setting for longer. Nationally the average age of residential aged care residents is understood to be around 84.6 years and across our two facilities it is 87.7 years. However the average age of the 16 Vietnam Veterans presently residing with us across our two facilities is just 76.1 years, which is 11.6 years younger than our average. Many Approved Providers will not readily accept younger applicants into residential care because usually these residents attract less government funding and require more "attention" to manage their complex behaviours, which in turn increases the resulting cost to the facility to provide staff and services.

69) The fact that some veterans have a requirement to enter aged care services younger reflects many complicated factors, which in our experience relates to issues such as the following:

a) Substance abuse

b) Family breakdown

c) Incarceration

d) Chronic health conditions

e) Homelessness

f) Post Traumatic Stress Disorder (PTSD)

g) Social isolation

h) Dementia

70) If a veteran is not able to obtain the level of care and support they require in the community due to their homelessness status, and they cannot enter aged

care as they are too young (in the industry's view), there are limited options left available to them to receive the support they require.

71) **PTSD).** Whilst PTSD was briefly mentioned in paragraph 70.f above (in the context of veterans entering aged care at a younger age), it warrants further attention concerning the specific impacts that it can have on veterans residing in residential aged care generally. In our opinion most Approved Providers of residential aged care services are well postured to manage the general cognitive issues associated with ageing (such as the various forms of dementia), but we feel that the aged care industry is less well informed and resourced to manage other mental health issues such as PTSD. This is of concern for the veteran community, because many veterans residing in aged care may not be receiving the support they require.

72) Veterans with PTSD can display a range of complex behaviours in the residential aged care setting, and these can be difficult for the Approved Provider to manage given they lack the specific funding and training to do so adequately. According to the Black Dog Institute those suffering from PTSD can display a combination of symptoms, including:

a) irritability
b) violent /angry outbursts
c) reckless behaviour
d) getting startled easily, feeling 'jumpy'
e) overly alert to danger (hypervigilance)
f) finding it hard to sleep
g) finding it hard to concentrate or experiencing distressing and 'intrusive' thoughts and memories
h) nightmares
i) flashbacks of the trauma, and reactions to things that remind them of the traumatic event
j) reliving the event which then leads to anxiety
k) avoiding reminders of the event (including avoiding people, smells, sounds, activities or objects)
l) not being able to remember part of the traumatic event
m) heightened sense of danger
n) blaming themselves or others for the event or its aftermath
o) feeling very down or numb
p) feeling strong guilt, horror or anger
q) being unable to enjoy things they used to find pleasurable
r) feeling detached or 'cut off' from people.

(https://www.blackdoginstitute.org.au/clinical-resources/post-traumatic-stress-disorder/what-is-ptsd)

73) RSL Care SA has seen all the above symptoms at one point or another in our veteran population, and in our view these behaviours can make it difficult for aged care services to meet the specific needs and expectations of either the veteran resident themselves, or to meet the needs and expectations of the staff, family, friends and other residents who are in contact with the veteran within the residential aged care environment. In our opinion this level of care

requires specialised skills and training, which is something that RSL Care SA has sought to address at least in part through our *Trauma Informed Care* training, which is something that we feel should be made more readily available to the aged care sector.

74) A point to note is that the PTSD symptoms explained above can combine to generate resident profiles that require significant support for Behaviours (BEH) in the residential care setting, however these care needs are not adequately captured within the current funding models for BEH (nor in *Activities of Daily Living* or *Complex Health Care* needs), and therefore the resident generates little revenue through federal funding. This aspect of funding is a barrier for veterans with PTSD who are attempting to enter residential aged care, and it is also a barrier to treatment once they are in.

75) **Smoking.** Even after adjusting for income and depression, veterans with PTSD have significantly higher rates of smoking than those without PTSD. (Zen *et* al, 2012) (Beckham *et al* 1995). However, many aged care facilities are smoke free and therefore such an environment can discourage veterans from seeking residential aged care support for themselves even if, in practical terms it is the most suitable accommodation and care option for them. I have personally had a veteran tell me that “If I can’t smoke, I’m not moving in”, despite them clearly needing care and support.

76) **Veteran Supplement**. The *Veterans’ Supplement* in Residential Care (the supplement) is available to Approved Providers who care for veterans with diagnosed service-related mental health conditions. The supplement is paid by the Department of Health directly to an Approved Provider on behalf of the eligible veteran and it is designed to ensure a veteran’s mental health condition does not act as a barrier to accessing appropriate care. However, following an audit of RSL Care SA’s population of War Veterans (39 residents), only six were found to be receiving the supplement (representing 15%), when it would appear, based on our assessment of clinical needs and information, that around 20 of these war veteran residents would have some form of mental health condition that warrants additional support (indicating the percentage of funding should be around 51%). This suggests that the coverage of the supplement is grossly inadequate.

