PRODUCTIVITY COMMISSION

COMPENSATION AND REHABILITATION FOR VETERANS

MR R FITZGERALD Commissioner
MR R SPENCER, Commissioner

TRANSCRIPT OF PROCEEDINGS

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COMMISSIONER FITZGERALD: Good morning, everybody. We might start. Our first participant is here, I think. I'll just read a formal statement, because many people in the audience are new today. So welcome to the second day of public hearings in Brisbane in relation to the Productivity Commission's inquiry into veterans' compensation and rehabilitation. And obviously, this follows the release of our report in December. I'm Robert Fitzgerald, I'm the presiding Commissioner, and my colleague is Commissioner Richard Spencer.

So the purpose of these public hearings is to facilitate public scrutiny of the Commission's work, and obviously to get comment and feedback on our draft report. We're immensely grateful to all of those that have participated in these hearings and provided submissions. We know it's an exceptionally large and complex report, and you had very limited time to respond to it, and so we're especially grateful that so many have contributed.

Following these hearings in Brisbane, we'll be in Townsville tomorrow, and potentially Rockhampton later in the month. So far, we've held hearings in Sydney, Melbourne, Wagga Wagga, Hobart, Adelaide, Perth, Darwin, and they've been very well attended in all of those particular venues.

We will be working towards completing the final report, which will go to Government in the last week of June of this year, and that will consider the evidence presented at these hearings and in submissions, as well as other informal discussions that we will be holding. Participants and those who have registered their interest in the inquiry will automatically be advised of the final report's release by Government, and the governments are required to release our report in full within 25 parliamentary sitting days after the completion of our report.

We would like to conduct these hearings in a reasonably informal manner, but I remind participants that a full transcript is being taken. For this reason, comments from the floor can't be taken, but at the end of today's proceedings, I'll provide an opportunity for any person who would like to make a brief statement or a brief presentation. And if you would like to do so, please see either Jared or Aaron, our staff, sometime during the morning.

Participants are not required to take an oath, but the Productivity Commission Act does require that participants must be truthful in their remarks. Participants are welcome to comment on issues raised in other people's submissions. The transcript will be made available to all participants, and will be available from the Commission's website

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following the hearings. Submissions which are currently being sought are also available on the website, and if you haven't yet put in a written submission and you would like to do so, I would encourage you to do so within the next couple of weeks. The deadline officially is today, but we are aware that some people will just need a couple more weeks to do that.

I would also like to note that a counsellor for Open Arms is in attendance, and if you require their services, please see our staff, and they'll refer you to that individual. Just in relation to workplace health and safety, the exit is in the door that you came through in the front of the room, and you'll need to follow the instructions of the hotel staff should you be required to evacuate.

The way the hearings are conducted is we'll ask each of the participants to make a brief opening presentation, around ten minutes or so, and then Richard and I will have a bit of a chat, questions and answers, and that's the format we'll hold for all the participants going through the day. And we'll finish sometime early to mid-afternoon, so it will go for most of the day, but we'll conclude around 2.30. So I would just like to call our first participant, Georgia Plunkett-Scott, please. Good. So, Georgia, if you could give your full name and the organisation that you represent.

MS PLUNKETT-SCOTT: Georgia Plunkett-Scott, representing Maurice Blackburn Lawyers.

COMMISSIONER FITZGERALD: Good, thank you very much. And if you could just give us the key points in about ten minutes or so, that would be terrific.

MS PLUNKETT-SCOTT: Certainly. So Maurice Blackburn represents, and have in the past represented veterans to access benefits under the Military Compensation Scheme, and my perspective will be from that of a veteran advocate.

The veteran community is unlike any other group that Maurice Blackburn works for. They are men and women who have chosen a vocation which is typified by high-risk activity, subject to frequent locations, and requires a level of mental and physical fitness far above that of the average Australian worker. We ask veterans to risk their lives and put themselves in significantly greater risk of injury and illness to serve for our country.

Today, we will highlight why that risk is just not worth it for veterans, due to the existing compensation scheme, despite many, or some of the recommendations put forward by the Productivity Commission. The unique nature of the work requires a unique compensation and

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rehabilitation scheme, one founded on profound respect, a clear understanding of the impacts of physical and psychological damage, and, at is core, the objective to put the veteran back into the financial position they would have been had they not suffered their service injury.

For up to ten years, Maurice Blackburn has assisted numerous veterans as they tried to navigate the complexities of the benefit scheme designed to help them. We facilitate access to justice for numerous veterans and their families, but we can't do that anymore. The scheme designed to benefit veterans is and has always been fundamentally flawed. It is so skewed in favour of the Government entities that for many decades, true access to justice for veterans has been impossible or extremely difficult to achieve.

We know, at Maurice Blackburn, from 100 years of experience supporting people with illnesses and injuries, that many compensation schemes can provide a fair go for victims, and these schemes do exist. Those fair go elements include a scheme that acknowledges the holistic impacts of the medical conditions, and applies a beneficial, simplified approach to causation; a dispute resolution process with meaningful access to independent courts whose judges take their independence seriously; and lump sum benefits, to enable people to get on with their lives, as distinct from demeaning and paternalistic drip-feed long tail schemes.

These long tail schemes render veterans restricted and dictated by the threat that, when is the next payment coming through? Finally, the ability to have most of the properly incurred legal fees paid to support the veteran in disputing any decisions made in relation to entitlements. Regrettably, the veterans' compensation scheme lacks, either totally or predominantly, all of these features.

We are very pleased to hear that the Productivity Commission was to conduct a review of the system, because years of smaller, less influential reviews had led to a patchwork of adjustments to the scheme; the application of innumerable, what we say, band aids to stop the scheme from falling apart. But none addressed the core deficiencies in the scheme that we say must be addressed.

In our submission to the Productivity Commission, we outlined that the status quo of three discrete underpinning pieces of legislation was confusing, unduly complex, and no longer fit for purpose. And we called on the Productivity Commission to make the decision which needed to be made, that the wholesale reconstruction of the legislative framework that determines the support offered to injured service personnel.

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We made suggestions as to how the administration of the scheme could be more user-friendly, including the use of case managers, and moving away from hard-copy files, which are siloed into offices right across the country. We were very pleased that the Productivity Commission's draft report made some very positive moves in the right direction, and to name a few piloting injury prevention programs, increasing the transparency of data, harmonisation of the heads of liability across the three pieces of legislation, and the merging of the MRCA and the SRCA into one compensation scheme, known in your recommendations as scheme 2.

However, Maurice Blackburn's core criticisms of the draft report are that the recommendations fail to address what is really needed to achieve simplicity and consistency, which is that the entire legislative framework underpinning services to veterans and their dependants requires fundamental redrafting, which, if that redrafting was to occur, is the only way to address the deficiencies within the broader scheme.

Particularly, the recommendations fail to describe a scheme which acknowledges the impacts of the medical conditions, with a beneficial and simplified approach to causation, including a dispute resolution process with meaningful access to experienced legal advocates in independent courts and tribunals, and offers lump sum benefits to enable people to get on with their lives; that is, the option of turning a long tail benefit scheme into a short tail scheme, with commuted benefits, on receipt of independent and appropriate sound legal advice that the commuted benefits are appropriate for that veteran.

So we would like to take the opportunity to discuss with the Commissioners the recommendations from three important sections of the report. Firstly, recommendations 10.1 to 10.4; whilst we agree with the formation of a single review pathway for claims, the recommendations fail to address the need for advocacy and support for veterans trying to navigate the system. Also, some specific benefits and decisions are still not capable of being appealed through the current proposed review mechanism, including, but not limited to, decisions made regarding repatriation healthcare cards. Those decisions are, for want of a better word, uneconomical to pursue, because they're usually direct to the Federal Court, by way of judicial review, as opposed to an internal reconsideration.

We also refer to report recommendations 12.1 and 12.2, which is in relation to the harmonisation of compensation packages. We think that is a positive step, but it doesn't go far enough, in our opinion. We think that, at a minimum, the compensation scheme needs to include income support for past and future income lost by a veteran as a result of their service-

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related injury; compensation for permanent impairment on a combined whole-person impairment basis, either as a lump sum or a weekly tax-free amount; compensation for aids and appliances, household services, gardening assistance, rehabilitation, including vocational rehabilitation; obviously, funeral expenses for dependants; importantly, a choice between long tail statutory benefits and commuting statutory benefits into a lump sum; and access to unrestricted common law damages for economic and non-economic loss, by an election in negligent circumstances.

We appreciate that many of these details will be refined throughout the ongoing process. However, the devil is in the detail, and these compensation elements need to be considered.

COMMISSIONER FITZGERALD: I'm just conscious of the time, so if you could just give a brief comment in relation to your 3 and 4 points, just very briefly, and then we'll have some questions.

MS PLUNKETT-SCOTT: Sure. In relation to recommendations 13, we don't perceive these to add up to be an ideal outcome. We say – and I'll repeat – compensation for combined whole-person impairment payable as either a lump sum, no thresholds for impairment, and also the inclusion of indexation of compensation amounts. Commissioners, my final point is to refer you to the submissions previously put forward by and on behalf of the Bird family, in relation to the tragic death of Jesse Stephen Bird. We acted for the Bird family, and work with them on an ongoing basis to achieve our mutual objectives of reform.

We know that the submissions put forward previously have been calling upon the Commission to look to changing the circumstances to prevent, in the future, Jesse's tragic fate, and we wholeheartedly agree with that. We also ask the Commission to, for a brief moment, imagine that Jesse was still with us, and had gained access to the scheme as it stands today, or under the recommendations put forward by the Commission. And we still think there would have been significant challenges ahead of him.

Importantly, we need consider that if he was continuing to get benefits under the scheme, he would need to have been paid on a drip-feed basis indefinitely. He would need to have fought with ongoing medical examinations, up to once per month. He would be at fear of those medical examinations providing an outlying opinion which might change the circumstances for which his claim is accepted. And if he wanted to appeal those decisions, he would not be able to have meaningful access to legal advice.

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And finally, his normal weekly earnings, or his incapacity payments would have been paid at the age that he was at his death into the future, with no consideration for what his earning potential or capacity could have been or would have been, with no superannuation contribution,
5 obviously placing him at a very significant disadvantage, not only on the open labour market, but as a financial member of society, providing for his family into the future.

COMMISSIONER FITZGERALD: Thank you very much. Thank you
10 for your submission and previous submissions and discussions with the Commission. Can I just go to the fundamental issue in relation to the scheme. We looked at whether or not we could do what you've suggested, and that is to bring all of the acts into a cohesive piece of legislation, a one-scheme approach. Our view was, in the end, that the disruptive effect
15 of that, particularly in relation to the VEA, could not be justified, and would be wholly unacceptable to that veteran community.

So we made a decision to retain the VEA. And I presume that what you're saying in your recommendation is that, effectively, you would have seen
20 the VEA DRCA and MRCA all combined into a new legislative framework. But notwithstanding that we've decided, at this stage, our draft recommendation, to keep the VEA, if we just look at the MRCA and DRCA side, which is the scheme 2, and ultimately would be the one scheme available to veterans, I would have thought that that combination
25 is capable of meeting many of your points.

So if I look down your list, under point 2, I just look at those and I think, well, many of those will in fact be part of that combined scheme. Not all, but many of those. So, am I reading your recommendation rightly, that
30 the major problem in our report, from your point of view, is fundamentally keeping VEA?

MS PLUNKETT-SCOTT: In fact, no, Commissioner. Upon review and considering the complexities of merging VEA, MRCA and SRCA, we, in
35 principle, support the recommendation put forward to keep VEA as standalone, and merging the MRCA and the SRCA together. My principal recommendation is that upon combining the SRCA and the MRCA, the devil is in the detail in relation to the compensation provided. And the mechanism with which we ensure that those heads of
40 compensation are provided we say should be considered in consultation and reliance on legal advocates who appear for the veteran and understand that (indistinct) practical circumstances.

COMMISSIONER FITZGERALD: And we hear that, but can I just
45 deal with a couple of issues. So, for example, your position in relation to

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statement of principles, we believe the statement of principles should be applied across the three acts. I know lawyers disagree with that, in some sense. The issue for us there is, if there can be one single burden of proof, or test, what should that be? Have you got a particular view about that?

MS PLUNKETT-SCOTT: We do. We say that it's a balance of probabilities test, as to whether the injury was significantly contributed to by the military service. So not dissimilar to the test already found in SRCA, but needs to be a balance of probabilities test or higher. Where we encounter difficulties advocating for the veteran is the prescriptive nature, or what we perceive to be the prescriptive nature of the statement of principles, providing an extra set of criteria that they need to navigate and meet, where if we just applied a common-sense approach to causation, to say, on the balance of probabilities, would they have been suffering that injury, but for their service?

COMMISSIONER FITZGERALD: Many of the ESOs have put to us that if there is to be a single test, it should of course be the reasonable hypothesis test. Do you have any particular views as to why that would not be the appropriate test?

MS PLUNKETT-SCOTT: The reasonable hypothesis test is obviously of greater advantage to the veteran, and certainly we would support that. But I understand that there are some complexities in allocating a reasonable hypothesis test in different circumstances of service-related injuries. Now, I also appreciate that we've submitted that the distinct difference between the types of service makes it complex. Certainly, we would support reasonable hypothesis, but at the very bare minimum, balance of probabilities.

COMMISSIONER FITZGERALD: All right. The second one, if I can just draw this out – and you've mentioned it in two of your points – a choice between long tail statutory benefits and community statutory benefits into a lump sum. In relation to the DRCA and MRCA combination, we believe that lump sums should be available under the combined act, and the option for the person to elect to take a periodic payment. So we believe that that option should be made available.

MS PLUNKETT-SCOTT: Is that specifically in relation to compensation for permanent impairment, or commuted benefits for incapacity into the future, effectively rendering a long tail to a short tail?

COMMISSIONER FITZGERALD: At the moment, it's specifically in relation to impairment payments.

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MS PLUNKETT-SCOTT: Our submission extends to including that to incapacity payments, so giving the veteran the opportunity to commute from the scheme upon appropriate medical evidence and legal advice.

5 **COMMISSIONER FITZGERALD:** Sure, but if we just take the impairment just for one moment, you would be supportive of a scheme that allows the choice between lump sum or periodic payment?

MS PLUNKETT-SCOTT: That's correct.

10

COMMISSIONER FITZGERALD: Yes. And of course, as you know, some veterans' groups, I have difficulty with that particular proposition. Can I go to the third one, and then Richard may have some questions. This whole-person impairment basis: as I understand it – and correct me
15 if I'm wrong, because you're the expert, not me – one act, MRCA, basically – sorry, one act allows for that, and one act actually just deals with condition by condition. And if I'm correct, MRCA allows for the whole-person impairment, and DRCA, at its current constitution, looks at individual conditions. Your recommendation is very clear, that you
20 believe the whole-person impairment approach is the preferred approach, is that right?

MS PLUNKETT-SCOTT: We might be talking about the same thing, but differently. We believe that the approach currently in MRCA for
25 impairments to be combined is appropriate.

