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Submission: Royal Commission into Defence and Veteran Suicide

February 2023

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 20,000 medical specialist physicians and 9,000 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the Royal Commission into Defence and Veteran Suicide and addressing suicide among Australian Defence Force (ADF) members and ex-members as a matter of national concern. The RACP are committed to improving the health care for ADF serving and ex-serving members. We hope to be part of the resolution process when it comes to addressing this health matter.

The RACP considers the health and wellbeing care that the ADF provides, and the ADF community it is serving, needs significant attention. Suicide among ADF members is a complex public health issue. As has been reported, the risk of suicide is highest among ex-serving ADF members and common characteristics were identifiable.[1]

The Royal Commission notes in its Interim Report that it is considering a wide range of matters not aired in that report. One of these must be health care, as around 18% of those who leave the ADF do so for medical reasons.[2] The 2021 Census found that three in five (60%) previous ADF service members had a long-term health condition.[3] Recent research among ADF veterans sleeping rough on their interaction with the health system, found that having more than nine hospital admissions in the prior six months was 5.2% higher among veterans than non-veterans (6.4% of veterans versus 1.2% of non-veterans).[4]

Our submission is based on significant long-term treating medical practitioner experience and expertise with the ADF patient population. It describes for the Royal Commission:

- Major healthcare needs.
- How ideal health care is either confounded or not easily accessible.
- The systemic areas that can change.

Two high impact and much needed broader cultural shifts could be achieved by:

- Greater attention to the organisational and systemic factors throughout training which can predispose injured ADF personnel to develop subsequent psychological and psychiatric issues following physical, psychological and/or sexual injury. This can start from pre-recruitment, continue through basic training and then to subsequent specialty training.
- Greater retention and continued employment of injured ADF personnel with transferrable skills, rather than moving down the medical discharge route if the person is no longer fully deployable. Early quality access to comprehensive medical and vocational rehabilitation is essential.

Between 2003 and 2020, the suicide rate for ex-serving males, by reason for separation, was lowest for those who separated either voluntarily or for contractual/administrative reasons (22.5 and 18.6 per 100,000 population per year respectively) and highest for those whose reason for separation was involuntary medical (69.8 per 100,000 population per year).[1]

[1] 2022 Australian Institute of Health and Welfare report

[2] Productivity Commission 2019, A Better Way to Support Veterans, Overview and Recommendations, Report no. 93, Canberra.

[3] Australian Bureau of Statistics. *Service with the Australian Defence Force: Census* [Internet]. Canberra: ABS; 2021 [cited 2023 February 22]. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/service-australian-defence-force-census/latest-release.

[4] Using secondary data collected through Registry Week surveys with people who were rough sleeping in major Australian cities and regional areas between 2010 and 2017. Wood L, Flatau P, Seivwright A, Wood N. Out of the trenches; prevalence of Australian veterans among the homeless population and the implications for public health. Australian and New Zealand Journal of Public Health. 2022 Apr;46(2):134-41.

The average term of service within the ADF is reported as less than 10 years.[5] Ready access to appropriate health and social support care should be easily facilitated for ADF members and ex-serving ADF members. Transitioning to civilian life can be challenging and supports before, during and after this process need improvement.

Our submission contains a proposed way forward drawn from the experience of our members, consultant and specialist physicians, to help the Royal Commission address the health care and wellbeing needs of the ADF community. We note for the Royal Commission that many of our members have significant ADF/Department of Veterans' Affairs (DVA) lived experience.