77) The barriers to the effective application of the supplement are assessed as being as follows:

   a) Among older veterans in particular, denial or avoidance of psychiatric symptoms is common (Phoenix Australia, 2019), meaning that the true nature of a veteran’s mental health condition may not be known at the time of admission. This means that an Approved Provider may not receive any funding to support a veteran, despite having to manage the resultant individual needs and behaviours for veterans who are undiagnosed but who do indeed display psychiatric symptoms.

   b) There is a requirement of the veteran to sign a separate form for the provider to then receive the funding. This creates additional paperwork for the veteran which can get lost in the process, or it can simply overwhelm the veteran at the time of admission to the point whereby they don’t complete the form.

   c) Payment of the supplement may only occur if a veteran or their nominated representative(s) have consented to their information being disclosed to the Department of Health (DoH) and their Approved Provider. This requirement for the veteran to specifically give consent for the release of their information to the DoH creates an additional barrier, which for some veterans generates suspicion. In the end some veterans do not feel

comfortable giving such consent (often with little understanding of the reality that we as the care provider already have access to their clinical information) and the Approved Provider is therefore unable to obtain the funding.

d) The information that the veteran is consenting to share is actually very basic, and simply confirms the veteran's DVA status and their name and file number. No details of the accepted mental health condition or any further information is shared with DoH or the Approved Provider, so we suggest there would potentially be other ways to manage this confirmation from DVA without the need for additional forms and specific consents to be required of the resident. One suggestion is that the Approved Provider could simply make a request to DVA if any veteran moves into their facility, and then DVA can complete their own assessments of eligibility internally without the veteran themselves having to fill out any paperwork.

e) As it presently stands Approved Providers cannot apply for the supplement themselves as it is issued by DVA following receipt of the resident's consent form, which can create issues if the form isn't filled out correctly or returned by the resident. As an example we have encountered an issue where the form was actually returned by the resident but it wasn't properly signed, meaning the supplement was not paid until we were able to follow it up on the resident's behalf.

f) For FY20/21 the supplement was $7.37 per day, which in our opinion is inadequate to bridge the gap in terms of costs when considering the many complicating factors associated with caring for veterans with PTSD. Whilst RSL Care SA hasn't done detailed research into the exact amount of funding required, it is suggested that $15 per day is a more reasonable figure ($5,475 annually), particularly if we are to achieve DVA's own stated goal for this payment which is to "*ensure a veteran's mental health condition does not act as a barrier to accessing appropriate care*". **Reference:** *DVA Fact Sheet HSV137 – The Veterans' Supplement in Residential Care, available from* https://www.dva.gov.au/factsheet-hsv137-veterans-supplement-residential-care

78) RSL Care SA is a specialised provider of veteran services, however the reality is that even we struggle to gain access to adequate support through the veteran supplement. We are therefore concerned that other providers who are not as experienced in veteran issues will simply not be receiving the funding they are entitled to, accepting that even this amount is inadequate. Without a doubt this means that some vulnerable veterans are not receiving the mental health support they need within the aged care sector.

79) **Reducing veteran population in aged care.** 993,000 Australians served in the military forces during WW2, representing around 14% of the total population at the time (National Archives of Australia, http://www.naa.gov.au/collection/explore/defence/conflicts.aspx), whereas only just under 60,000 Australians served in the Vietnam War (AWM, https://www.awm.gov.au/articles/event/vietnam) representing well under 1% of the population at that time. Naturally these populations then move through life into aged care, meaning that as a percentage of the population accessing residential aged care services over the next 5 years, veterans will be an ever-diminishing group as the WWII numbers dwindle. This will see a much-reduced capacity for the residential aged care sector to respond to the cultural, social and clinical needs of veterans, and it is quite possible that in the near years ahead an approved provider operating a 150-bed facility may only have one single war veteran in their care. Over previous generations of aged care cohorts the WW1 and WWII veterans have held a much more

prominent and visible position within the aged sector, creating many opportunities for Approved Providers to facilitate specific cultural and social engagement activities for these populations. However, in the coming years generating such activity and support to meaningfully reflect the unique cultural and social values that veterans hold will become an increasingly difficult undertaking for the sector. The sad reality is that the aged care sector's ability to meet the specific needs of veterans is diminishing, and this may have a very real impact on an older veteran's sense of wellbeing.