COMMISSIONER FITZGERALD: Yes.

MS PLUNKETT-SCOTT: Where the SRC Act encounters difficulties is
30 where an individual has three different types of injuries or conditions. They each meet 9 per cent. Together, they amount to just under 30, but they get nothing, because they don't meet the 10 per cent threshold. So that is why MRCA is the most appropriate scheme in that regard.

35 **COMMISSIONER FITZGERALD:** Yes, we are talking about the same thing. So basically, we end up – your preference is for the way that MRCA deals with that issue.

MS PLUNKETT-SCOTT: Yes.

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COMMISSIONER FITZGERALD: All right, thank you very much for that.

COMMISSIONER SPENCER: As you know, Robert Cornell's report
45 has been finalised and handed to Government, but it hasn't been released

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yet. And we're urging Government to do that as soon as possible, because that will respond to, and we will examine that from the point of view of advocacy. Because, as you rightly say, the future of advocacy and how best to support people through this process, even if it is a simplified process, will still be complex, and there will be a need for support there.

MS PLUNKETT-SCOTT: That's correct.

COMMISSIONER SPENCER: So we'll certainly have more to say about it. I just want to come back to the issue you've raised, obviously, in terms of legal representation and being able to challenge decisions. As you know, we've put forward the proposal around VRB, trying to bring more of that – what is – so far seems to be a reasonably successful ADR process in the VRB, to bring that forward earlier into the determination, the reconsideration process. And as you know, we've said that this area is quite unique, in terms of two determinations, whereas in most other areas, it's only the one, obviously, the AAT. So we're sort of pushing in that direction.

I think you may be pushing back in another direction, but how do you see that? So it seems to me there are two issues: 1) what is the right way for, in a sense, justice to be done when things go wrong? 2) which is a very – and we hear this often, a very legitimate issue, and that is one of, well, what are the cost issues here? Who pays for this? So could you just expand a bit on your thoughts about how that should be handled?

MS PLUNKETT-SCOTT: May I ask a question firstly, Commissioner. With respect to the recommendation put forward, it is to continue with – as I understand it, a reconsideration would be requested. The matter then progresses through to the Veterans' Review Board. If it's unable to be – or if the veteran continues to undertake steps to appeal it, they would then proceed to the Administrative Appeals Tribunal.

Our concern is not the steps. Our concern is the access to appropriate legal representation and support throughout those steps. At this stage, the Veterans' Review Board provides an avenue for appeal, of which legal advocates are unable to be present. But there's also a restriction on the veteran to ensure that they have every piece of medical evidence they intend to rely before the Veterans' Review Board, and if they do get subsequent evidence at a later stage, because the VRB has not made the correct decision, there are consequences to legal costs in the tribunal, which, we're already looking at a tribunal with legal costs are significantly lower than what they would be in any other court.

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Our concern is that you are restricting – you are asking the veteran, at that Veterans' Review Board stage, to have an understanding of what their legal case is and what their evidence needs to be, but no ability to go out and brief a medical doctor on the right legal test or questions of causation, but without advocacy and support. So if it is the case that the recommendation is to keep the process reconsideration, Veterans' Review Board, AAT, our strong submission is that independent legal advocates should be brought in at those earlier stages of reconsideration, to support the veteran through that process, and reasonable legal expenses of that advocacy are repaid by the MRCC to the veteran in the event of a successful outcome.

COMMISSIONER SPENCER: And as you know – and we're continuing to look at this issue, but as you know, we hear a strong view that people welcome the fact that the VRB, and the ADR process in particular is not adversarial, or is perceived to be non-adversarial. So there are both arguments for and against in this issue, so it's a difficult area. But in terms of going to the AAT, we understand there's an uneven landscape around Australia in terms of Legal Aid, that in some states – I believe in New South Wales, there is – Legal Aid has more capacity to support veterans in that state than other states. Do you have a view on that, on how Legal Aid should play a role in this?

MS PLUNKETT-SCOTT: Not only do I not have a view, but I'm unfamiliar with the fact that Legal Aid can play any role at all. I was unaware that Legal Aid can play any role at all in the support of a veteran through this process. If that is the case, certainly we should be telling all the veterans that call us, who are unable to get assistance.

COMMISSIONER SPENCER: Our understanding is – and this may not be right – is that it's pretty uneven. Some states have dedicated sections within their Legal Aid to support that, and in others it's virtually non-existent. So it's an issue that's part of the landscape. It's important to think about how – a very real issue, that is, the financial capacity of individuals to take their cases forward should be handled –

MS PLUNKETT-SCOTT: In the event that a Legal Aid framework is considered, our submission would be the need to have expert veteran advocates in that space. I don't think it would be possible for – just to expand the scope of any Legal Aid practitioner to be just assisting a veteran in the process, because, as we know, it requires that deep dive into the scheme and the veteran's circumstances, because it's a very niche expert area of law.

COMMISSIONER SPENCER: Yes, I understand. Robert.

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COMMISSIONER FITZGERALD: Just your last – point 4, which is the general one. You've stressed again there the consistent thing, which is (indistinct) of the framework rewrite, in relation to MRCA and DRCA at least, if you're agreeing to keep VEA. But I don't know – it says the recommendations fail to describe a scheme which acknowledges the impacts of medical conditions. I know that you have some concerns about the SOPs, but I don't quite understand your statement there. I would have thought even the current scheme does that. Certainly a future one should, but I'm not understanding where the deficiency is in relation to that.

MS PLUNKETT-SCOTT: The deficiency is in relation to the failure of the scheme to acknowledge the ongoing financial impact, beyond the compensation that is currently awarded. Principally, the incapacity payments are paid without any contribution to superannuation payments, and also any consideration of future earning capacity. So the veteran is paid as at the rate that they were when they were injured, which – I explained how significantly disruptive that is, if you're injured at 22 versus 52.

COMMISSIONER FITZGERALD: So, again, just to be very clear, your point there is largely around – in fact, exclusively around the incapacity payments issue.

MS PLUNKETT-SCOTT: The incapacity payments, yes, and to the extent that, if I might make another submission, a practical example, the provisions of repatriation healthcare cards is to provide treatment under a gold card a white card system. If the veteran decides to reach out to new treatment, a different type of medication, something novel, things haven't been working, they normally have to apply for the repatriation healthcare card to cover that. There are restrictions on what can be covered, and there is no appropriate economic legal avenue to dispute that currently. So we say it's the broader holistic financial impacts of the medical condition and access to treatment outside of what is –

COMMISSIONER FITZGERALD: Can I just clarify that. If I go back – my medical condition has changed, and I need to add to the white card, for example, an additional condition, I put in a claim. That claim is subject to the normal reviews processes which we've outlined, isn't it?

MS PLUNKETT-SCOTT: That's correct.

COMMISSIONER FITZGERALD: So when you say that there's no legal capacity to dispute that claim, are you simply say there is, but it's difficult, or are you saying there isn't, and I've got it wrong?

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MS PLUNKETT-SCOTT: Two different things. First of all, if I have post-traumatic stress disorder, and a certain treatment is recommend for me with post-traumatic stress disorder, the steps are PTSD is accepted, a repatriation healthcare card or a white card is provided, and I can access treatment for the PTSD. I'm unresponsive to treatment, my condition changes and significantly deteriorates. It's now a major depressive disorder. I have to know, upon receiving that diagnosis, to go and lodge a new claim form, to then get a decision whether MDD is going to be accepted as a different condition, and then talk with my treating practitioner about what treatment I need for MDD.

If a new treatment might be available, something that is experimental, or something that's not yet used in Australia, and I'm recommended to give it a go by my treating practitioner, I apply for that to be paid under the repatriation healthcare card, and it is rejected as a form of treatment, for various reasons – some may be good, some may be bad – I have no avenue to appeal that.

COMMISSIONER FITZGERALD: Right, so we've got the two things. As I said, you've got the change in condition, which is one stream, and that is appealable, in a sense, or reviewable, as we've indicated. The other one is where you simply – the condition is not changing, but the treatment that you seek or need is changing, and you've got to get approval for that. And you're saying, in relation to that second one, there's really no avenue to have that reviewed, is that correct?

MS PLUNKETT-SCOTT: There is an avenue, but it's uneconomic and onerous.

COMMISSIONER FITZGERALD: What do you mean it's uneconomic?

MS PLUNKETT-SCOTT: Currently, it would be a decision – the decision to reject that particular treatment under the repatriation healthcare card is just a letter. It doesn't have any notice of rights attached to it, but the veteran needs to know that that is subject to a 28-day appeal time limit to the – judicial review to the Federal Court. Upon taking steps to appeal to the Federal Court, they would need to – there's an adverse costs order risk, but solely for –

COMMISSIONER FITZGERALD: So why do you think that – and again, this is my ignorance – why wouldn't that decision in relation to the treatment not follow the same sort of review process as a claim? So it

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ends up at the VRB or AAT. Why has it got to go through the Federal Court? Why do you think that is the case?

MS PLUNKETT-SCOTT: Well, we don't know why. We think it's the wrong approach. So we don't know why it was put in place to be that way, but the reason, legally, is because it is not considered to be a determination pursuant – or a reviewable decision, a decision capable of being reviewed in the SRCA and MRCA, probably principally because it's covered under the VEA. So I think it's because it's – the authority is in the VEA, and it's not identified as being a reviewable decision. So it would be simply a matter of the legislative framework. And this would be the case for, in the rest of our submissions, any other benefit that we say is not currently capable of being appealed. We just think it's a matter of the legislation confirming it's a reviewable decision.

COMMISSIONER FITZGERALD: Now, at first instance, that sounds logical, what you're putting. What's the perverse effect of that, if any? Are there unforeseen or unintended consequences of doing that?

MS PLUNKETT-SCOTT: Not coming to mind, Commissioner. I think this could just be the – I think it could have come about because, practically, no one is agitating these issues, to say, "Well, hang on, this is a problem."

COMMISSIONER FITZGERALD: All right, well, that's very helpful. Thank you very much for that. We're out of time, but is there any final comment that you would like to make, or any particular point you would like to press upon us?

MS PLUNKETT-SCOTT: Can I just have one moment?

COMMISSIONER FITZGERALD: Sure .

MS PLUNKETT-SCOTT: Commissioners, just one final comment, for the record, and is that if we, as a country, cannot afford to compensate an injured veteran, to put them back into the financial position they should have been in if they hadn't suffered the injury, we cannot afford to prepare them and send them to war. This is a cost that our Government can and must expend.

COMMISSIONER FITZGERALD: Thank you very much.

MS PLUNKETT-SCOTT: Thank you.

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COMMISSIONER FITZGERALD: Could I please have Angela Rainbow and Lisa Smith, please. Angela and Lisa, could you please give your full names and the organisation you represent, if any, or if you're appearing as individuals.

MS RAINBOW: Yes. I'm Angela Rainbow, and I'm here as an individual.

MS SMITH: Lisa Smith, appearing as an individual.

COMMISSIONER FITZGERALD: Good, thank you very much. So you know the routine, it's ten minutes to give us the key points, and then we'll have a bit of a conversation.

MS RAINBOW: Yes. So, thank you for the opportunity to speak with you again. I actually did speak at the Perth forum. I was actually unwell leading up to that, for ten days, so I did – the purpose for coming today was to highlight some additional points – only two – that I feel are worthy of communicating first-hand.

I'm here because I want to ensure the wellbeing of veterans. I'm an operator of a business providing occupational therapy services to the veteran community for 21 years. I'm acutely aware of the wellness benefits achieved by veterans accessing allied health services, and I believe there is a lack of strong advocacy within the allied health industry. We are a group of health professionals who typically just like to help people, and as a result, can be vulnerable to unacceptable working conditions, which in turn does impact on the service quality and delivery. And that's why it's important for me to be here again today, representing my industry.

I would like to raise two points with you. Firstly, the allied health statistics and research within the draft report and subsequent conclusions drawn by the Commission, and I would like to speak about the current referral system framework. In regards to the allied health statistics and research within the report, I believe some information, research and data provided to the Commission has not been suitably analysed or verified, nor fairly or deeply considered.

In particular, I wish to refer you to the AMA submission, February 2016, which was the review of dental and allied health arrangements; DVA statistics, page 602; and Medicare expenditure on allied health versus DVA allied health expenditure. I believe it is of great importance to discuss this information, as I am concerned the AMA and the Commission have concluded there are great inefficiencies in the provision of allied

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health services, and a level of service provision that persists beyond what is clinically indicated.

Regarding the AMA submission to DVA – and we've provided you a copy here – on page 602 of your report, the Commission directly references the AMA submission. The Commission make references to the AMA suggestion that DVA's allied health arrangements do not sufficiently guard against high levels of service usage. The Commission in their report continues by directly quoting from the AMA submission:

> *Current referral arrangements do not encourage allied health practitioners to report back to the GP, and may, in some circumstances, encourage treatment by an allied health professional to persist beyond what is clinically indicated.*

Furthermore, the AMA, in a 2016 submission, on paragraph 5, offer the following comment:

> *We note with some concern, for example, that according to the background paper that shows from July 2014 to June 2015, that of the average 25 services provided to DVA clients, the dental and allied health services, almost 23 of these are for musculoskeletal services.*

We have obtained a copy of the background paper, which we've also provided you today. And this was provided to the AMA, which – the AMA drew their conclusions, and it appears the AMA have made an error in their interpretation of the facts within table 2, service utilisation, 2014 to 2015, page 6. The data demonstrates that it is incorrect for the AMA to say that the proportion of musculoskeletal services equates to 23 out of the 25 average number of service, or 92 per cent.

To determine the average number of dental and allied health services per client, the total number of services, which is 3.9m, is divided by the total number of clients, which was 155,000. This results in the average of 25. To determine what proportion of total allied health services is attributed to musculoskeletal services, the number of services for the musculoskeletal group, which was 2.8m, must be divided by the total number of services – 3.9 – which results in a proportion of 72 per net, not 92 per cent.

We wish to also highlight that the musculoskeletal group includes six allied health disciplines: chiropractic, physiotherapy, occupational therapy, podiatry, exercise physiology, and osteopathy. This is a large group of the most commonly accessed allied health providers. It is our opinion that the proportion of total services therefore is very reasonable.

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This proportion has remained stable, with a 71 per cent proportion of total allied health services in 2011 to 2012, and 75 per cent in 2016 to 17.

COMMISSIONER FITZGERALD: So you 'll just have to come to a
5 couple of conclusions in relation to this one.'

MS RAINBOW: Sure.

COMMISSIONER FITZGERALD: And then move to your second
10 point.

MS RAINBOW: Yes, sure. So I guess just finally, the current DVA stats 2016/17 reveal the average number of dental and allied health services is 28.5 per veteran. This equates to roughly one service per
15 fortnight from a group of 19 disciplines. My professional experience tells me this is a very reasonable and acceptable utilisation rate and also you've got to remember that the veteran population typically have comorbid and complex conditions. In fact, I believe the service utilisation rate is on the low side and at a cost of $2200 per veteran is a bargain. I'm not too sure if
20 you're aware that the average cost for medical treatment is $25,000 per veteran.