Key recommendations

The RACP recommends:

1) **The Royal Commission examines the provision of health care to ADF members** from entry, through their service career, to their transition to civilian community and thereafter. This examination should be against criteria of a continuum of health care that is appropriately holistic, biopsychosocial and multidisciplinary. This health care also needs to available through primary care, the public and private mental health sectors, and consultant physicians across a range of relevant specialties. For example, addiction medicine, occupational and environmental medicine, rehabilitation medicine and sleep medicine. This is a key service provision sector with significant interface with ex-serving ADF members.
2) **Increased strategic integration of the role and expertise of occupational and environmental medicine physicians** in ADF health care and that this be recognised by the Royal Commission as being integral to addressing many of the issues identified in the Interim Report. Occupational and environmental medicine physicians should have a greater role in providing advice and assisting the ADF to actively prevent avoidable mental health and other work-related injuries from occurring.
3) **The adoption and strong reinforcement of a primary prevention approach to health care**, coupled with effective and timely workplace-based rehabilitation and claims processing.
4) **Further consideration be given to the support issues for Aboriginal and Torres Strait Islander peoples,** relevant to the systemic issues and risk factors concerning ADF and veteran death by suicide**.**
5) **Reducing delays in access to specialist medical treatment** to help prevent physical and mental health deterioration, before and after discharge from the ADF service.
6) **Better facilitating communications** between the separate organisational components that may be engaged in health care, such as between the ADF, DVA and wider (civilian) healthcare systems.
7) **The DVA adopt a more supportive approach to facilitating the compensation claims activation/resolution process,** and that this approach reflects a biopsychosocial model for the provision of health care services.
8) **The ADF instruct serving members, and ADF health services, to initiate claims for compensation when diagnosed or treated for a work-related condition**. Earlier determination of legal liability will enable veterans to continue to obtain funding of treatment commenced during ADF service on separation. This will contribute to reducing veteran mental health issues (and potential suicide risk).
9) **Improving the treatment of injuries and long-term rehabilitation planning** (including possible medical discharge) within the ADF's health services by an increased focus on personnel retention and reducing the need for medical discharges; an increased engagement of occupational and environmental physicians and rehabilitation physicians,

[5] Gill GF, Bain R, Seidl I. Supporting Australia's new veterans. Australian family physician. 2016 Mar;45(3):102-6.

and promotion of injury rehabilitation programs and benefits. This should include actively reducing fears of involuntary medical discharge due to injury.

10) **Improving the availability and access to best practice models of care for chronic pain** and ensuring there is more equitable access to multidisciplinary pain management programs.
11) **Expanding access to multidisciplinary chronic pain clinics and services**, including using telehealth.
12) **Improving the linkages between mental health, drug and alcohol, and chronic pain services** to ensure a “no wrong door approach” for people experiencing concurrent issues.
13) **Supporting the development of consumer-led health promotion programs** that address stigma and misperceptions around chronic pain and how to access support.
14) **Considering extending cover to serving ADF members for chronic pain for life**, such as is already provided for all mental health conditions on a non-liability basis, recognising the inherent risks, claims process issues and stigma. This approach would also overcome systemic disparities for different card holders.

Suicide risk and physical injury

The RACP agrees with the statement in the Interim Report (page 185) "*that the veteran compensation and rehabilitation system should aim to do no harm to veterans, and instead provide medical and rehabilitation services that reduce injury and disease, compensate for harm incurred and encourage a full life, including a return to work whenever possible"*.

As noted earlier, about 18 per cent of those who leave the ADF do so for medical reasons. Physical injuries can also have an adverse effect on mental health and research supports the association between physical disability and suicide.[6, 7] It is suggested that many ADF related injuries are avoidable.

The RACP argues that primary and secondary prevention approaches to workplace injuries, and health care in general, will have a significant and positive impact on ADF personnel. Throughout this submission we emphasise the need for reorientation of health care services towards prevention, as well as ensuring more comprehensive and multidisciplinary health care. Further, improving access to high quality health care, and the right health care, whilst also concertedly addressing primary prevention, may reduce the incidence of suicide.

Attention is also drawn to the role occupational and environmental medicine physicians can play in preventing workplace illness and injuries, and the associated mental health issues resulting, as outlined in the RACP's Health Benefits of Good Work initiative.