80) **Personal choice**. In our experience some veterans are reluctant to engage aged care services, particularly residential care. In one example a Vietnam Veteran from rural SA who had been a "revolving door" patient of the state's Veterans' Mental Health Service at the Repatriation General Hospital (Ward 17) came to our attention. This veteran would spend two or three weeks a month in the acute inpatient mental health setting (costing around $1,500 per day), before returning to his small unit in country SA where he would invariably drink an excessive amount of alcohol over a number of days and then experience suicidal ideations, requiring him to once again be admitted into the acute inpatient setting. When we offered him a place in residential care the veteran was quite 'expressive' at his lack of desire to move into an aged care facility, so instead we simply offered that he could stay with us in a vacant room at the War Veterans Home as a guest for as long as he wanted, rather than having to actually move in. After six straight months of "staying over" at the War Veterans Home the veteran decided on his own merits that he would like to move in, and he then became a full-time resident in a licensed bed. In the 3.5 years that this veteran stayed with us as a resident he did not return to the acute in-patient setting once, demonstrating that what he actually needed was person-centred care, not necessarily expensive acute mental health interventions.

81) **Aged Care Funding**. The issues and examples discussed in paragraphs 67-80 above combine to create a range of additional costs and requirements for Approved Providers to consider when seeking to admit veterans into their facilities. The various issues of aged care funding have been well documented through the Aged Care Royal Commission so we will not cover that ground again here, although RSL Care SA would particularly like to highlight the lack of funding made available through the *Behaviours* domain (BEH), for which many of the behaviours explained above for veterans require a genuine person-centred care response but are inadequately funded. By way of example as at 1 July 2021 a resident with *High Activities of Daily Living (ADLs)* receives $116.76 per day and *High Complex Health Care (CHC)* needs receive $70.61 per day, whereas a resident with *High BEH* receives just $38.23, which RSL Care SA feels is inadequate when considering the costs associated with delivering person-centred and culturally safe care to veterans.

82) In total, RSL Care SA conservatively commits in the order of an additional $75,000 annually in staff salaries to meet the specific needs of veterans in our care (which includes the salary of our Veteran Support Officer and recharge for other staff and leaders), along with around $7,000 annually for ancillary costs associated with milestone commemorative events and veteran activities, none of which is funded by the government.

ADF SERVICE HISTORY RELEVANT TO HOMELESSNESS

83) While the causes of homelessness amongst veterans are often multifactorial, it is reasonable to conclude that creating a reduction in the homelessness

rates for veterans will only help reduce the overall rates of suicidal ideation and attempts.

84) It is for these reasons that efforts should be made to understand the service history of veteran who subsequently find themselves on the homeless spectrum, so that this information can be used to identify 'upstream' factors that can then be targeted with suitable intervention strategies as part of an overall program to prevent veteran homelessness. Its much easier and cost effective to prevent an occurrence of veteran homelessness upstream, than it is to try and solve the issue later downstream. Prevention is almost certainly better than cure.

85) Complicating this desire however is a reality that the implementation of such strategies would necessarily be multi-faceted within Defence, requiring meaningful engagement across the services and throughout the depth of a veteran's individual service life to be effective. This is no simple task, however perhaps a reasonable starting point for action is to educate and empower the Joint Transition Authority (JTA) to better understand and influence aspects of service life and transition that are consistently associated with housing instability for veterans once they leave the forces.

86) To help inform this discussion, the service histories of ARVL's homeless veterans are provided in the following section of this submission. The purpose of including this information is to enable the RCDVS to gain an insight into the specific characteristics of a cohort of veterans who have been actively homeless, in the hope that this information may then help to target future interventions and prevention strategies within Defence and the JTA.

Service history of ARVL's homeless veterans

87) Through the 10 units at Sturt (used entirely for crisis/emergency accommodation, as described in para 23.d.i), ARVL has provided crisis accommodation to 145 veterans who have been actively homeless (as at 13th Sep 21), representing well over 15,500 individual bed nights.

88) The service history of these homeless veterans is provided as follows (data report as at 1 Aug 21):

Figure 5: Military Service: The vast majority of residents served in the Army.