COMMISSIONER FITZGERALD: Yes.

25 **MS RAINBOW:** So I'll just move on briefly, the second comment was the Commission makes reference to a DVA stat and commentary on page 602 of the report. It says, "There are other signs that suggest health service usage is not fully explained by ageing. Since 2010 the age profile has not changed much yet from 2011 to 12 the average number of dental
30 and allied health services per patient has increased by nearly 50 per cent." Whilst this commentary seems relatively innocuous, it does precede the AMA suggestion that DVA's allied health arrangements do not guard against high levels of service usage.

35 The Commission also offer no explanation for the rising number of health services. A reader may draw the conclusion that the Commission is eluding to the fact that the rising levels of service usage is in fact attributed to over-servicing. Our health care system is much advanced than it was nine years ago as I'm sure the legal system is too. There is
40 earlier detection of medical conditions and injuries, hence treatments and therapies are commenced earlier. Emerging health disciplines such as psychology is generally more utilised now in the community as well as exercise physiology. So these things can help to account for the rise.

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There's no evidence around best practice and also veterans, just like the general public, are better informed about health care, wellness and the role of allied health.

5 **COMMISSIONER FITZGERALD:** Sorry.

MS RAINBOW: Yes.

COMMISSIONER FITZGERALD: We'll just read the rest of that.
10 Can you go to the second last point - the current referral system framework and then we'll have a discussion.

MS RAINBOW: Sure. Okay, can I just briefly just say I wanted to talk about the Commission also does commentary comparing Medicare
15 expenditure for Allied Health versus Veterans' Affairs.

COMMISSIONER FITZGERALD: Yes.

MS RAINBOW: But I just wanted to say that the Medicare and rebates
20 for Allied Health is very undeveloped and limited and it's not correct to be using it as a comparator and it's misleading to do so. Even in 2011, the Australian Health Review published a journal article about Medicare allied health programs and it affirmed the low uptake of the Medicare allied health program. We as occupational therapists, we don't participate
25 in the Medicare (indistinct), such as a chronic disease management, because the actual remuneration rate equals $25 per hour so that's just one example so, I mean, you're better off comparing perhaps private health insurance but once again, typically people with private health insurance don't have comorbid and complex conditions like the veterans. Perhaps
30 you might want to compare it to the motor vehicle insurance compensation. So just moving on to the current referral system and framework - - -

COMMISSIONER FITZGERALD: Just briefly.

35

MS RAINBOW: Yes, briefly. Okay, so once the current system of annual or continuing care referral supports a collaborative approach between GP and the allied health provider, it can still interfere with veterans accessing timely allied health. An example of a recent referral,
40 the veteran told us that he spent a year talking to his doctor about whether an occupational therapy review would be beneficial. He has PTSD and a number of orthopaedic conditions. After a year, a referral was made to an OT. He's got difficulty mobilising around his home, getting in and out of the shower and on and off his toilet. He had a general clinical need for the
45 service and it was actually turns out that, you know, we were able to, you

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know, positive impact on his wellbeing and we just want to point out as a part of the DVA Veteran Centric Reform, July 2019, a 12 session treatment cycle initiative is being introduced whereby the veteran must go back to the GP on a regular basis purely to request or gain consent for continuing or completing clinically required allied health.

This Reform does not support the Commission's focus on wellness and instead adopts an archaic and non-contemporary model of health care. It's a very disempowering form of health service delivery and does not align with contemporary Australian models of health care such as NDIS and My Age Care which are based on choice and control.

COMMISSIONER FITZGERALD: All right, well we'd like to stop it at that point.

MS RAINBOW: Sure, thank you.

COMMISSIONER FITZGERALD: Because we can read the rest and we've had the opportunity to hear from you before, but I just want to go back to a couple of points.

MS RAINBOW: Yes.

COMMISSIONER FITZGERALD: We've used the AMA submission and we're grateful for your analysis and your information and we will look at that information that you've given to us. But I do want to raise this question: it's not simply AMA but there have been indications that the system itself doesn't seem to capable of in fact monitoring and dealing with over-servicing so either yourselves or others from the allied health services have said, "Well, there are the ethical standards that surround those industries" and I should just clear - my sons a physiotherapist so I understand allied health. But when we looked at the system, notwithstanding the AMA's submission, there didn't seem to be many checks and balances in it.

MS RAINBOW: Yes.

COMMISSIONER FITZGERALD: So I was wondering how you approach that? So whether or not there's over-servicing, put that aside, but the potential for over-servicing seems to us existing because the system doesn't monitor the whole of the health service, frankly, very well so what's the right approach for dealing with that issue?

MS RAINBOW: I think it's about developing an internal quality assessment team so the NDIS have actually got an assessment team as

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well where they actually go out to work places. Even in our practise, we monitor, you know, the client conditions and the visits that our therapists are doing as well so I just sort of think a systematic regular review, a bit like the ATO doing audits and things like that, would work along with the fact that we've got (indistinct) two bodies and, you know, we've got to work with a level of - a high level of integrity.

COMMISSIONER FITZGERALD: Just if I can be a bit specific. You think that an auditing regime of some description would be a good step?

MS RAINBOW: I think so.

COMMISSIONER FITZGERALD: Run by DVA or whomever is going to be the commissioning of these health services.

MS RAINBOW: Yes.

COMMISSIONER FITZGERALD: You say that you question the AMA's conclusions and we'll look at that. You've also indicated that you think, for your information, that in fact the level of servicing by the allied health industry is appropriate, reasonable or adequate.

MS RAINBOW: Yes, yes.

COMMISSIONER FITZGERALD: And you rightfully point out that it's much cheaper than medical treatment which is self-evident.

MS RAINBOW: Yes.

COMMISSIONER FITZGERALD: Can I just deal with that last point first. We've heard a number of submissions over the course of the public hearings and prior to that, about the pricing policy of DVA in relation to a whole range of health services. So I was just wondering whether you have a comment about that? Are allied health works, in your experience, being paid at an appropriate rate in order to be able to provide access to services?

MS RAINBOW: Well, as I mentioned in the Perth hearing, I said that the current rate that we're paid by DVA is 20 per cent of other State and Commonwealth health services so our rate is $40 an hour whereas if you work for the NDIS it's $180 an hour, yes.

COMMISSIONER FITZGERALD: So we just want to make that point. And again, do you believe that it should be equivalent to the NDIS rate or do you believe, as somebody said yesterday, the government

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should sort of - could come to the position of saying, "It's X less 20 per cent" or what have you, so you get a clarity or you believe that it should be equal to, for example, the NDIS rate?

MS RAINBOW: Well, I think it should be the same. I mean, we're providing a very similar service and it's - you know, their equal client populations, their people that are entitled - Australian members of our community, entitled to good health care services.

MS SMITH: And it's not also equal to occupational therapists providing rehab services to active members so they can receive the remuneration levels as per Comcare.

COMMISSIONER FITZGERALD: So just to explain that for those that are not aware of it; if you were servicing as occupational therapists providing services to a serving ADF member and you were providing the same service to a veteran who has left the service, what would the differential be, not in precise terms, but roughly?

MS RAINBOW: Twenty per cent of what someone assisting, someone within the ADF.

COMMISSIONER FITZGERALD: So even between just Defence and DVA there's a big differential let alone between that and other systems?

MS RAINBOW: Yes.

COMMISSIONER FITZGERALD: And when your industry, your professional bodies, have put that to DVA, what's been the response?

MS RAINBOW: They just - what do they say? I mean, they just like listen and they just say - I mean, they've put us off for - they moved us around. We, you know, we were talking to the clinical advisors about it and they were saying "No, you've got to go to your association". Our Association starts writing DVA letters, then they'd answer and say, "Bring it up at this allied health forum", and the other health members say the same thing and then the chairs of the DVA, allied health groups, change and it just - it gets delayed and delayed and then they say, "Oh...", and then lastly they said, "Look, we're going to address it in this allied health review" which was commissioned in 2015/16 and it came out in July last year, or May, and they're still not addressing anything in a meaningful way either, so.

COMMISSIONER SPENCER: Just to that very point, because I was struck by this sentence in your submission on page 9 where you say,

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"There appears to be an attitude within DVA that proactive engagement between veterans and providers is not support".

MS RAINBOW: Yes.

COMMISSIONER SPENCER: So I suppose it's trying to understand what's happening here and there can be different explanations; one is not valuing allied health; another one is perhaps in the areas of control which comes back to this issue of trust about is there over-servicing going on or what's happening there, so I think there can be several issues that are about this but I come back to, with reference to NDIS and Aged Care and the notion of choice and control which you refer to, those have been significant advances in other forms of human services and, you know, it's often said giving agency, giving - empowering the individual to make choices about what is in their best interest; what do you see as the potential for a consumer directed care model around both allied health and other needs that individuals have, it's - as you know, and NDIS said, it comes up in other areas as well, the sort of home support that people.

Once again, the big movement there has been to say that the trade-off between government controlling and being precise about everything you get and the accountability for that versus trying to have a system which does some sort of assessment up front and then gives the, you know, once again back to that choice and control, within parameters as the NDIS does, are to fashion the services they need. So when you reflect on all of that, and you see this in other areas of your work, how can this be more fully utilised in the veteran space, do you think?

MS RAINBOW: Well, I mean, personal for me, I mean, I know even RSLs support just the veteran being able to approach the allied health member just as anyone usually can approach them and then just looking at - so that's empowering them and given them that choice and then with an internal quality assessment team, they're just - you know, they're just safeguarding to make sure that all the services are appropriate. I mean, it's the same as, I mean, dental specialists, GPs and optical, I mean, there's no gates or loopholes that they need to jump through and there's that level of trust so I think - you know, think it's time that they need to, you know, set up measures to develop that trust.

And I just wanted to say also, back in 2002 the AMA had a big (indistinct) with Veterans' Affairs because they weren't enabling them to service veterans and there was a big hoo-ha yeah just around, you know, paying for their services and things like that so I feel like, you know, ten years on allied health is facing the same challenge and just trying to break down the

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barriers and just the cultural sort of attitude towards allied health and what we provide.

COMMISSIONER SPENCER: Look, just a question around the Gold Card because you've come back very strongly and said you disagree with our view that the Gold Card about (indistinct). So one view of the Gold Card is, "Well, it enables you to go to providers and get what you need" and as we know, and we've heard, that often that is not the case. You can't get what you need. So in some ways it can be a bit of a blunt instrument, it does have advantages but there are some limitations to it. So would it be helpful to explore this area of package assessment, consumer director care, around the things you're talking about which would mean that the individual gets what they need, the right time, right place, right service, rather than sometimes this having to play out through a card system which may or may not give you what you need when you go out to access the service that you want and need?

MS RAINBOW: I think one of the fundamental considerations, whether it's a package or a Gold Card, is the access - well, the providers providing or being available to provide that service so if that provider is not funded appropriately, they're going to choose to engage in a different scheme so, for example, the Medicare chronic disease scheme package, we don't participate in it because it's not a viable service so people can't access it, so whether it's a package, it's got to be funded appropriately so the quality of service is available for the veterans to access. As more and more service providers withdraw from providing service, the quality of the service will decline.

COMMISSIONER SPENCER: Right. So it is interesting, we often come back to this question of the fee schedule and I understand what you're saying, it is a bit of a mystery to us when we hear the huge disparities between different schemes and certainly understand the impact that can have on the availability of a service.

COMMISSIONER FITZGERALD: Sorry, can I just go to that point, the previous one that Richard was just canvassing with you. You've made a strong representation against the changes to the July of this year reforms.

MS RAINBOW: Yes.

COMMISSIONER FITZGERALD: As I understand it, that is that the Department if now requiring veterans to return to the GP after 12 sessions; is that correct?

MS RAINBOW: Yes.

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COMMISSIONER FITZGERALD: So where do you see the gatekeeper in this? Is it the case manager, the rehabilitation consultant or rehabilitation case manager, if that's the scheme or is it the GP or how do we get the right balance there? So, obviously you believe what's being proposed to take effect this year is adverse to the veteran but what is the right approach?

MS RAINBOW: I guess it just goes back to my idea of, you know, that all allied health professionals who engage in servicing the veterans that they, as apart of their condition of servicing the veteran, is that, you know, that they will be audited and you need to justify, you know, look at the number of treatment sessions and conditions and, you know, there's just some auditing process that goes on.

COMMISSIONER FITZGERALD: We have discussed - sorry, yes.

MS SMITH: No, I was just going to say we're not adverse to continual communication with GPs as the (indistinct) have suggested that perhaps that's lacking. However, there's no mechanism in their proposal to facilitate that communication with GPs. It continues to stand that they don't fund reports, they don't fund any kind of case conferencing or anything like that, so there's no way for us - I mean, we do it anyway because it's the appropriate practice and, you know, we have to meet our code of conduct and all of that and of course we report back but it doesn't support allied health professionals to communicate with GPs or whoever that person is to coordinate that care, so.

COMMISSIONER FITZGERALD: That's fine. And then what's the role of the rehabilitation case manager, if I can use that term, I know it has various terms, what's their fundamental role?

MS SMITH: In general or?

COMMISSIONER FITZGERALD: It should be, in this case.

MS SMITH: In this case, well there is none really. There's isn't a case manager. What would it be anyway? I mean, I don't really know exactly what - I mean, they've just got I guess an understanding of all the allied health roles and the benefits and they make a judgement about - - -

COMMISSIONER FITZGERALD: So who do you relate to in DVA in terms of feedback on the client's outcomes or don't you?

MS SMITH: No, well we don't. Yeah, we don't.

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COMMISSIONER FITZGERALD: And that's part of the missing system. Again, we made a comment yesterday, whilst people support DVA and the policies, this is completely lacking in any outcomes focus which is it's completely unusual in the human services space that we're in at the moment. And in your space, any other provider of a compensation scheme would at least want to know the outcomes of the clients.

MS SMITIH: Yes, I mean when we write back to the doctor one of our headings is, "The interventions and our outcomes" so we're reporting back to the GP about the outcomes. But the DVA are unaware of that unless they call for the notes or something like that but I think in the submission we recommended like, just standard - use of some standardise assessments that will measure - yes, the interventions of allied health.

COMMISSIONER FITZGERALD: Good. Is there any final comment that you'd like to make before we finish?

MS SMITH: Just thank you for your time and - yes, and just that I trust the independent nature of this inquiry and (indistinct).

COMMISSIONER FITZGERALD: Now, you've raised a number of issues in a number of forms and we're very grateful for that so we again thank you for that and thank you for your number of submissions, that's terrific.

MS SMITH: Okay, yes thank you.

COMMISSIONER FITZGERALD: Good. Could we have Deborah Morris please. Good morning, how are you?

MS MORRIS: Good morning.

COMMISSIONER FITZGERALD: Deborah, if you could give your full name and any organisation that you represent.

MS MORRIS: Yes, Deborah Morris. Independent, so independent research capability in development and particularly I focus on (indistinct) militaries.