Suicide risk and health care support for priority population groups

Factors that may increase the risk of suicide in ADF priority population groups, such as First Nations people, females or LGBTIQA+ people, include psychological distress, stressful life or work events, illness or injury, alcohol and/or substance use, past experiences of trauma or abuse, or a co-morbidity of these factors. Factors that can reduce the likelihood of suicide in these ADF priority population groups include access to culturally safe, trauma informed, affirming health care and workers; a supportive workplace that embodies a sense of belonging at work; supportive social networks, and acknowledgement of inclusion, diversity and equality in the ADF.

First Nations people

There are significant proportions of serving ADF members (3.7 per cent) and ex-service members (2.3 per cent) who identify as having Aboriginal and/or Torres Strait Islander origin.[8] The RACP recognises the past, present and future service of First Nations people in the ADF.

Specific attention to effectively meet the cultural, physical and mental health needs of First Nations people in the context of the Royal Commission's Terms of Reference should be part of the Royal Commission's final report. Further, ensuring cultural awareness and cultural safety in health care services provided to First Nations current and ex-ADF members should be a fundamental principal.

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[6] Khazem LR. Physical disability and suicide: recent advancements in understanding and future directions for consideration. Current opinion in psychology. 2018 Aug 1;22:18-22.

[7] O'Connor SS, Dinsio K, Wang J, Russo J, Rivara FP, Love J, McFadden C, Lapping-Carr L, Peterson R, Zatzick DF. Correlates of suicidal ideation in physically injured trauma survivors. Suicide and Life-Threatening Behavior. 2014 Oct;44(5):473-85.

[8] Australian Bureau of Statistics. *Service with the Australian Defence Force: Census* [Internet]. Canberra: ABS; 2021 [cited 2023 February 22]. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/service-australian-defence-force-census/latest-release.

Females

Accessing timely and appropriate health care is a risk mitigating factor in any approach to reducing suicide ideation and suicide rates. Although the number of female suicides among serving and ex-serving ADF personnel is significantly lower in actual numbers than those reported for men, the number of women in the serving population is increasing, as is the size of the contemporary female ex-serving cohort each year.[9] The address of female suicide among serving and ex-serving ADF members warrants serious attention in the context of health care service provision.

Culturally and linguistically diverse people

Also in this regard, it is equally important to consider the needs of LGBTQIA+ people and people of culturally and linguistically diverse (CALD) backgrounds. Ensuring that appropriate services are available and that any barriers to accessing services are identified and addressed is important.

Access delays to specialist medical care

Our RACP members indicate there are multiple reasons for delays in ADF members accessing specialist medical health services. These include:

- *The need for an appreciation of how much health issues impact employability and associated repercussions.* This includes an accurate understanding of what the member's job entails and an informed risk management approach to getting people back to work as soon as possible.
- *Limited health care seeking options for ADF members.* ADF members have limited capacity and options to seek medical care/treatment outside the centralised ADF healthcare system, as the ADF covers their medical costs.[10] However, the ADF has an employer duty of care to ensure appropriate and necessary health care is available and accessible to ADF members.
- *Centralised and restricted access to health care records.* Under the centralised ADF healthcare system all health care contacts are recorded centrally, along with the medical records of its serving members, which are not accessible to medical practitioners outside the ADF system. Communications between the internal and external healthcare system components that may be engaged in health care should be better facilitated.
- *The generally limited scope of health care available in the ADF.* For example, to primary healthcare services. The ADF maintains a list of preferred specialist providers, however this could be expanded.
- *The low physical availability of medical and health practitioners to service the ADF.* Health practitioners are necessary for referrals to medical physician specialists (who in turn may also have wait times). There are also long wait times in rural, regional and remote areas where many ADF personnel are based. This availability and access to health practitioners inhibits timely and appropriate health care. Potential supply mechanisms such as fly in-fly out services could be considered, as was previously done in relation to psychiatric services in NSW.
- *Limited financial and funding arrangements for medical services to the ADF and veterans.* Defence and the DVA do not cover all fees for clinical services. Some specialists therefore cap the number of DVA/ADF patients they see because these are a cost to them. Other specialists do provide services at their own cost, bearing in mind the chronic, long term, complex conditions that are often associated with significant mental

[9] AIHW National suicide monitoring of serving and ex-serving Australian Defence Force personnel: 2020 update

[10] For full time serving members, most of their medical costs are covered by Defence and they do not pay a Medicare levy

health and/or chronic pain issues for this population. This situation impacts access to services.