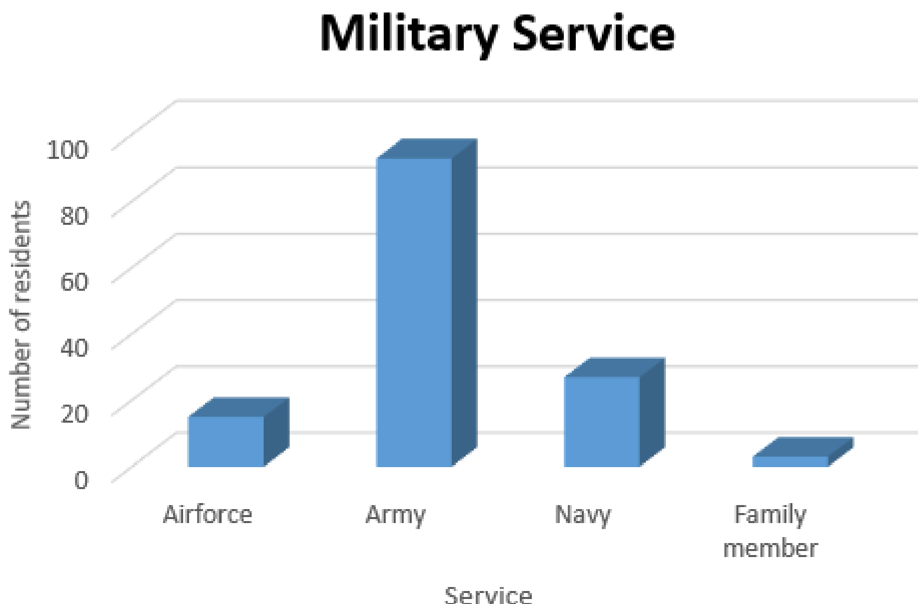


Figure 6: Army Corps Allocation. The majority of the Army veterans served in combat related corps.

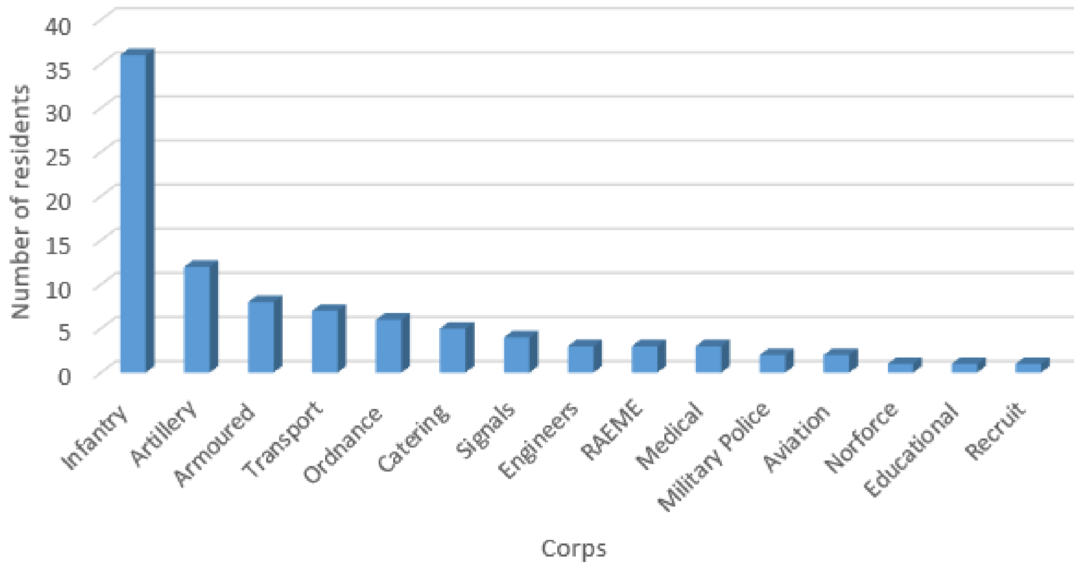


Figure 7: Operational Service. The majority of homeless veterans have not deployed, although 35% have, some multiple times.