COMMISSIONER FITZGERALD: And you're engaged with which institution at the moment?

MS MORRIS: Griffith University. I'm also a contemporary veteran.

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COMMISSIONER FITZGERALD: Good, thank you very much. Deborah, if you can give us the key points in ten to 15 minutes, that would be terrific.

5 **MS MORRIS:** Certainly. So I do welcome the draft report produced by the Productivity Commission, A Better Way to Support Veterans. The draft report is comprehensive, particularly for lay people that aren't aware of the whole military system and it offers insights and avenues of much required reform. Whilst many may view the reforms as going too far, I
10 would argue that many of the reforms do not actually go far enough. What we're looking at here is we need to make the system fit for purpose now and into the future. Any reforms must be total systems approach including strong reforms and incentives within the ADF not just DVA.

15 I'm sure that you've heard numerous times that DVA inherits many of the complexities from the ADF and that's what I'm kind of going to outline for you today. Without the reform within the ADF, there is a real risk of future and increase harm to veterans and their families which will inevitably create future burdens and costs on the system. So honestly it
20 will create a system that is perpetually not fit for purpose for anyone.

Currently there are numerous systemic limitations with the ADF including the tension between capability and the (indistinct) imperatives which is pretty much in military and civilian divide. Tension between the ADF
25 being both an institution and an organisation. How military personnel are socialised and institutionalised and the authoritarian rank and command structure which creates continual and systematic possibilities of abuse of power. The institutional denial and lack of transparency from the ADF, (indistinct) management of ADF protocols including processes, systems
30 and policies, and the abuse of the military justice system including inquiries, investigations and reviews.

These systemic limitations within the institution create an environment where individuals have no capacity but to submit. Within the
35 contemporary setting, systemic limitations are a significant contributor to poor veteran outcomes yet this knowledge is continuously hidden under the traditional narratives about post-traumatic stress disorder. Recent investigations and enquiries have studied the effects of diminished agency and institutionalism within military institution. The findings of this
40 research suggests that it is the regimented system's governance which contributes to and exasperates poor outcomes for veterans. In other words, it is the day to day effects in military socialisation and the systems of power coupled with no foreseeable end in sight that breaks the person more than the actual trauma or the injury that has occurred.

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So in making the system fit for purpose, it is actually important to understand what contemporary service entails. Everyone speaks about contemporary service but nobody has really defined what it is. So I propose that contemporary service is about a professional occupation within an institutional environment, an institution that serves the Australian people through individual sacrifice. This is what makes it unique today. The abolishment of conscription in the 1970s saw the ADF organisational structure centralise and builds upon the premise of a career orientated volunteer force. This shift from institution to occupation significantly changes the military experience. An institution is usually legitimised in terms of shared values and norms and are looking at something higher then themselves whilst an occupation is legitimised in terms of the market place.

This is a core consideration and it's going to be the balance act that the Commission is going to really need to look at. The principle interest being that there has been a significant change in the relations between civil society and the military. In today's military, young people take up a well-compensated occupation but it's in a highly institutionalised workplace, one that sees them separated from the wider world. The dual structure of the ADF as both organisation and institution means that its members are not simply employees but are considered appendices of the State.

Within the institutional setting personnel become institutionalised and lose a lot of their individual agency. The way in which the ADF institutionalise members means that there is a quantifiable need for the Australian Government to provide care and support for them and their family because it is actually the regimented structure of the ADF which creates a climate in which systemic limitations readily lead to individual human rights, workers' rights and civil right violations.

Arguably, when you have been looking at a lot of the submissions coming through, this is what many veterans understand but struggle to articulate. It is actually why there is a real fear of the demolishment of the DVA because currently at the moment DVA is the only check on ADF power available to the veteran. So I urge the Commission to seriously consider this information and conduct further enquiry and analysis before reaching its final conclusions. In that sense I would like to take the time to propose a very brief alternative model to the one suggested in the draft report.

COMMISSIONER FITZGERALD: Yes.

MS MORRIS: Whilst I agree theoretically, in a single unified portfolio department I do not agree with the proposed arrangements. As the ADF is

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both in part an institution and organisation, any reforms require strong incentives to ensure transparency, accountability and welfare as personnel at all stages of a military engagement and beyond. Creating change within institutions and organisations steep in history and tradition is an onerous and difficult task. For the ADF it is about striking the right balance between capabilities whilst ensuring the welfare of individuals within the institution. I believe that this balance can be struck by counterbalancing the vertical and hierarchal structures of the ADF, which is the institutionalisation, with a horizontal wrap around care structure which could be administered by either the proposed VSC or alternatively where DVA is at the moment.

As a model that uses wrap around care, it could run horizontal to the different stages of service beginning at the beginning of in-service, transition and post service. It would afford the opportunity to create a similar system that is focused on the wellbeing from the beginning of the member's military career. In this sense it's a preventative measure and we're all aware that prevention usually costs less at the end of the day than actually looking at the back end. It has the capability to balance wellbeing and agency against the limited agency. It has the potential to keep individuals actively engaged within wider society and means that transition would be a process that begins from the first day in service.

With this scheme it could look at coordinated care so it could look at a case management. I would argue that that needs to be completely outsourced. A big problem within Defence is that because of that limited agency, there's no back door so you do become institutionalised. So giving members the capacity to have more say, more control, whilst they're in and also be advocated for by an outside source back into ADF, is very, very, important. I believe that this would assist in the reduction of high mental health rates and assist in the prevention of suicide, particularly for junior ranks and medical dischargees. It targets the vulnerable populations which we know are necessary whilst ensuring a level of assistance for all and it creates resilience through greater autonomy and less co-dependency on the ADF which potentially could elect to better action outcomes and reduce overall costs. In terms of that I'd like to speak to some of the draft recommendations.

COMMISSIONER FITZGERALD: Well, you probably won't have time. But if you want to pick one or two and then we'll come to a discussion. So we've got your paper and it's extensive so thank you for that. So if there's one or two issues you want to put in the next couple of minutes and then we'll have a discussion.

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MS MORRIS: Yes. The most important thing for me is transitions because I don't think a lot of people looked at it and it goes really coupled with what I'm talking about. So the draft Recommendations 7.1, 7.2 on transitions; I do agree Defence should take responsibility for transitions and transition services need to be consolidated in one area. I agree with the functions outlined for transitions within the draft report. I strongly oppose a Joint Transition Command. A command structure within the ADF is counter-intuitive to assisting personnel transitioning smoothly just as joint health command, as a command structure, is actually counter-intuitive to assisting personnel with their help within Defence.

What is being asked for is institutionalised people to tell other institutionalised people how not to be institutionalised when they leave the institution. This would be particularly harmful for those undertaking a medical discharge. Transition is about re-orientating to a new environment and not continuing in the same. Transitions have been likened to a reverse culture shock. A good transition model should assist and orientate members gradually and supportively to ensure positive outcomes, keep members connected with wider society and create options and choice. A command structure does not liken itself to this model. A transition model should be focused on de-institutionalisation and not reinforcing the institution particularly so close to discharge. Further, many ordinary ranks don't trust command to put their welfare first as there are too many systemic limitations inherent in the system.

COMMISSIONER FITZGERALD: All right, thank you very much for that and thanks for your participation prior to the draft. Can I just explore a couple of issues: The most fundamental of the ADF; you say that if we leave ADF the way it is it will perpetuate a system that is not fit for purpose.

MS MORRIS: Yes.

COMMISSIONER FITZGERALD: And there are elements in our report that clearly that is the case. But what's happened in this public hearing is quite interesting, is that people acknowledge the weaknesses in the ADF at all levels and have opposed our view of putting policy and we never put the administration of the scheme into the Defence department. Only policy, they have resisted that on a number of bases; that they don't believe that they can do the job; it's a conflict of interest with the core responsibility of national security, they've had previous experience that ADF in their view is not a good policy maker generally, the issues would be swamped and so on. So what struct us is that people say, "ADF should be responsible but we don't think they can be and therefore you shouldn't ask them to be".

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MS MORRIS: Yes.

COMMISSIONER FITZGERALD: And that's very perverse. It
5 doesn't happen in any other inquiry we've ever done.

MS MORRIS: No.

COMMISSIONER FITZGERALD: People would be now standing up
10 saying, "You must get Defence to change". The veterans' community by
and large says, "We don't' believe in it but leave it alone". So your
position of trying to change the culture and in fact the systems and
practices within Defence, is a big ask.

15 **MS MORRIS:** Of course.

COMMISSIONER FITZGERALD: But what is the core thing that you
think needs to happen in ADF to, in your terms, make it a fit for purpose
service in relation to at least serving and recently discharged members?
20

MS MORRIS: It is an onerous task.

COMMISSIONER FITZGERALD: What's the starting point?

25 **MS MORRIS:** You know, I guess when we're looking, it is always that
balancing act between capability so it's between what Defence is there to
do, which is pretty much, you know, our national service, against the
wellbeing of people within it. I think where people fall down and there is
a big fear of that if we flick it into the Department of Defence that, you
30 know, policy et cetera, that people's wellbeing will not be looked after.
That's because within the system itself there has been these particular
limitations and it is the core and the stem of where majority of the
problems come from, it's the mismanagement.

35 Now, there's a difference between when we look at what the ADF is as a
command structure and the whole Department of Defence. My argument
would be is actually balancing that so it can be in Department of Defence.
I know that that will create a lot of, you know, tension within the
community and I understand that because at the moment DVA is the only
40 power that separates to ensure that they're being looked after, however
Department of Defence is not the ADF so it would be about ensuring
checks and balances within the Department of Defence and ensuring that
there is a separation of those powers between the ADF and Department of
Defence to ensure that it happens.

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Within the ADF itself, I really do think that it comes down to there's no back door for anybody to actually come out of that command structure. It's actually the command structure and the hierarchal kind of power within there that doesn't give any veteran, particularly the junior ranks, a say in what is going on or have any support or human contact around them.

COMMISSIONER FITZGERALD: So it seems to me an indictment on the ADF if it so that in fact you don't have, and others don't have, faith that that agency can in fact deal adequately with the wellbeing of its own personnel.

MS MORRIS: As I said, how do you - how can people that are institutionalised actually have a critical reflection on their actual institution? Should we allow an institution, particularly a public institution, to continuously investigate itself without transparency and without accountability. These things are paramount. ADF is not a stand alone organisation and institution. It is adherent to the actual public and our government however at the moment it doesn't seem to toe the line and adhere to that.

COMMISSIONER FITZGERALD: In relation to your wrap around model, and Richard may have some questions in a second, I'm not understanding how that works given that culture. So let's assume for a moment it doesn't matter whether it's DVA or Veterans' Services Commission, ultimately that takes responsibility for veterans but whilst people are serving or transitioning, how does your wrap around model of care actually work within that sort of ADF context because it seems to me you don't have much confidence that it can work in that space, this is fundamental change within ADF?

MS MORRIS: Look, I actually believe that, as the Commission has rightly pointed out on a number of things within the report which I thought was fantastic, is the historical changes that we've seen and so how pretty much society has changed, ADF hasn't. One of the arguments is that do we need Joint Health Command actually caring for the all of the health veterans? I would argue we do not and I would argue that Joint Health Command in itself, it's like when you actually have rehabilitation in there, then you have rehabilitation there, sometimes people can go through three different rehabilitation processes which has been highlighted.

Now, it would be changing a system. I don't know if you would ever to be able to take the power away from Joint Health Command, which is an argument, "Why would you give them the power of a Joint Transition to

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command if then you can forward a way?" but as far as changing it and pulling back Joint Health Command, I would argue that they could still be looked after with the operational services. I'm very aware that, and as the Commission highlight, that ADF is looking at a flexible workforce. So if they're looking at a more flexible workforce, would it make sense to actually see, "Well, how can we make the whole system more flexible?"

COMMISSIONER FITZGERALD: Sorry, Richard is going to ask a question but can I make the last point. I mean, one thing that's become very clear to us in talking to the Defence Department, ADF and everybody else, is the workforce of today is not the workforce of the future and the workforce arrangements are going to be entirely different between permanent, casual, part-time, and so whilst we're looking at the model as it is today, everyone is saying to us, "Ten, 20, 30 years from now, that workforce, the way it's configured, is going to be entirely different" and we're trying to create a veteran support system that is robust enough and flexible enough to accommodate a world that we haven't yet envisaged and that is a real challenge because it's not going to be the same as it is today.

MS MORRIS: Okay.

COMMISSIONER SPENCER: Deborah, thank you very much for your description of the cultural issues because I think it's something that - it's often not commented on but it actually underpins a lot of the fundamental issues we're talking about. I suppose it comes back to what we're being asked to do and that is to look in the longer term what is a fit for purpose system. So some things that we put on the table now, people will say "Well, that can't happen, it can't happen tomorrow but over a 20/30 year period how would you move towards a system like that?"

So one of the fundamental things we're grappling with, which Robert has commented on and you have as well, is when you have an institution within a very tight culture and one that really doesn't welcome outside influence or oversight, how over time do you change that, and as you've acknowledged that's difficult, but I suppose as a fundamental point there, do we just accept that for the future and therefore we build things around that culture to kind of minimise and lessen the impact or do we fundamentally have a view that the institution's culture can change over time? So, look just a thought on that. We've looked at other military systems as you know and I think we may have talked about his before, but in other military systems, looking at it from a distance, that do have that joint responsibility, what is often described as the "duty of care" and the "duty to prepare" and nobody underestimates the complexity and the

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challenge of that that the ADF has and Defence has around that. It's very complex.

But in some of our discussions, with other military systems they grapple with that issue right at the heart of their militaries so one could say that, and I don't know the history, but if they had come from a place that we are at the moment, over time they have managed to change the culture within those institutions which, to your point, your very powerful point, minimises a lot of the long term consequences of what you described as mis-management.

MS MORRIS: Yes.

COMMISSIONER SPENCER: So I think that's what we're grappling with. So when it came to the Joint Transition Command, just to give it a background on that, and this might be are naivety but we thought the - it's been put to us that often if you say , "You should do this, you should do that", nobody really responds unless there is a command structure in place do to that. So the notion of a Joint Transition Command was to give authority and ultimately responsibility to this very challenging issue of transition, which as you have said and many have said to us, is a key moment. So your concern is that, "Well, that just gets absorbed into those people that are institutionalised?" but would it not be possible to construct that in a way with some external oversight, there can be a beginning of a change process in order to incorporate the sort of considerations you're talking about into the culture?

MS MORRIS: When you're looking at the culture, as I said, one of the biggest things is the command structure and, you know, there have been 60 investigations over 40 years into the military justice system, cultures of the ADF, where (indistinct) position time and time again from outside reviews, that Defence needs to stop administrating and investigating itself and it needs to be pulled outside where there is an independent authority because systematic abuse has continued to occur. The pathway to change which is a cultural review of 2012, was supposed to actually hit it at the core.