Removing barriers to the availability and access to health care should involve a reorientation of ADF health care services, with a focus on prevention and early intervention. Improving access to timely, high quality and the right health care will impact the incidence of suicide.

Rehabilitation

Rehabilitation should be seen as a key part of early intervention and appropriate treatment to restore an injured ADF member to an optimal level of function as soon as possible. The need for greater focus on the prevention of injury and illness, rehabilitation and transition support was also specified in the 2019 Productivity Commission report.[11]

There are three main issues that need to be addressed:

1. **The need to counter any negative associations with rehabilitation and postings to rehabilitation units**. Feedback from our RACP members is that within some parts of the ADF, being injured and posted to a rehabilitation unit signals an irreversible step towards being medically discharged from the ADF. Instead, participating in rehabilitation programs should be actively encouraged within the ADF to overcome the perception that unless a serving member is fully fit and deployable, they risk discharge. Such a perception incentivises the non-disclosure or minimising of any injuries, and compounding of physical disabilities, which may reduce chances of early and effective rehabilitation.
    - A long-standing attitude experienced within the ADF is a view that if the serving member is not fully fit and deployable, then they are likely to be medically discharged from the ADF. The implications of this culture are powerful, especially for a rehabilitation program, and may induce members to mask or minimise their injuries. This can exacerbate issues; members may suffer higher levels of physical and mental disability or believe there is no hope of full and effective rehabilitation. Members need to be able to resume their normal duties (deployed or otherwise) rather than needing to be "fully fit".
    - There are positive indications that senior levels of the ADF now accept that mild mental health issues can be successfully treated/managed, including with long term medications, and that these mental health issues *do not* constitute automatic grounds for medical discharge. It has been noted that this is not always the attitude amongst junior ranks, where there is often more scepticism, and the fear such people may "let their mates down" in a critical situation.
    - There can be interplay of the culture and backgrounds of ADF personnel who may have experienced socially or educationally disadvantaged backgrounds or significantly higher levels of family and sexual violence prior to joining the ADF. This can be compounded by further experiences of bullying, harassment or sexual violence in the ADF. The RACP Health Benefits of Good Work initiative recognises this.[12]
2. **The need to improve the approach to health care and rehabilitation.** Time is an important factor in the rehabilitation process and a goal should be to prevent the impacts we know to be associated with longer periods away from work, including mental health issues.
    - We stress that the focus should be on maintaining patient employment within fair and reasonable restrictions. Related to this is the clear benefit of health practitioners having a good understanding of ADF job requirements and developing an effective risk-

[11] Productivity Commission 2019, A Better Way to Support Veterans, Overview and Recommendations, Report no. 93, Canberra.
[12] Health Benefits of Good Work® (racp.edu.au). This initiative is based on compelling Australasian and international evidence that good work is beneficial to people's health and wellbeing and that long term work absence, work disability and unemployment generally have a negative impact on health and wellbeing.

managed program of return-to-work. Any medical downgrades should be done for the right reasons (pertaining to employability), for the right medical conditions, for the right amount of time.

- The provisions for the treatment of injuries within the ADF system, and long-term rehabilitation planning, including possible medical discharge, could be improved through the increased and wider scale strategic direct involvement of occupational and environmental physicians and rehabilitation physicians. Such an approach would better address gaps in healthcare services for patients with complex care needs, and better support their reintegration into the community.
- For many, the 'posting cycle' of the ADF means that for most serving members, and especially for young recruits, there is frequently a significant physical distance separating them from family, friends and other established community support mechanisms. This is accentuated when the serving members is injured, undergoing rehabilitation or trying to recover without a support network to help the process or the member. Current systems could be improved to address this experience.