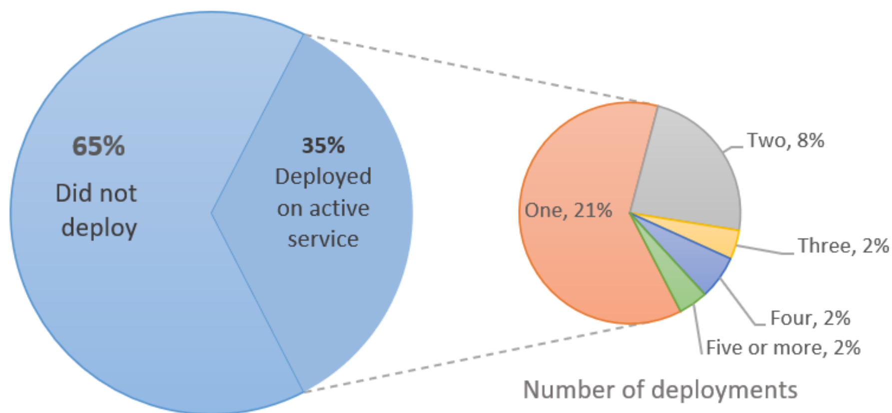


Figure 8: Length of Service in the ADF. The average length of service for ARVL's homeless veterans is 7 years, although many served less than 4 years.

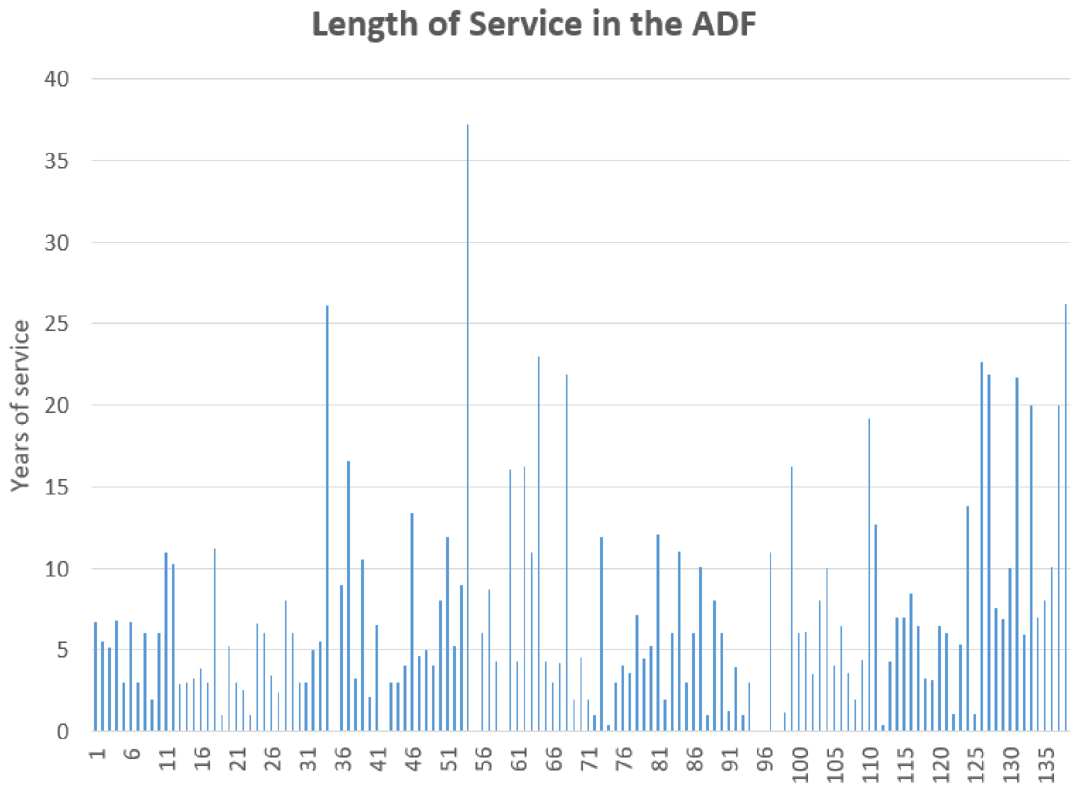


Figure 9: Gender of residents. The majority of residents are males; however, the overall number of female residents is increasing (from 11% to 14% in the past 12 months, and at times this figure has been as high as 16%):