I argued the ADF itself does not even understand itself as an institution and organisation. So if the institution and organisation does not understand itself, how can you be sure, putting it into any type of conveyance structure which is known as actually one of the systemic problems, that you're going to get good outcomes, I would argue that you could not. Can you have an outside influence within a command? No. A command structure is hierarchal, it's authoritarian.

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When you want to look at it in the context of Defence being a family, you're actually looking at the structure in the terms of nearly being the authoritarian figure in an abusive relationship. They have all the power. They have the power to give and take and it's the people within the system, and usually it's the higher rank people, officers, that have the position to either say yay or nay of how it goes on. If these people are administering the command decision, it actually means that they have the capacity to continue on with the abuse of the system.

COMMISSIONER SPENCER: So in your alternative model, if that in a sense is outside how does that break through that command structure because - and look, I guess just what we've observed on bases, and we've been on many bases around Australia, what we've observed is that the good things we see often depend on people who take the initiative.

MS MORRIS: Yes.

COMMISSIONER SPENCER: And the command structure on that base, (indistinct) in fact leads on it. In other places it doesn't happen. To put in the vernacular, it's the tick and flick exercise. So there will always be some element of that but we're looking at the structural response. So what gives the power and authority of the outside intervener into this process that can, if you like, chip away at what you're describing, as a very rigid command structure?

MS MORRIS: Look, I think, you know, if you're looking at an outside influence coming in, you need to check the balance of that command structure. So where the Commission has rightly said that the ADF needs incentives, these incentives need to be enforceable so there actually need to be outcomes when the command structure is broken, there actually needs to be a consequence for actions that suit what has actually occurred and this is one of the problems, and systemic, within the actual institution is that when problems are highlighted, they are usually hidden, denied, so again we come back to transparency and accountability to the system.

What I've seen with rehabilitation providers actually going back into Defence and standing with actual Defence personnel for rehabilitation, is quite often even - within the command structure there, command will turn around and say, "No, there's nothing wrong with you", "No, we don't agree to this, you need to start walking again". However, the power of the people that are the outsourced rehabilitation providers coming in and advocating for those personnel, is actually what pushes it through because I've known instances where the rehabilitation providers have said, "If you do not adhere to this and this and this, within civil society, within civil court, you are in breach of this law and you can't hide behind Defence, it's

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a personal thing because you've done that" and it's been enough to pull them back in and say, "Oh, this is where we need to be".

COMMISSIONER FITZGERALD: So can I just deal with that, just to follow Richard's point; Defence has been outsourcing a huge percentage of its activities for a decade and when you go on a base, a lot of the people you need are in fact outsourced. Now, we have no problem with outsourcing generally but there is a point at which an outsourcing operation simply becomes about shifting risk and shifting the need to change culture so there have been some people that say, "Oh, well let's just outsource transition of the whole, we'll give it to somebody, either a non-government organisation or somebody else, and they'll deal with it" but taking Richard's point is most people would think the PC would like that but we actually don't and the reason is because we actually are fundamentally trained to deal with this, that there needs to be a cultural change within Defence.

MS MORRIS: Yes.

COMMISSIONER FITZGERALD: So going back to Richard's point, whereas right at the moment there would be people in government elsewhere, you know, prepared to outsource just about everything to deal with DVA and Defence, we are actually saying, "This is not necessarily the right way to go". Now, that will surprise lots of people. It may surprise some people in Government as well. And so I just want to test this thing, outsourcing it, "I can understand we can get a credible operator and it'd be terrific. As you know health has been outsourced to Medicare Private and now BUPA" but again, we're not quite prepared to give up on the fact that both ADF does have a duty of care, and it does, and that some of the culture and practices can change.

MS MORRIS: Yes.

COMMISSIONER FITZGERALD: But are we completely naïve about that, that's really the point I'm asking, and outsourcing, it seems to me to outsource risk, responsibility and frankly avoids the issues that we're trying to address.

MS MORRIS: Yes. Look, I really appreciated the draft report of trying to have incentives and accountability in the Department of Defence, I think that that's very important. The idea of putting up a VSC I think could actually work. You could run a horizontal care package because it still will be within the Department of Defence. Where DVA stands at the moment - - -

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COMMISSIONER FITZGERALD: Well, the Defence portfolio, yes.

MS MORRIS: Yes, the Defence portfolio, sorry. Where DVA stands at the moment you could argue that DVA could still do a similar thing so
5 you wouldn't have three different rehabilitations, there would be horizontal wellbeing care, whilst you would have ADF coming down in the vertical care. So I do appreciate the problems and concerns. I am very good at highlighting the core issues. I believe that finding the right balance and finding a way forward will be about bringing particular
10 stakeholders into round-tables or more appropriate things to actually talk about it. The more discussion, I believe will actually be able to - you'll be able to find a better balance of the military and civil divide that continuously come up.

15 **COMMISSIONER FITZGERALD:** Right. Just a quick one, Deborah. I'm just interested in your comments on - you've talked about "reverse culture shock" deinstitutionalisation and as we know many people join the ADF at 17 or 18 and they can be leaving at, you know, 25 through to their late twenties, so they've in a sense never been a civilian, never lived as an
20 adult and that raises a number of issues. So when one looks across cultural work in other context, to your point I think, the biggest shock is actually not when you "go" to a different culture, it's often when you go back to what you "think" is your own culture.

25 **MS MORRIS:** Yes.

COMMISSIONER FITZGERALD: And you suddenly discover you're different, it's different.

30 **MS MORRIS:** Yes.

COMMISSIONER FITZGERALD: Do you think that's underestimated in terms of transition?

35 **MS MORRIS:** A hundred per cent, 100 per cent underestimated. You know, there's actually a lot of research coming out from the Netherlands at the moment as well which actually looks, particularly with post-traumatic stress disorder and looks at institutional narratives around that and what's predominantly coming out is that the lived experience of what people have
40 gone through is usually different to the institutional narrative for the people that are giving them care so there's clash of what's actually going on. You could argue that's what happens with veterans too.

A lot of it is shifting your worldview, it's a shifting your worldview and
45 it's the institutionalisation but it's also the things that you're expected to

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do, it can be the things you're expected to see. Can you clinicalise all of that? Can you say that it's a medical condition when sometimes maybe people will step forward, they maybe understand or perceive society completely differently, so it's like how do you keep them connected in
5 society so they can see those changes happening in society but still be able to maintain the capability that it's required within the ADF. It's a challenge.

COMMISSIONER FITZGERALD: But just in relation to that issue.
10 We had a presentation the other day which is along the same presentation, that is, we continuously hear that, you know, the system breaks you down and rebuilds you into a military character.

MS MORRIS: Yes.
15
COMMISSIONER FITZGERALD: But at the other end there's no attempt to reconvert you back into a civilian character.

MS MORRIS: No.
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COMMISSIONER FITZGERALD: So there is transition but whilst all this effort is to turn you from a civilian character.

MS MORRIS: No.
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COMMISSIONER FITZGERALD: So there is transition, but whilst all this effort is to turn you from a civilian to a military person, there's no effort to turn you from a military person to a civilian, other than the current transition arrangements. That's really the point I think Richard is
30 raising. We've discovered that – is that really a contentious issue? I mean, it doesn't happen, we understand that, but is it in the military circle understood that if you change the character of an individual at the beginning, maybe there's an obligation to change the character at the end. Is that a contentious sort of view, do you think?
35
MS MORRIS: From an outsider point of view, from a bird's eye view of looking at the whole system, I think I said it before, I don't actually believe that ADF, as an organisation or institution actually understand who it is, what it stands for and what is actually going on. So if they're
40 not actually understanding how they actually socialise people and break them down and build them up as something else, how would they even understand or comprehend that maybe we need to put them back together before we put them out.

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However, what also needs to be understood is that whilst we do have institutes, we also have individual needs. And so different individuals will have different experiences and understand different things. So it's always that contention between the institution and the individual as well.

COMMISSIONER FITZGERALD: Yes, and I want to acknowledge that according to the figures and according to many hundreds of veterans we've now spoken to, many leave the Defence Force and live perfectly good, adequate, you know, meaningful and productive lives. So always it's about the individual. And we've heard from many that are very successful in post-military careers. So, again, I suppose our attention is always to those that have struggled and are struggling.

MS MORRIS: I agree.

COMMISSIONER FITZGERALD: Whether it's through medical or other conditions. So our lens is always a bit distorted in that way. Look, again, thank you very much for that. Is there any final comments you wish to make before we conclude?

MS MORRIS: No, it's fine. I just hope that there's some more investigation and more analysis before the final report comes out. I'm sure it has been called in, in many different places, but a good way to actually get to assessing what is happening in the ADF would be to call a Royal Commission. Thank you.

COMMISSIONER FITZGERALD: All right. Thank you very much. We will now break for just 10 minutes. So there is tea and coffee, I hope, and we will be back in 10 minutes, and you can bring your tea and coffee into the room, if you wish. Thank you.

SHORT ADJOURNMENT **[10.32 am]**

RESUMED **[10.48 am]**

COMMISSIONER FITZGERALD: We will resume. Thanks very much, and you can sit closer to the front, if you like. As I've often said, it's not the Catholic Church, so you can sit closer to the front. So, Gerry, if you could just, take your time, grab a seat, and then give us your full name and the organisation you represent, please.

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MR GARARD: Okay. My full name is Gerry Garard and I represent an organisation, a fairly young one called 4 Aussie Heroes Foundation.

COMMISSIONER FITZGERALD: If you could then just give us
5 about 10 minutes of your key points, and then we'll have a conversation.

MR GARARD: Well, okay, I hope you're not going to be too disappointed after the last speaker was quite eloquent and learned.

10 **COMMISSIONER FITZGERALD:** We're never disappointed. That's fine.

MR GARARD: Very briefly, national serviceman, conscripted into the Army, went to Vietnam, got out and went into the commercial world, and
15 when I retired a few years ago decided I wanted to put back. I had researched the PTSD situation, mainly in the military, and so my wife and I founded the foundation in 2016 and since then we've been working towards developing programs and getting a retreat organised where they would be delivered. And in those two or three years, the experience I've
20 had with DVA and ADF has been a very, very steep learning curve.

I guess I wanted to come along to share a little bit of that last two years. I've struggled going right through the Commission's report, draft report, and so I really just wanted to hone in on my experience with DVA and the
25 ADF, and Joint Health Command, as a volunteer, which I am, and the organisation is basically volunteers, and that experience, and it hasn't been a good one. My view, as I said in the short submission, is that DVA is hopelessly out of date. They are inflexible. Some of their guidelines are more relevant to second world war or first world war veterans, and they
30 don't seem to want to listen.

There's no sour grapes in this at all. It did, however, or was sparked by an application to help fund a program. We got together some learned psychologists, psychiatrists, exercise physiologists, psychotherapists, to
35 write live-in programs from scratch. And our research was that those programs should be conducted in a rural or natural environment, was the best place. This committee came up with a format for these programs, and to help us with the very first inaugural program, we asked DVA to support it financially, and they said no.
40

I give them a tick because they at least were then willing to listen when we asked, "Well, could you explain why?" And they did. That then grew into us questioning a number of things, and seeking a meeting with the head of DVA, which was at November last year. We gave a brief for that
45 meeting, which was conducted with the Deputy of DVA, because the head

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of DVA was called away to an estimates hearing, I think it was. We tabled a written brief as to what our issues were, and when we left Canberra we asked could those issues be addressed.

5 In the three months since then, we have been totally ignored. They haven't had the courtesy to even acknowledge our letters, emails and phone calls. So I'm not sure whether it's arrogance or there's something wrong with the system, or it's just too hard for them, because some of the issues we raised, and their initial response, was absolutely scandalous.
10 And if I could give an example, our program has clinical sessions which are sessions which are delivered by clinical psychologists. And we have a lot of adjunct sessions in the 12 days, equine assisted therapy, exercise physiology, canine support, those sort of things.

15 They said, "Sorry, you don't come in under any of our grant schemes." You've either got to be a medical or clinical focus, or you've got to be the adjunct focus, but we don't do anything that's a combination of the two, which was appalling from our point of view. Absolutely appalling. In some of the discussions they told us that some of the medical sessions, if
20 we didn't have a clinical psychologist delivering them, they would fund it, which is scandalous. So I could get someone off the street to go in and deliver that program and it could be fundable, but because we had the medical focus and it was delivered by a clinical psychologist, it wasn't fundable.
25
We sought an issue in relation to where the funding went, because we felt it was unreasonable, but most of the funding from the grant scheme that we asked for, went on bus trips for veterans to wine regions, and to carpet floors in club houses and that sort of thing. Our request was specifically
30 for a rehabilitation live-in 12-day program in the bush. So there's two elements to what I wanted to say today. One was a course that in everything we've had to do with DVA in Canberra, you know, outdated, old-fashioned, inflexible, unprofessional.

35 Then, on the second hand we're just blown away that a foundation predominantly of volunteers in a charitable area, won't answer our questions. We were – some of them are relevant to, well, other grant schemes or we look at the type of grant schemes that you have. We believe the money, in many respects, is just going the wrong way. It's not
40 there for what it should be. I guess that's the two aspects. One is it has not been given the opportunity to have our questions answered, and the other one is that we believe what is happening is just, you know, it's ridiculous. I would just like to put that, if that's okay.

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COMMISSIONER FITZGERALD: Good. Thank you very much, Gerry.

MR GARARD: I hope you're not too disappointed.

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COMMISSIONER FITZGERALD: I'm not disappointed at all. Can I ask a couple of things? The foundation, as you say, was established by yourself and your wife. And the particular target group of veterans you've described, as I understand it, were those that had been conscripted and went to the Vietnam - - -

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MR GARARD: No. No. Definitely not. No.

COMMISSIONER FITZGERALD: Who is your - - -

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MR GARARD: It's veterans with PTSD or related mental health issues.

COMMISSIONER FITZGERALD: From any part of the service?

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MR GARARD: It's predominantly – the people we're talking about are predominantly out of Afghanistan and Iraq, East Timor, Somalia.

COMMISSIONER FITZGERALD: Right. So it's open to that group?

25

MR GARARD: Yes.

COMMISSIONER FITZGERALD: The second thing is, the model that you've just mentioned, as I understand it is a – what – a 12-day residential bush-based program. Is that correct?

30

MR GARARD: That's the program that's operating at the moment. The committee are developing transitioning programs, so we're having a lot of discussions with the ADF about transitioning, and also peer support, which we see as a really big aspect of the rehabilitation process.

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COMMISSIONER FITZGERALD: Just to clarify, how long has the foundation been going, Gerry?

MR GARARD: Well, it started in 2016 and – but it has been a steep learning curve and it's very much in its early days.

40

COMMISSIONER FITZGERALD: When you've dealt with DVA in relation to funding, they've basically said you don't fit within any of their categories.

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MR GARARD: Yes, that's basically it.

COMMISSIONER FITZGERALD: So when you've presented your proposal, have they been willing to acknowledge the fact that it is a well-
5 designed or a good program? Do you get to that point? I mean, they may not say that but do they get to the point of saying it's worthwhile but you just don't fit within our categories?