3. **The need to increase the timely access to specialist medical treatment.** Delays in access to timely specialist medical treatment within the ADF healthcare system, particularly in rural, regional and remote areas where there are significant ADF locations and personnel, may accentuate the attitude towards injury disclosure.

It should also be noted that within rehabilitation units there will be those members who will be able to be rehabilitated and those who will not.

Systemic issues and health care needs

The compensation claims process

We support the Australian Government's support for Recommendation 1 of the Interim Report, which called for the development and passage of legislation to simplify and harmonise the framework for veterans' compensation, rehabilitation, and other entitlements. We see this as a positive step.

The compensation systems which apply to ADF personnel have been noted as complex and difficult to navigate.[13] The RACP concurs with the Royal Commission's Interim Report that veteran compensation and rehabilitation legislation processes are legislatively and administratively complex, difficult to navigate and are frequently perceived as inequitable, and that this combination places unacceptable stress on claimants. Any effective way of addressing these issues should include drawing on the expertise and workplace experience of occupational and environmental medicine physicians who are key stakeholders in a wide range of civilian workers' compensation systems throughout Australia and Aotearoa New Zealand. This expertise and effective approach to health care in workplaces is set out in the RACP's Health Benefits of Good Work initiative and It Pays to Care, a call to improve health and recovery outcomes and reducing barriers to care for people experiencing work injuries.

Key factors on the compensation claims process include the following:

- By and large, most ADF personnel do not proceed with the necessary steps for a compensation claim until just prior to their medical discharge, even though current serving members are able to lodge DVA claims while still in service, and preferably close to the time of injury. The RACP supports similar statements and recommends that the ADF adopt a proactive approach to initiating the claims activation process for currently serving ADF members, and that the DVA likewise adopt a more supportive approach to facilitating the claims activation and resolution process.

[13] Maguire AM, Keyser J, Brown K, Kivlahan D, Romaniuk M, Gardner IR, Dwyer M. Veteran families with complex needs: a qualitative study of the veterans' support system. BMC health services research. 2022 Dec;22(1):1-5.

- If the ADF were required to direct serving members, and the ADF healthcare services, to commence claims for compensation at the time of diagnosis or treatment for a work-related condition, this would overcome current issues of:
    - Compensation claims not being submitted at the time of diagnosis of illness or injury.
    - Lengthy claims determinations periods.
    - The treating doctor not being available where it is several years after the illness or injury was diagnosed and treated. Similarly, workplace supervisors may not be available to provide the employer's input into the claim to complement clinical notes to determine liability (as can happen with non-ADF claims). Without ADF input into a claim, there is no confirmation from an employer or immediate supervisor to validate a claim for injury.In these situations, the DVA must seek expert specialist advice, often leading to multiple specialist reports and investigations requested.
- Medical specialists can be relatively unfamiliar with the ADF workplace and the requirements of DVA compensation processes. Transitional medical assessments to assess and assist veterans prior to submission of claims and before they separate from the ADF, engaging with occupational and environmental physicians, would address issues raised above.
- The compensation and rehabilitation processes significantly impact veteran and family functioning. A recent Australian study[14] shows:
    - System fragmentation was perceived to impede care coordination and delay access to holistic care for veteran families with complex needs.
    - Requirements to establish proof and substantiate service-related claims were found to impede rehabilitation efforts.
    - The biomedical focus on pathology and diagnosis, and the medico-legal emphasis on deficits and incapacity, were perceived to harm veteran identity and undermine health and wellbeing outcomes.
- The 2019 Productivity Commission report reinforced the need for the veteran support system to have a focus on the lifetime wellbeing of veterans and incorporate best practice and evidence-based approaches to workers' compensation and social insurance schemes, as adapted to this ADF context.[15] This will change the incentives in the system so more attention is paid to the prevention of injury and illness, rehabilitation and transition support.[16]
- The RACP supports a biopsychosocial approach to worker's compensation and have produced an evidence based report on its impact and potential application - It Pays to Care.
- Addressing the claims backlog is important. The Interim Report referred to the need to eliminate the claims backlog, as statutory compensation may take significant amounts of time to finalise over months or years. Noting this was agreed to by the Australian Government, we highlight that occupational and environmental medicine physician expertise is underutilised with respect to:
    - Timely claims processing, especially for complex cases.
    - Reducing the number of future claims, by helping to reduce preventable workplace-related illnesses and injuries.
    - Reducing the cost of future claims, via improved workplace-based outpatient rehabilitation.