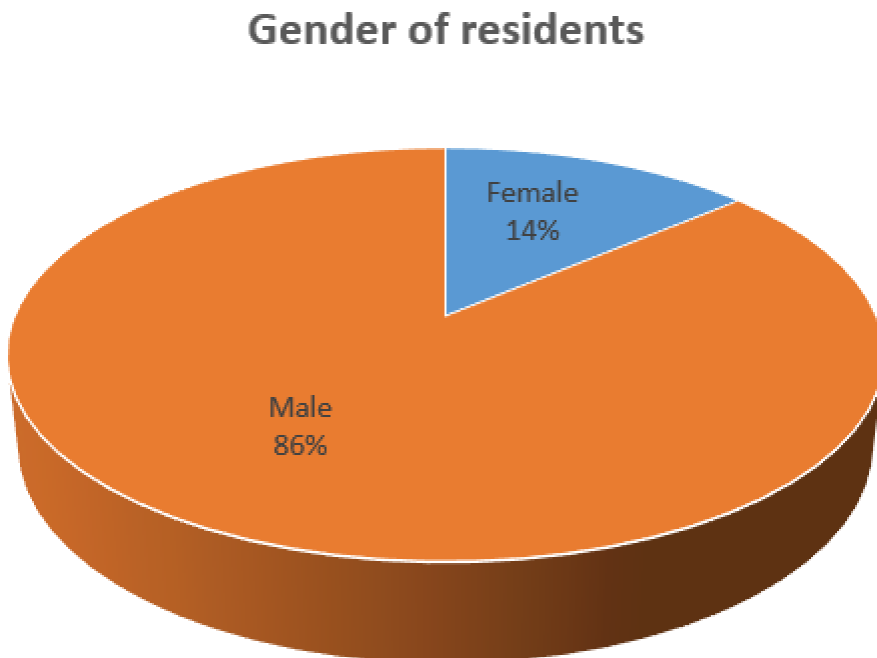
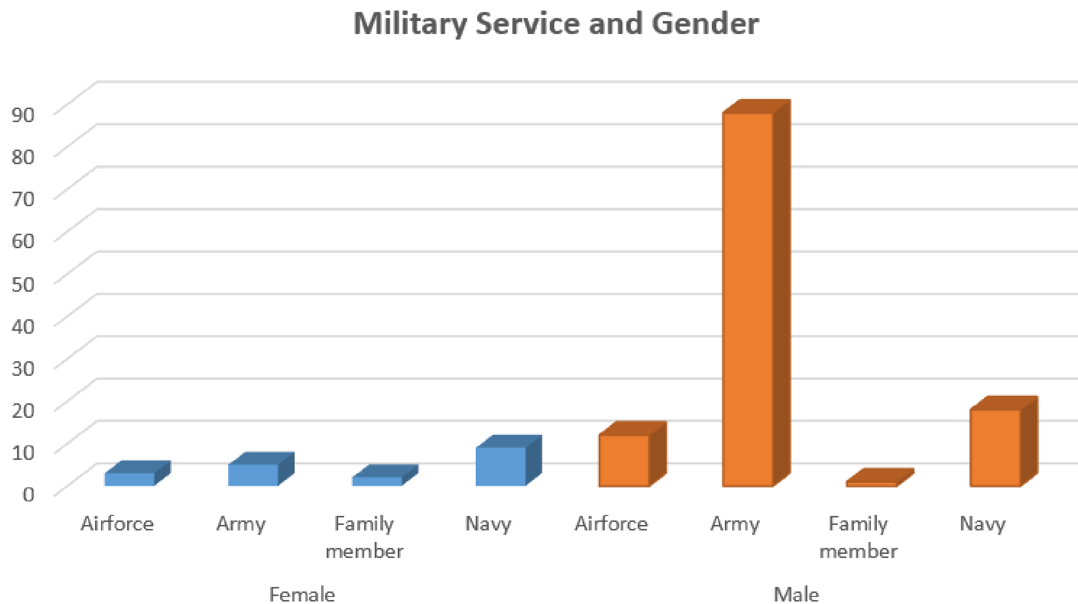


Figure 10: Military service and gender. The largest portion of male veterans served in the Army, and the largest portion of female veterans served in the Navy.



89) As can be seen from this data there are pockets of identifiable risk that could potentially be used as indicators to create profiles of *future housing risk* for veterans who are separating from the forces. This ability to look at early indicators for those who are still serving may then enable agencies such as the JTA (and the command elements of the ADF more broadly) to develop and implement preventive strategies that specifically target groups who are identified as having an increased risk of experiencing housing vulnerability post-separation. This profiling could potentially provide an indication of future suicide risk, noting the strong correlation that exists between suicidal ideation and homelessness.

90) While the ADF is generally well equipped to identify veterans who are transitioning from the ADF into a situation of housing vulnerability, unfortunately in general terms the ADF lacks the necessary expertise to support veterans into a suitable affordable housing pathway. This is not a criticism of the ADF and is instead a statement that reflects the incredibly complicated landscape surrounding people who are entering a situation of housing vulnerability, or indeed who are already actively homeless. The provision of homelessness services is a specialised field, and it is therefore recommended that the JTA in each state should establish formal housing pathways to help support veterans who are transitioning from the services into positions of housing instability.