MR GARARD: No. DVA - - -
10
COMMISSIONER FITZGERALD: Or you don't get to that?

MR GARARD: DVA haven't said that. They've been very guarded. But everyone else that we've spoken to has, from Seven Brigade
15 Commanders, from Joint Health Command, from people within the ADF, the Deputy Chief of Army at the moment, everyone thinks it's innovative, it's brilliant and it's going to be good.

COMMISSIONER FITZGERALD: As a foundation, do you regard
20 yourself as an ESO or do you regard yourself simply as a foundation?

MR GARARD: That is a difficult one, to be quite honest. So I don't put us in a category but we go to ESO forums that are run by the RSL or by Seven Brigade out at Enoggera, so we're very much considered within the
25 military context as an ESO, but we see ourselves as a foundation that can work outside that. In fact, at the moment we have broadened our focus of late, and we do now include first responders in some of the work we're doing.

30 **COMMISSIONER FITZGERALD:** And the basic principle or principles that underly your approach, how would you describe that to us? What's the basic principles that guide your foundation and the services that it provides?

35 **MR GARARD:** The underlying principle.

COMMISSIONER FITZGERALD: Or guiding philosophy or whatever you might think? Do you have a particular philosophy or approach to rehabilitation of veterans?
40
MR GARARD: It's very basic, and in the research I did before we started it, I didn't want to reinvent the wheel, so we looked at where there might have been a gap. And to me there has been a gross underestimation of the value of a rural environment. Lots of the things we wanted to do
45 were being done in CBDs and things like that. That was one aspect. And

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the other aspect, there didn't seem to be a holistic program where someone who's suffering and has either been medically discharged or is now out of the Army or in the military or still in the military, there was really nowhere I felt that they could go and get a taste for all the different things.

That's why the adjunct thing, which I was, you know, studying equine assisted therapy from the States. DVA wouldn't accept that it's a genuine therapy. The rest of the world does, and slowly but surely it's becoming well-known. Gallipoli Medical Research Foundation are doing, you know, studies into it and, you know, gone are the days of just giving an ex-digger tablets and, you know, saying, "Goodbye and I hope you get better," band-aid, crazy.

You know, you've got to – PTSD is an interesting thing. I am not a medical person, I'm not a health professional. I left school at 15 and have not – and everything I've learnt since then has been from people and just using some common sense and intelligence, I believe. So people were doing, you know, treks to Kokoda and others were concentrating on equine therapy, and others were doing meditation and yoga. We wanted to bring it together and have the whole ambit in a live-in program where they could choose.

Because if someone comes to us from Mount Isa and they really are positively affected by their experience with horses or dogs, and they go home, well, you know, we've got to help them develop that aspect of their recovery. So we're all about actual recovery and giving those people a better quality of life. One fellow I was talking to this very week, he's an Afghanistan veteran in a terrible state at the moment, and his exact comments to me was, "I'd love to come on your program. I'm not medically well enough to come on it." And the programs are free, by the way, the foundation raises funds. And he said, "DVA gave me a quarter of a million dollars and I was discharged." And he said, "That was great in some respects but all I really wanted to be was healed."

COMMISSIONER SPENCER: Gerry, first of all, terrific initiative to actually look at an issue and to think about what could be different and how might that be responded to. So if you think more broadly about human services, there are other examples of that, of people like yourself and your wife taking that initiative. Your experience is not uncommon, though, when government systems run into innovation and new thinking. And government struggles generally with how best to respond to that. And typically what happens is the response is but it doesn't fit our funding models.

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So what can be done about that? So I'm just thinking, when you think back on your experience, what could have helped earlier on to know whether you're on a pathway that's of interest to them, and, secondly, what sort of information, innovation funds within the Department or some indication that the Department could be open to a productive discussion around what you're doing and whether they would be interested in, in a sense, partnering with you. When you look back on your experience and what you're learnt now, what would have been different that would have helped you to formulate your thinking and ideas with the possibility the Department would come on board or could come on board with that?

MR GARARD: If they had have shown any interest in what we were doing, and the people that were involved and who were developing the programs. It basically was, look, you know, you don't fit into one or the other and so we can't help. In one of the discussions with a very senior person at DVA, for example, I spoke about where the funding was going under the one grant scheme that we had applied for and got knocked back. And I said, "I can't understand that running a program with, as we were, gets no funding and yet bus trips to the wine regions are funded."

The answer was, "There's only a certain size pie and what do you expect us to do? Take off from those people that we have been giving that money to for years?" I'm a pretty down to earth person but I was just – I was gobsmacked that that was the attitude of the hierarchy of DVA. So all they had to come and do, and show some interest, but to say it's either got to be medical and clinical, the whole program, or it has got to be adjunct and be fun and enjoyable. To me, the common sense approach was this innovative program that combined the two things.

You know, where they could do equine assisted therapy, they will go on boat trips, they have comedians come and they do laughter and humour therapy, the whole thing. It was suggested that, well, we should pull the program apart and have two different programs, and then we could possibly get funding for the two. But they would have to be separate applications and be clearly separate. How ludicrous.

COMMISSIONER SPENCER: Yes. So what you're describing is an appetite for – or no appetite for innovation or fresh thinking around this - - -

MR GARARD: That's right, yes.

COMMISSIONER SPENCER: - - - in the current model. This may not entirely respond to the experience and the issues you have, Gerry, but we're certainly saying in our report that more input, more expertise

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informing the choices that DVA makes, would be a good thing. And that can come from professional expertise, it can come from new thinking, new models, new ideas, and like the model you've put together. Typically in other departments that deal with human services, it is to quarantine some funding to sort of work out where do we go next, what might be different, what might challenge some of our current thinking.

So I think in our report we will be exploring that space and saying more about it. So and if that's responded to, it unfortunately may not be there for what you're trying to do, and it's not there at the moment, but it might open up an avenue for an earlier and productive discussion about what are the possibilities here and what might be possible. So where to from here, Gerry? I mean, was your model built on relying on DVA coming to it or - - -

MR GARARD: No, not at all.

COMMISSIONER SPENCER: - - - you're going straight ahead?

MR GARARD: We're continuing.

COMMISSIONER SPENCER: Yes.

MR GARARD: We just raise more funds through our various fundraising measures. We have philanthropic trusts who think it's a great program, who are putting in tens of thousands. We have sponsors in the commercial world who are doing it, so the programs will continue without it.

COMMISSIONER SPENCER: Right.

MR GARARD: That's a sad indictment when you - - -

COMMISSIONER SPENCER: So your ask to DVA was more of a co-funding model rather than - - -

MR GARARD: Yes. It was for an inaugural or a program which starts in less than 10 days. The program was – because it was a specific program, it was going to cost about $130,000 to conduct it. And we asked them for 29,000 from the 130, and they said no, so we just went out and raised another 29,000.

COMMISSIONER SPENCER: Right.

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MR GARARD: But it's that they won't engage with us about anything. We said, "Well, you know, are there any other grant schemes that this might fit under?" And basically there wasn't, other than there's a younger veterans scheme, and to me it was almost discrimination. Yes, you might be able to do what you're doing but it's for one class of veteran, and it's not the older veterans.

COMMISSIONER SPENCER: So, Gerry, just a quick comment as well on the – we did a review of Human Services last year, which is largely government funded, but a range of terrific organisations through civil society doing all kinds of interesting work, right on the frontlines of services. So what we had proposed there, and we would like to see that more evident in this space as well, is that government, in this case DVA, gets more engaged with both ESOs, the kinds of services we've heard a lot about that in these hearings and the other hearings.

There are terrific services being provided across multiple locations, and how does government leverage the value of those, and government can do that mostly through some financial contribution. So to our mind when we look at what's happening at the moment under some programs, there doesn't seem to be that level of strategic thinking about what is new and different, informed by evidence and results on the ground. How does government get really smart about what it invests in, and helps – and that's across – usually across new models that have potential.

There's risk associated with that but you don't change anything unless you invest in new possibilities. But how do you do that thoughtfully and strategically? We think that's missing – largely missing in what we see in the way, you know, what is funded. And also the level of funding that's devoted to supporting not only what's happening at the moment but new initiatives and ideas by ESOs and foundations like yours. It doesn't mean to say every idea gets up, of course, but at least there's a strategic and thoughtful way to go about investing in that to help the wider system, and it's not just a government system, it's a much larger system, which involves obviously all the ESOs and the kind of work you're doing.

So I think your experience is very helpful to understand although disappointing obviously from your point of view, to inform how could that – how could there be a different engagement and response in the future to really think about what often is described as co-designing. In other words, seriously sitting down and saying, "Well, no, no, we have our model and you don't fit our model, therefore, it doesn't work," rather than, "Let's talk about what you are seeing, what you're experiencing, what you have researched, what your evidence is, and what can we do about that." And this is this element of co-design around human services.

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It’s a struggle for government to do that because most governments will default to say, “No, no, we worked that out, and you either fit our model or you don’t” but we'll be encouraging perhaps even more that DVA should be, we think adopting what we see in other human services, more open as to new ideas and initiatives and how to leverage the value of that.

COMMISSIONER FITZGERALD: Could I just ask one question in relation to transition: how are you being engaged in the transition process by Defence?

MR GARARD: How are being engaged in - - -

COMMISSIONER FITZGERALD: So you've talked about three things, you've got this residential program, you talked about, peer on peer or peer to peer, which is terrific, and then you talked about being involved in transition?

MR GARARD: Our committee is currently developing a five day program relevant to transition which will include everything from employment, housing and those sorts of things. It's changing dramatically I must say. There are some of the ESOs that are now - you know, have identified this plus the ADF, out at Enoggera 7 Brigade, they're big on this sort of thing but, you know, it is a different life. You know, as you said previously before morning tea, about some of these people have gone into the Army or military when they're 17 or 18 and for whatever reason they walk out the door, you know, six or eight years later, they've never applied for job, they've never written a CV, all those sorts of things. So we're looking at a program but the Board, we have an incredible board of directors, and there is some interest in - well, not interest but we are looking at what's being done currently from within the military and by some of their organisations, RSL Mates for Mates, that are now really looking at that seriously and they're also in the process of doing really good work in relation to that.

COMMISSIONER FITZGERALD: Sure.

MR GARARD: So, you know, it's an important issue because it's a different way of life as you would be well aware. You, they've discharged, they lose their military family, and often if they've got issues, mental health issues, very quickly they lose their traditional family and they're out there, you know, with no support whatsoever.

COMMISSIONER FITZGERALD: Yes. All right, thank you very much for that, Gerry. We very much appreciate that. Good, thank you.

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MR GARARD: I appreciate that opportunity and thank you and all the very best.

5 **COMMISSIONER SPENCER:** Thank you very much to you too, yes.

MR GARARD: Thank you.

COMMISSIONER FITZGERALD: Good. If we could have Graeme
10 and Teresa. Thank you. Good, thank you very much. If you could both give your full names and organisation that you represent.

MR MICKELBERG: Graeme Mickelberg. I'm the chair of the Liberal National Party of Queensland's Defence and Veterans' Affairs Policy
15 Committee.

COMMISSIONER FITZGERALD: Good.

MS HARDING: Teresa Harding. I'm the secretary of the LNP's Defence
20 and Veterans' Affairs Policy Committee.

COMMISSIONER FITZGERALD: And just like you've seen, if you could give us ten minutes of your key points, that would be terrific.

25 **MR MICKELBERG:** Certainly, thank you. Good morning, Commissioners, and we welcome the opportunity to present to you and the people who have come today to listen to the proceedings. With regards to veterans specifically, the constitution of the LNP seeks an Australian nation in which men and women who have been members of
30 the fighting services and their dependents, shall enjoy honour and security and where preference and generous repatriation benefits are recognised and I think it's important that I preface my comments by that statement from the constitution of the LNP.

35 I'm a former career infantry officer in the Army with 47 years of service in both the regular Army and the Army Reserve. I'm accompanied today by Teresa Harding who is the secretary of the Committee. She has also served in the Army and for many years was also a senior Defence public servant. Teresa's husband and son are both currently serving in the
40 permanent ADF.

The role of our committee is to consider and debate Defence and veterans' affairs policy issues affecting serving and ex-serving veterans, their families and widows and to communicate those views and the views of
45 ordinary members of the LNP to State and Federal LNP MPs and senators

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and where necessary to represent those views to relevant Federal and State ministers which we do fairly regularly. I think it's important to note that Queensland has approximately 265,000 serving and ex-serving members and families residing in the State which represents seven per cent of the population, a fairly significant number.

Our committee communicates regularly with ex-service organisations including RSL Queensland, the Defence Force Welfare Association, the Alliance of Defence Service Organisations and Legacy. We consider that these and other ESOs do an immense amount of valuable work throughout Queensland helping veterans, veterans' families and widows and in doing so they act as a bridge between their fellow veterans and DVA. Unfortunately it's also a reality that many veterans, including younger veterans and widows, are unable to cope with the demands of preparing claims and dealing with DVA and there is reasons for that which some of which you've heard today.

We consider that the work undertaken by ESOs add real value to the national approach to supporting veterans and even more so because of the real empathy they bring to what they do. Any changes to supporting the system of supporting veterans, their families and widows, must ensure that the work undertaken by ex-service organisations is facilitated and able to be integrated with any new arrangements that come into play as a result of your recommendations.

Our committee has provided comments to many of the recommendations in your draft report, that was in a separate document that we've provided, but only to those recommendations that we felt qualified to do so. We would however like to give emphasis to the following points: and the first is we consider that the draft report doesn't give sufficient acknowledgement to the need to ensure a system to support arrangements for veterans' families and widows and indeed your own terms of reference, I don't think mention widows at all and hardly give any emphasis to families both of whom of course are as affected by the service of serving members as anyone else.

Moving to the work undertaken by DVA: we consider that the criticisms in the report of DVA are at odds in many cases with feedback that we have had from ex-service organisations of positive outcomes of the work done by DVA which in our view reflects a general level of satisfaction with DVA and the arrangements that they administer. That doesn't mean that we think the system is perfect.

I want to now move to a key recommendation of your draft report which of course is the recommendation to, or draft recommendation, to transfer

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responsibility for veterans to the Defence portfolio. We are strongly opposed to transferring this responsibility to the Defence portfolio. As you mentioned earlier, Defence is charged with defending Australia and it's national interests. To do this requires a focus on training and equipping the ADF for the conduct of operations. In undertaking this responsibility, Defence is often, in fact more often than not, having to look outwards and the tempo and nature of training and operations is such that, in our view, it can ill afford to be distracted with other additional responsibilities. Indeed, if you take the British example where Defence is responsible for veterans, if you were to talk to veterans in the UK they would tell you that it's failed dismally.

I think the other comment we'd make on this particular recommendation is although this is a key recommendation of your draft report, the report doesn't address the strategic risks to taking an established system of support and transferring it to an organisation that lacks the structures, policies, resources and culture, need to ensure that the needs of veterans, their families and widows, are well supported. And I don't believe that necessarily we should entrust any government with thinking about those risks after the event because that generally is where we end up with a system that doesn't actually serve the needs.