The Royal Commission may consider:

[14] Maguire AM, Keyser J, Brown K, Kivlahan D, Romaniuk M, Gardner IR, Dwyer M. Veteran families with complex needs: a qualitative study of the veterans' support system. BMC health services research. 2022 Dec;22(1):1-5.
[15] 2019 RACP submission to the draft Productivity Commission report 'A Better Way to Support Veterans' racp-submission-to-the-draft-productivity-commission-report-a-better-way-to-support-veterans.pdf
[16] Productivity Commission 2019, A Better Way to Support Veterans, Overview and Recommendations, Report no. 93, Canberra.

- Establishing an Expert Medical Advisory Panel as an effective means of providing strategic-level health advice regarding these and other Royal Commission recommendations.
- Improvement of the claims system administration with the assistance of occupational and environmental medicine physicians who can facilitate:
    - Development, implementation and sustainment of a patient-centred comprehensive workplace injury and illness reporting system, as an essential component of a truly holistic claims management system.
    - Effective and efficient administration processes within a truly holistic claims management system.
- The barriers to vocational rehabilitation do not pertain to impairments, but to the lack of guaranteed access to customised plans of timely support and development. For further detail see the RACP National Vocational Rehabilitation Policy which describes how vocational rehabilitation as an approach and a formal intervention or service, based on the concept that being at work can be therapeutic and have a positive impact on health.

Chronic Pain

Chronic pain is recognised as a major problem for many ADF members as a long-term consequence of their service-related physical and mental health injuries. The Royal Commission has found chronic pain has a strong association with suicide, that multidisciplinary approaches are important to effective chronic pain management and have identified there is a 'reluctance' to seek treatment amongst some ADF members. Access to best practice models of care for chronic pain is vitally important for serving and ex-serving ADF members, and specifically, access to multidisciplinary pain management programs.

Barriers to access such programs include:

- **Availability and access**: people living in rural, regional and remote and rural areas are less likely to have access to multidisciplinary chronic pain programs as there are fewer programs available in these regions. However, this increases the burden for GPs, who are also often fewer in number in these areas, under-resourced or insufficiently supported to manage these complex conditions. Compounding this lack of access is that people living in regional and rural areas also have higher rates of mental illness and prescription opioid mortality rates, compared with their metropolitan counterparts[17], increasing both the demand and need for services.
- **Inhibiting stigmas:** stigma about chronic pain and mental illness can also affect treatment access. Serving and ex-serving ADF members may have been exposed to a culture of withstanding hardship and this may exacerbate the stigma and shame around experiencing mental health, substance use and/or chronic pain issues.

A key benefit of multidisciplinary pain management programs is that they enable patients to be simultaneously reviewed by multiple relevant health practitioners, such as pain specialists, physiotherapists, pain psychologists, and psychiatrists. This multidisciplinary approach supports the creation of shared management plans which emphasise appropriate use of pain medication alongside non-pharmacological strategies. A biopsychosocial approach to health care can assist in recognising that emotional trauma can also impact on the experience of chronic pain.