91) From RSL Care SA's perspective we suggest that the ADF seek to engage with specialist providers to establish separation pathways for those individuals who are clearly demonstrating aspects of housing vulnerability, and this engagement be done as part of an overall wellbeing program to support particularly vulnerable veterans. As a starting point it is recommended that any such program should seek to target the following cohorts who are discharging:

a) Discharged under the age of 30

b) Served less than 4 years

c) Discharged for administrative or discipline reasons

d) Discharged for medical reasons – specifically mental health or severe physical disability

e) Discharged in a location that is away from social support networks

f) Poor/deteriorated relationship with the member's chain of command

g) History of substance abuse (either alcohol or illicit substances)

h) Victims of physical abuse

i) Victims of sexual abuse

j) Criminal perpetrators

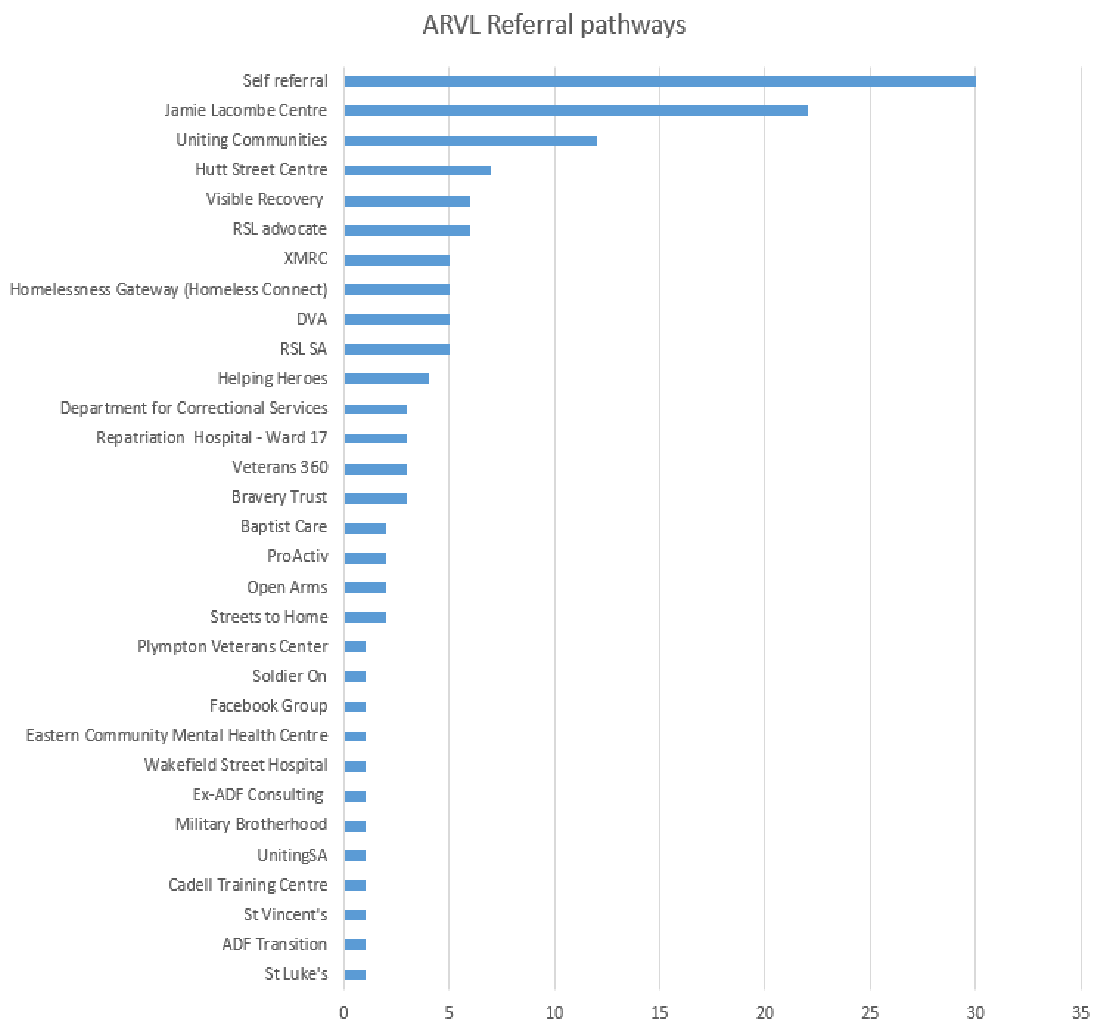
k) Those with limited support networks outside of Defence

l) Those that have had particularly disruptive posting cycles, potentially reducing their ability to source and maintain their own permanent housing solution outside of defence.