The report at certain places tends to focus on comparing the benefits of a contemporary worker's compensation and social insurance schemes to whatever the system might end up looking like for supporting veterans. We consider that despite that a draft report acknowledging the unique nature of military service, the report overlooks the reality that veterans' entitlements had been earned as a result of sacrifices by veterans and their families; sacrifices that I would emphasise are not shared in any other form of employment in Australia. We consider that cover provided by a market based workers compensation insurance scheme is unlikely to be compatible with the military workplace in comparison with a civilian workplace and the unique tasks that are undertaken by the ADF and the consequent risks to the safety and health of ADF personnel who are compelled to follow orders and undertake those tasks in peace and war.

We are of the view that the statements of principles and the guide to the assessment of veterans' pensions which underpin the broader arrangements and entitlements provided by the nation, to support our veterans, widows and their families, are likely to be viewed as unnecessarily onerous by commercial insurers. A system similar to industry based compensation is also likely to be unwilling to fund the significant cost associated with the treatment of conditions for veterans which increase they get older. That is a reality, gentlemen. I've lived through it myself. It's not until you start to get in the latter years of life

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that things start to break down, a bit like a car when you run it too long; and this is a significant challenge for DVA and of course for government.

I want to move now to rationalising veterans' affairs legislation. We support the rationalising of existing legislation. The three Acts have made the preparation of claims by veterans, their families, widows and the advocates of ex-service organisations, and, I might add, the consideration of those claims by DVA, unnecessarily complex. That complexity can often result in lengthy delays for some veterans in having their claims resolved and sadly it can also result in tragic circumstances.

In rationalising the legislation it's critical to ensure that legislation is written in plain unambiguous language a lay person can understand which can be interpreted and applied easily by DVA staff and the bodies charged with considering appeals to decisions taken by DVA. I include, for example, the AAT, the Federal Court, and dare I say it, the High Court on the odd rare occasion. Your draft report describes veterans' entitlements as generous however it would be manifestly unjust for any rationalisation of legislation be seen as an opportunity by Government to reduce benefits currently provided to veterans, their families and widows. We are particularly emphatic on that point.

Moving to the question of transition. We strongly support the draft report's recommendation with regard to putting in place more effective arrangements for the transition of veterans from the ADF. Indeed I believe, or we believe, that the ADF has a moral responsibility and indeed a command responsibility to embrace these arrangements, whatever they shall be, at some future point.

The last area I wanted to address isn't addressed at all in your report from what I can see, although I haven't read the report in full, is the provision of knowledge for financial advisors. The complexity of existing legislation also presents them with significant challenges in providing advice to veterans about just which option they should take up. I would give you the example, I guess, if a veteran, say like me, who is covered by the three Acts, potentially there are a range of different entitlements that may be present there which an advocate will give me advice to understand but arguably at some point there will be taxation implications, for example.

I'm of the view, and I've spoken to several accountants who have said to me that they find the legislation very complex and they don't understand how to give proper advice to their clients and I think it became particularly evident following the Black Hawk disaster in 1997 where a number of the young widows were confronted with a government that was pleased to try and help them financially recover from the disaster and they

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5 were at odds at which direction to go. We're of the view that the committee should consider the need for DVA to work with peak bodies that represent the financial advisory sector to develop training to provide financial advisors with the knowledge needed to effectively advise veterans and widows of their entitlements.

10 This already happens in relation to changes to the Taxation Act. The financial industry mandates that financial advisors must do certain online training every 12 months. I would see some sort of module, potentially, that can be bulk developed and bolted on there, which I think would help the current situation. That concludes my comments, gentleman.

15 **COMMISSIONER FITZGERALD:** Good. Teresa, do you have any comments you want to make?

MS HARDING: No, Graeme's - - -

20 **COMMISSIONER FITZGERALD:** That's fine. Well, thank you very much for that comprehensive coverage and if I can just now deal with a few issues. I suppose going back to the central one that you have the strongest objection to, is moving policy for veterans and I just need to clarify, we were never putting the administration of veterans into the Defence department, it was only policy.

25 **MR MICKELBERG:** Sure.

30 **COMMISSIONER FITZGERALD:** The second thing I just need to say, and it's not your mistake but everyone's done it, is that DVA is currently in the Defence portfolio today.

MR MICKELBERG: Yes.

35 40 45 **COMMISSIONER FITZGERALD:** It's not the Department, and there's been much confusion so we will absolutely clarify that, but we've heard from many people who would support your position that moving policy into Defence is not a good idea, and I suppose you may or may not have heard in the last few presentations, just this question and I won't go over it all; we think, and you acknowledge through supporting our transition, that ADF does have a duty of care thus has a responsibility. But you've identified I think, correct me if I'm wrong, three reasons why putting policy in there might be a bad idea. One was culture, one was structures, and frankly, if I'm reinterpreting what you're saying, you don't actually have the policy capacity to deal in this area, as the question for us is: should we simply accept that that is the case or should we be saying to ADF, "Actually you do need to involve a capacity in this space later on",

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admitting that, at the moment nobody is supporting our proposition to move it across immediately along the terms, as ADF have a role in the policy space. Or do you think, really it should just be completely separate?

MR MICKELBERG: I think it should be completely separate. If I look at the worst case scenario, and we haven't seen total war since World War II, but Defence exists. It's core business is war fighting, that's why it exists, and anything that might distract them from that core business, in a worst case scenario for example, I don't think we can afford to take that risk with national security. I mean, fundamentally everything we're talking about here today and in all the proceedings that you've had, come about as a result of history and I'll - in my concluding comments I want to talk a little bit about that. But no, I would be - we're of the view, and we discussed this at length when we prepared our submission, that we consider that it should stay where it currently is.

COMMISSIONER FITZGERALD: In relation therefore to your transition and you're supportive of most of our approaches, if not the detail, and we'll look at that in your submission. You do acknowledge that ADF has the fundamental responsibility of transitioning its own people. You've heard, and I'm sure your party has heard, but we've certainly heard, the transition is the key issue for contemporary veterans and the present time. What is that you think fundamentally needs to change in the transition space? Now, we've given that a thorough go but there might be a couple of things that you think are particularly important?

MR MICKELBERG: I think one of the strategic issues is it's lacking - and look, there's a hell of a lot of programs out there, the Prime Minister has an employment taskforce, for example, if you look at it as a triangle.

COMMISSIONER FITZGERALD: Correct.

MR MICKELBERG: To me there's a distinct lack of integration between programs at the strategic level, at the operation level, and dare I say at the tactical level, as a military person would break it up. My own son recently left the ADF after seven or eight years of service including Afghanistan and elsewhere. His view is that arguably Defence, the ADF, are failing in that area of, I guess, bridging that transition. My view as a long term practitioner is we talk a good talk about the Defence family from when they enter basic training to right through their career and yet where we're failing is, they're dropping off the edge when they're discharged from the services, that young lady eluded to earlier in her presentation, and some of them are disappearing into an abyss and sadly there are consequences of that.

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But there are all sorts of other groups, humans services as your colleague mentioned earlier, who are trying to help but I think where things are failing is there's a lack of integration. Defence's involvement is to ensure, because they spend a hell of a lot of time fostering this Defence family ethos, I did it myself, and it's got to extend beyond that. The ex-service organisations, they do a hell of a lot of good work in trying to maintain that but again there's a lack of integration between themselves as entities, but between them and the AVF, RSL Queensland have done a power of good work with recovery centres at some of the bases in Queensland and I know it's happening elsewhere. But I just think a lack of integration is where the big problem is.

COMMISSIONER FITZGERALD: I would - - -

MS HARDING: May I make two comments on it?

COMMISSIONER FITZGERALD: Yes sorry, go right ahead.

MS HARDING: I've got two comments, probably on two different groups. One on people who have been medically discharged and secondly for veterans who don't intend to make a clear, they're just transitioning out. Firstly, we deal with medical discharge. If someone's being medically discharged there's not a "smooth" transition when handed over from DVA. Where the ADF say, "Look, thank you for your service. We acknowledge that you're broken in bits and pieces in certain places so we're now going to medically discharge you." There's not a smooth transition for DVA to say, "Thank you, we 'acknowledge' that you had these issues and therefore here is the rehab and the compensation", that needs to be smoother. It's a very stressful time for those members of the ADF and their families.

Primarily too, a lot of the members of the ADF may be the primary breadwinner for their family. They are usually quite nationalistic and patriotic so to be in this No Man's Land and not know what's happening financially or with them as a person, is incredibly stressful for those people. And secondly, for those veterans who don't intend to make a claim and will never make a claim on DVA, but having some of those - they've got outstanding skill sets. It's in our best interests as a nation to make sure that they are supported to transition to civilian jobs so we can maximise the benefits of the training that they have received.

MR MICKELBERG: Interestingly, I sat in a forum after I'd left the regular Army and there was the state manager for DVA there and he said, "Why is it that a lot of these veterans don't put claims in until years after

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they leave?" and I said, "Well, the reality is what they're wanting to do is embark on their next life, their new career, and that is your secondary importance particularly when you're in your late twenties and there's nothing really you want, but mostly wrong with them healthwise, and it's not until later in their life that claims become important" and I think that's an area that sometimes overlooks but I agree with what Teresa has said. It's a very turbulent time for a lot of people when they're leaving because they are starting a new path in life.

COMMISSIONER FITZGERALD: And so one of the thrusts of our report is in fact to take a life long approach, or a whole of life approach, to the veteran and their families and we agree with your point that people often don't - the conditions or the impacts of their conditions don't become apparent until later in life and so want a much more seamless system that travels with them through that life and I think at the moment it's lots of disjointed bits and pieces.

MR MICKELBERG: But I'm not sure that social insurance or a workers' compensation-type scheme is going to cater for that because generally speaking they're about lump sum settlement and then we're onto the next customer.

COMMISSIONER FITZGERALD: If I just may just do that and then Richard's got some questions. I want to be clear, we are not trying to impose a workers' compensation scheme into a military compensation system and we're not talking about outsourcing this to any private operator at all.

MR MICKELBERG: No, No, I understand that.

COMMISSIONER FITZGERALD: So what we try to do, however, is to say that over the last 10 or 20 years there's been lots of learnings in the workers' compensation/accident compensation fields and the nine governments themselves have had to deal with this; how do they deal with workers' compensation of their own employees, as has the Commonwealth. What there are very clear to us, a whole lot of practice in those areas which are absent in the current veterans' things, including a whole lot stuff around employment, engagement of people to help them to return to work if they're able to do that, outcome based models, much tighter funding controls so that you actually get better and more targeted outcomes for individuals.

So we've never indicated, and it's out fault because everyone is saying this is what we say, we're not trying to turn it into a workers' compensation scheme. What we are trying to do is say, "Are there best practices, are

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there learnings from those schemes that then can be imported into a military compensation scheme?" So I just want to make that point. So we agree with your view and the social insurance model is exactly the same. There are some issues around the funding of those premiums and so on that we are exploring but I want to make the point clearly that we have no intentions of turning the military compensation scheme into a workers' compensation scheme but we are keen to learn from some of those schemes.

MR MICKELBERG: If I can suggest that often the people who will interpret this point won't be the Minster, they'll be bureaucrats who work for the Minister, therefore there needs to be some fairly emphatic statements made to that effect so that they don't rush off in a tangent and say, "Hey, let's create a social insurance scheme for the ADF".

COMMISSIONER FITZGERALD: No, no. Well, that's not our intention.

MR MICKELBERG: No, I know.

COMMISSIONER FITZGERALD: But we are ambiguous about this, we do want to bring some of the learnings and some of the financial issues, the ways of managing these schemes, into a compensation scheme for veterans.

MR MICKELBERG: Makes sense.

COMMISSIONER FITZGERALD: But we understand where this confusion has come from but we are not trying to turn into a pure workers' compensation scheme because frankly, we actually believe that the scheme "should" be different and just in relation to the word "generous"; it is a generous scheme by world standards but necessarily we think that that's not a bad thing. Where we're concerned about is that all the money should be targeted in the way that it delivers better outcomes but that's a different issue, an entirely different issues.

COMMISSIONER SPENCER: Yes and just to add to that, I mean, we do make the statement which we think entirely appropriate that these Australian community expects this to be generous. The question is how does that get worked out through the detail but that is appropriate so that's an important principle. Just going back, I hear your comments on families and widows and we've heard that from a number of different organisations and the public hearings, so we will have more to say on that because it is a vital part and I think there's been a sense in the past that it's sort of kind of an "add-on" sometimes to other inquiries but it's not front and centre of

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the impact on families but also how families are integral to the good health and wellbeing of veterans so we will be paying attention to that.

The third area, it comes back a little bit to the previous discussion we had with Gerry, but this is - as you know Robert Cornall has been doing his report which goes largely to the role of advocacy and what that will look like in the future and of course that's extremely important to many ESOs that are deeply involved in that program. But it goes well beyond that and we've suggested this already in the draft but we'll have more to say about the role of ESOs and the responsibility of Government and the Department to be clear about what are the services out there that can really assist veterans that frankly often can't be delivered by Government. I made the statement a couple of times yesterday that sometimes the people most in need and most isolated are unknown to Government and would remain unknown to Government and it's the ESOs and other organisations through their networks, through their Peer to Peer relationships, that can find these people and put them on a pathway to the services they need.

So we think that's important and, you know, you reference human service thinking and in other areas of human services we see that much more proactive approach to sort of bring in the organisations that are more on the frontlines of service and say, "What do you think?" and really have conversations and dialogue about that, inform the design of programs and strategies with that input, and then be very clear about how to fund that. And I've made this comment a couple of times, we've been surprised frankly at the modest amount of money that goes into this effort at the moment. We think there's probably a pretty significant investment opportunity there for Government to leverage a much more strategic approach to the wide range of organisations that are out there, both ESOs and NGOs about how they can better support.

So look, the final part I come to is a question. We've been struck by the, and it first happened here in Queensland, and that is the State-based Governments, or State Governments, starting to be more involved and interested and trying to work out what's the service provision that can support, a more integrated approach to the welfare of veterans' families in the fuller sense of the word. And in many ways I think we've seen more evidence of that in Queensland than elsewhere but from your point of view, what is the potential for State Governments to be both doing more, working more collaboratively around these efforts, because sometimes we hear from veterans, "When I was living here I had these benefits but then I moved interstate" and they don't have those benefits, so we'd all agree that that's not a very good situation. So what's your thinking behind that

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and what efforts to see underway to try and get a more integrated State Government response to this as well?

MR MICKELBERG: So I'm aware of an initiatives in Townsville, for example, and you're going there shortly I gather and no doubt you'll hear from the people up there, particularly - hopefully John Caligari and others.

COMMISSIONER SPENCER: Sure.

MR MICKELBERG: And I think they’re very positive steps and the local Government indeed has been involved there. Again, I think the issue that is a stumbling block for all of this is a lack of integration, you know, like anything in this country, three levels of Government. I would draw a parallel with the British approach to the covenant which they bought in there largely because their system of supporting veterans and their families failed there as a result of their experiences in Afghanistan in particular. And so what's happened there with the covenant is that you have - because they don't have State Governments there, they have County Governments and they have the Commonwealth Government, is they've entered into covenants.