Chronic pain and addiction medicine

There is evidence for the interconnection of veterans' social health, principally homelessness and substance use/misuse, with veterans' mental and physical wellbeing.[18] Addiction medicine physicians have an essential role in managing alcohol and other drug use

[17] NSW Health. 2022. Opioid use and related harms in NSW, Surveillance Report 2021.
[18] Oster C, Morello A, Venning A, Redpath P, Lawn S. The health and wellbeing needs of veterans: a rapid review. BMC psychiatry. 2017 Dec;17(1):1-4.

disorders and chronic pain, which is often accompanied by prescribed opioid dependence, and which may have become the dominant problem for individuals.[19, 20, 21]

What is needed is:

- Expanded access to multidisciplinary chronic pain clinics, including using telehealth.
- Improved linkages between mental health, drug and alcohol, and chronic pain services to ensure a "one door approach" for people experiencing concurrent issues.
- Consumer-led health promotion programs that address stigma and misperceptions around chronic pain and how to access support.

Chronic pain and post-traumatic stress disorder

There are many risk factors for post-traumatic stress disorder (PTSD) and mental health disorders which have traditionally been embedded within military culture. All ADF members are at high risk for PTSD due to the nature of their work. Those who see combat are at a higher risk as well.

PTSD, mood disorders and other mental health issues directly impact on chronic pain, which can develop years after service has ended. This often leads to delay in approval for treatment in the non-Defence Health sector as there may be assumption that the chronic pain that developed after service ended is not related to the ADF members' time in service. This is a problematic situation because it is not easy to categorically determine when the changes to the person's body occurred and is now causing chronic pain. Therefore, one of the biggest barriers to treatment is establishing the linkage between initial injury, investigation and approval for treatment.

Our RACP members note that white card holders, which covers clinically required medical treatment in Australia for accepted service-related injuries or conditions and may also cover treatment for mental health conditions, are often not approved for chronic pain treatment or must wait for special approval. It is suggested that ADF members should have chronic pain cover extended for life.

Closing remarks

Any death from suicide is a tragedy whose impact extends to families, friends, and wider communities. The RACP believes that the Royal Commission's recommendations will assist in prioritising the necessary and important work ahead to better support ADF serving and ex-serving members and their families. This submission from the RACP speaks to the value of improving this population's access to timely comprehensive health care.

Members of the ADF have potential exposure to a broad range of physical, chemical, biological, psychological, environmental hazards, as well as those hazards associated with combat. The incidence of workplace illness and injuries in the ADF is greater than any other organisation in Australia. We consider that at least twenty percent of presentations to ADF healthcare services are work-related, compared to only two percent in general practice, suggesting there is plenty of scope for prevention.[22]

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[19] Saunders JB, Conigrave KM, Latt NC, Nutt DJ, Marshall EJ, Ling W and Higuchi S. *Addiction Medicine (Second Edition).* Oxford: Oxford University Press, 2016, 672 pages. ISBN: 978-0-19-871475-0. (see Chapter 13)

[20] Kuehn B. Chronic pain prevalence. Jama. 2018 Oct 23;320(16):1632-.

[21] Steven K. Dobscha, Benjamin J. Morasco, Jonathan P. Duckart, Tara Macey, and Richard A. Deyo. Correlates of prescription opioid initiation and long-term opioid use in veterans with persistent pain. Clin J Pain. 2013; 29: 102–108.

[22] 2019 RACP submission to the draft Productivity Commission report 'A Better Way to Support Veterans' racp-submission-to-the-draft-productivity-commission-report-a-better-way-to-support-veterans.pdf

The RACP suggests the health and wellbeing approach to the ADF community should also emphasise preventative person-centred health care and early intervention and adopt a best practice workplace approach to evidence-based health care.

The RACP has members with extensive experience in providing healthcare services to ADF serving and ex-serving members and are available to speak to this submission and to the Royal Commission. Our RACP members also can offer advice in identifying underlying issues and working towards feasible solutions with the Royal Commission.

For further information, please contact Policy and Advocacy via policy@racp.edu.au.