POST-SEPARATION ACCESS TO SERVICES

92) With the exception of the Crisis Accommodation Program (CAP) run by Open Arms, which itself has limitations, there are very few government agencies that will specifically support veterans experiencing homeless in the community. As an example, Figure 11 below demonstrates the various organisations that have needed to refer homeless veterans to ARVL for crisis accommodation:

Figure 11. ARVL Referral pathways



93) As can be seen, many large government-funded organisations such as DVA, SA Health (Jamie Larcombe Centre), Open Arms, and the Department of Correctional Services have needed to refer homeless veterans to ARVL (a small not-for-profit service), which provides evidence of the lack of suitable housing options for vulnerable veterans at both state and federal levels.

94) While numerous agencies will advertise that they support homeless veterans few are in a position to provide an actual ‘bricks and mortar’ solution for emergencies or to provide long-term stable accommodation. This is a fundamental issue reflecting the chronic shortage of affordable housing nationally, which can mean that vulnerable veterans are left to bounce around various referral agencies without ever actually finding an accommodation solution.

REPORTING AND RECORDING HOUSING STATUS AT ENLISTMENT

95) Many individuals who experience long-term housing instability had occurrences of homelessness in their youth.

96) According to the 2016 Census (ABS), youth aged 12–24 years made up 32% of total homeless persons living in 'severely' crowded dwellings, 23% of persons in supported accommodation, and 15% of persons living in boarding houses.

97) Identifying an early history of homelessness, when coupled with other potential markers of adverse health and wellbeing outcomes, may help Defence to form a more complete picture of an individual’s future suitability for military service. It is also a potential marker that can be used to help identify those who may struggle to maintain an adequate level of housing stability in life post-separation.

98) RSL Care SA suggests that a veteran’s housing status should be recorded at the point of enlistment.

PROTECTIVE AND REHABILITATIVE FACTORS- POTENTIALLY REDUCING SUICIDE THROUGH HOUSING

99) According to Bommersbach *et al* (2020), rates of past-year suicide attempts and past-year homelessness were strongly associated, suggesting that homelessness and suicidality strongly co-occur.

100) The focus of this submission is fundamentally around the protective and rehabilitative influence that stable housing can have on veterans who are otherwise vulnerable. Of all ages, including the elderly.

101) Unfortunately there are limited housing options for veterans who are faced with housing instability.

102) In their 2020 study, Elbogen *et al* (2020) concluded that psychosocial rehabilitation and holistic approaches targeting financial well-being, homelessness, resilience, self-care, social support, spirituality, and work may offer a promising avenue in both veteran and non-veteran populations for treatment and suicide risk management and prevention. Elbogden *et al* (2020) also found that meeting basics needs and resilience were related to lower suicidal ideation, and that the number of protective factors reliably predicted lower occurrences of suicidal ideation.

THE AVAILABILITY OF SUPPORT SERVICES FOR FAMILIES SUPPORTING HOMELESS VETERANS

103) When a veteran is actively homeless, most if not all of their family and social connections have deteriorated to the point of being non-effective.

104) In some cases however, some remnants of the veteran's previous life remain, and these connections can usually be found in the form of parents who continue to be an active and concerned stakeholder in the veteran's wellbeing, albeit often from afar.

105) Unfortunately parents are not entitled to access support and services from agencies such as DVA and Open Arms in the same manner that spouses and children can, even though they are often the only people left trying to support the veteran.

106) Parents in this situation need to be recognised as adding value, and they should be eligible to access the same level of relevant services that are open to children and spouses.

107) It is recommended that veterans should be able to nominate who their primary support person is, and that this person should be eligible to receive the support of Open Arms.

CONCLUSION

108) RSL Care SA appreciates the opportunity we have been given to make comment on these important issues as they affect veterans, and herein we respectfully make our submission.

109) Any questions regarding this submission can be directed to Nathan Klinge, on 0477 709 327, or via email nklinge@rslcaresa.com.au.

110) I have read the privacy statement on the DVA website concerning this consultation process.

111) I consent to the publication of this submission with my name.

Dated this 15th Day of September 2021

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Nathan Klinge
Chief Executive Officer
RSL Care SA

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