So the County Government would enter into a covenant with the base commander that might say, for example, "When you have people posted into your base, instead of them going to the end of the line for public housing here, we will acknowledge and unique nature of their military service by giving them greater priority", for example. And I think my view, and we're about to enact - well, there's a Bill before our Parliament, the Veterans' Recognition Bill, which includes a covenant. In my view that's the precursor - my vision is that it's a precursor to us taking a similar approach in this nation where States get involved. Now, South Australia has a covenant. I think New South Wales has one. Victoria may have one, I'm not sure.

Ultimately my vision is there are covenants in each of the States but that covenant should mean more than just, it's Government. It should include business which gets (indistinct) it starts to look at this, how do you facilitate transition? It starts to breach into the area that the previous presenter was talking about, about trying to enhance programs that might be sponsored by a business as part of whatever the covenant might be in this State if there is to be one. But again, I keep coming back to the issue; integration, integration, integration. And of course the other issue is resourcing. I mean, every State Government is confronted with deficits and at the end of the day there's a cost.

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MS HARDING: Thank you, Commissioners. I've got four things I think the State Government could do immediately that would certainly support veterans and their families and serving members. One is, and Graeme touched on it, public health waiting lists. So just say I'm posted to RAAF base Williamtown in New South Wales and my kid or myself was on a public health waiting list to have some surgery or some treatment and we get posted, we'd like that priority so we don't lose our space. I'm not asking for us to be at the top of the list but for us not to lose any seniority in that.

The same with childcare centres where there was waiting lists for that, so we often - we do get post around at short notice, you know, with two weeks' notice when you got three kids, lots of fun. So to have that in place. The third jobs for the ADF, as they transition out I see the New South Wales Government, that they have some numbers and I think some targets there for how many former members of the ADF that they would employee, that would certainly I think work really well here in Queensland.

And thirdly, support of spouses. In the Federal Department of Defence, certainly with Defence spouses as your spouse gets posted around, there is some priority in you getting a job if you work in the Department. I currently work in the Queensland State Government, nothing to do with veterans, I work in IT. My husband this year is at RAAF Base Edinburgh in Adelaide, was last year as well. Our youngest one's in the Army, our two eldest ones are at university so they're more then capably left behind. I would love it if I had the opportunity, and so would others, that I could work here to stay in the South Australian public service for a year or two with my husband and know that my job is secure here. So if the State Governments had some type of arrangement where they would keep jobs open for up to three years, they do that in the Department of Defence, that would certainly aid a lot of families.

COMMISSIONER FITZGERALD: Good. There's a number of other issues but we won't go through those. You've gone those in our submission. I just want to come back with one issue and then, I think, you wanted to make closing comments. This issue of the "Defence family" and you've indicated that Defence promotes this notion. Before starting this inquiry I was sort of under the impression that family members of serving personnel, serving veterans, that may have improved over time but having done this inquiry I'm not so sure anymore. So can I just explore your view. We've got the rhetoric, Defence family. What's the missing ingredient that actually turns that into a reality?

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MR MICKELBERG: I think it's many of the measures that Teresa has just captured. In other words, some practical measures that are apparent to the families that the nation, which Defence is part of, is actually operationalising that rhetoric. I mean I as a commander can operationalise that with the, in my case, soldiers in terms of who I'm responsible to lead but it is totally different making it real for the families and, you know, to be frank they suffer significant disadvantage because of the service of their husbands or wives or sons as the case may be.

COMMISSIONER FITZGERALD: So is there a barrier to that happening within Defence? So I suppose you've heard our comments about the culture within Defence and the contested space around that but do you think there are identifiable barriers that stop that operation or is it simply, like so much things, willingness and resources?

MR MICKELBERG: I mean at the root of Defence in terms of inculpating values, right from the get-go it's you've joined Defence, this is about war fighting, and it will involve you being taken away for protracted periods of time for training, undertaking high risk activities, and on occasions going into a war area where you're going to be shot at. That's the priority. Everything else is of secondary importance ultimately. Now, there'd be a lot of people who might say, "That's not the case" but that's the truth of it. But somewhere in the middle there I think there is some middle ground that can be exploited to achieve what we're talking about, to facilitate a lot of these other issues that are being raised by all the speakers.

COMMISSIONER FITZGERALD: Good. Well, we agree.

MR MICKELBERG: Yes.

COMMISSIONER FITZGERALD: We at least think that should be the case I should say.

MR MICKELBERG: Yes.

COMMISSIONER FITZGERALD: Do you have any final comments before we finish?

MR MICKELBERG: I want to make two points I guess. One that I've mentioned in our submission and that is DVA's business practises. I met with the previous minister for Veteran Affairs a while back and I said to him, "You know, I think there's pretty much a general level of satisfaction with the Department but one of the problems is some of the business practises are actually hamstringing them from doing their job" and he said

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"Such as?" and I said, well, in years gone by if I was a veteran in Townville, for example, the local advocate at the RSL would help me do my claim and it would be submitted to the DVA office in Townsville and then if the DVA officer there had some issues that they wanted to talk to me or the advocate about, they would ring up the advocate and say, "Teresa, can we meet for a coffee? I want to talk about Graeme's claim" and we'd meet and talk about it - well, they'd meet and talk about it and sort it out. That's not possible now because for various reasons, I think for economies, the DVA has decentralised its approach and I, in Townsville, might find my claim being dealt by someone working in Hobart, or worse in Perth which is two hours' time difference.

That makes it difficult for me if I'm doing the claim on my own as a veteran or the advocate. It also makes it difficult for the DVA staff member most of whom genuinely want to try and do the right thing by the veterans who they're administering. I actually think DVA need to seriously look at changing that back to the way it was and I think the only reason it's happened is because probably the Treasurer in Cabinet has said, "Hey, there's some savings that need to be achieved. Here's your savings, Minister for Veterans' Affairs" and then flick passed it to the Secretary and therefore, "And how the hell are we going to achieve these savings?" and this is one of the ways but I do think it's a shortcoming.

I want to close by talking about history. The impact of history has served to frame the approach for the way in which we as a nation care for our veterans and it shouldn't be overlooked in War World I and War World II we lacked standing Defence forces. They were largely volunteers and they were raised for both the wars and there were large numbers of casualties so there were lots of widows and there were lots of disabled people and that set the scene for how we care for veterans. Subsequent to World War II things have changed. Wars are no longer global conflicts, well haven't been to date, and as consequence standing Defence forces were raised in Australia; standing Army, standing Airforce, standing Navy.

That resulted in those Defence forces undergoing lots of training. At the same time as training of course, they're training for war which involves significant risks and sadly a lot of people get injured in training. In fact, now more people are injured training and, dare I say it, potentially more are killed than in war and I agree with what you've recommended by doing away with the two burdens of proof in relation to peace time service and operational service. I think it's a nonsense, it's created two classes of people. But we ought not overlook the fact that the system that we have in place which your report is potentially going to reform, has come about for various reasons and I believe that the expectation this trained

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community has is that whatever system we put in place needs to acknowledge the unique demands of military service that are placed on serving members, ex-serving members, families, and widows, and those unique demands are about to be recognised in the Veterans' Recognition Bill. Whatever comes out of your review needs to put in place a system that caters for those unique demands in the future for the future generation of veterans and their families and widows. Thank you.

COMMISSIONER FITZGERALD: Thank you very much for that. I should just make the comment as Richard's made earlier, this report is about the "future" system. It's not about tomorrow. So your aspiration is ours as well. We have to build and construct a system that is going to be sustainable for the next 20 or 30 years; that isn't by tinkering with what we've got, it's actually by making some changes and that's going to be difficult but that's the ultimate aim to have a very robust system which recognises the contribution of veterans and their families and I agree with you. Our experience has been the community expects that.

The challenge is how do you actually do it? You can have improvement but you've also got to have changes, that's always challenging. All right, thank you very much.

MR MICKELBERG: Thank you very much.

COMMISSIONER FITZGERALD: Thanks for your time, much appreciated.

MS HARDING: Thank you very much.

COMMISSIONER FITZGERALD: Could I have Trever and Helen. Good. Can we just get some fresh glasses? Trever and Helen, if you could give us your full name and the organisation that you represent please?

MR KLAEHN: Okay, my name is Trevor Klaehn and I'm vice president of the Naval Association of Australia, Queensland section.

COMMISSIONER FITZGERALD: Good.

MR KLAEHN: I'm also the welfare coordinator as well.

COMMISSIONER FITZGERALD: Good, thank you. And Helen?

MS YENCH: My name is Helen Yench. I'm also a vice president of the Naval Association of Australia, the Queensland branch, and president of the Navy Women Association.

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COMMISSIONER FITZGERALD: Thank you very much. And as you know, if you can give us ten minutes of key points that would be terrific and thank you for your submission which we've received.

MS YENCH: Okay, first of all we'd like to thank you for the opportunity to be able to attend this meeting. The first point that I want to make is regarding the disbanding of DVA. Currently the Naval Association has a very good relationship between DVA and the ESOs. They conduct round table forums that allow the ESOs from many different areas to inform others about the focus. So, for example, Mates for Mate, Open Arms, Red Six, Veterans Care, et cetera. There are literally thousands of ESOs.

These ESOs assist in the overarching association being able to advise veterans in need of different types of support. We depend on DVA to expand our knowledge of these organisations. We oppose the disbanding of DVA most vehemently. It requires a single department with a Minister for Veterans Affairs. Do you want to do the second point?

MR KLAEHN: Okay. The second point regards claims. There have been some mention of the use of Centrelink to process these claims. The training of staff to be able to understand ADF careers, movements and health would be very expensive. Already Centrelink is understaffed and difficult to deal with. The frustration of having veterans who have served their country, having to line up with others with no ambitions for a career is degrading for the veteran.

MS YENCH: Regarding claims, when we undertook our discharge from the Navy – we are both ex-serving members, as you probably have been made aware – we were required to have a medical examination. It was a very simple one. It was more of a tick and flick on about 30 different topics. At no time during that discharge medical were we ever told that there was a 25 year limit to lodge a claim for any compensation. So many of the illnesses and injuries and exposures were not necessarily recorded in our medical files. Putting in claims is a very, very lengthy process and very stressful, some taking five years and more just to get a result. I think Trevor you're in a five-year one already, aren't you?

MR KLAEHN: Still going.

MS YENCH: For that a veteran experiences pain and suffering. It becomes very anxious for that veteran and also causes depression or worse. The 25 year limit on claims needs to be removed, and the claims system simplified. A combination of the Acts would be of benefit, and all claims needs to be considered as benefitting the veteran, not disproving

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what the veteran has claimed. Regarding the information requested, 8.2, 9.4 and 10.1, the specialist medical review council would be better managed by specialists in the field after first being assessed by GPs.

5 Specialists currently working for DVA are often older doctors, sometimes retired, and are out to disprove the claim for the benefit of DVA, not necessarily the member. For 9.2, the DVA staff on the whole are considerate with dealing with veterans and their families, however, it would be much better if veterans transitioning from the ADF be employed
10 within this department because they have a better understanding of service life and the effects it has on the member and their family. We agree with 13.3, a period of two years maximum before a member is offered permanent impairment compensation.

15 **MR KLAEHN:** Okay. Next one. All reforms must reflect the unique nature of military service where every veteran is subject to a lengthy application of force with the likelihood of injury or death. Support one injury, one compensation or entitlement. No detrimental to current or future veterans from any legislation or administration form. And change
20 to the basic on objective evidence and rational arguments underpinned by the unique nature of military service.

Now, Mr Commissioner, we are dealing with Navy people, naval personnel. We have over 1,000 members in Queensland, and there are
25 probably another 500 ex-servicemen who are not involved with this. We find that members of the Naval Association who joined the service in the 60s and 70s have been forgotten. We are just a forgotten race. When we left the services way back then, like Helen said, we weren't told anything. When we put claims in about the weights we used to carry or the job we
30 used to do, nobody understood it, because they said, "Well, that shouldn't have happened," or, "That doesn't happen."

Well, it did happen. You know, you couldn't go to sea if you couldn't carry your mate up three flights of stairs. You couldn't – and you had to
35 do a survival at sea course. And when you load ship with your vittles, you're carrying 40, 50, 60 kilo pound bags of tomatoes, or potatoes and things like that. So the Navy is unique in what we do. You know, everyone in this Commission, everyone talks about the ADF, and that's going to be the future, the three services merge in one. But they keep
40 forgetting about the older generation.

You know, we have a lot of respect for DVA and they do help us out, but we go to advocates and the advocate is usually ex-Army or ex-RAAF. He does not understand our language or doesn't understand our work. So we
45 would like the Commission to look at that. Thank you.

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COMMISSIONER FITZGERALD: Okay. So you have given us a number of comments on our recommendations.

5 **MR KLAEHN:** Yes.

COMMISSIONER FITZGERALD: You've proposed a number of recommendations. So we might, if we can just raise some questions. Can I just deal with that last point first, Trevor?

10

MR KLAEHN: Yes.

COMMISSIONER FITZGERALD: Where do you think the current system fails Navy veterans? So if I just ask this question, you can clarify
15 it. One issue you've identified is this 25 year limit.

MR KLAEHN: Yes.

COMMISSIONER FITZGERALD: I presume that's under the VEA.

20

MR KLAEHN: Yes.

COMMISSIONER FITZGERALD: The second one is you say that it doesn't adequately recognise the distinct nature of naval service.

25

MR KLAEHN: Yes.

COMMISSIONER FITZGERALD: The statements of principle that apply to the VEA, do you think that they're not contemporary or they're
30 not understanding of your service, or have they been improved? So what's your general view about the putting in of claims now with the statement of principles under the VEA, for example?

MR KLAEHN: Well, I've got – I'm going through two compensation
35 Acts at the moment, but I find that the older veterans are finding it difficult to deal with being in one Act for a few years, and one Act in the next years.

COMMISSIONER FITZGERALD: Sure. Sure.

40

MR KLAEHN: Right. So the merge of SRCA, MRCA and all of them, would be a good idea as long as everybody understands the old and the new in the future. I mean, today's sailors we think have got it pretty easy compared to what we had it. They're more high tech people, and when
45 they leave the service there's not many jobs out there available for them

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for their skill. The old sailors, when we got out, we had to do other jobs. We had to learn other jobs because what we did in the Navy did not reflect the service outside in civvy street.

5 The point is that if there is transition with Navy at the moment, the way we understand it, is pretty secretive. Navy – we've been trying to get into Navy at HMAS (indistinct) and have one day a week with them, and down south the Admiral says, "No, we can't do it."

10 **COMMISSIONER FITZGERALD:** So, Trevor, I'll come back to that in a moment.

MR KLAEHN: Yes.

15 **COMMISSIONER FITZGERALD:** I just want to come back to this claim area. Your experience with the statements of principles, just to go back to my question, and again you may not have a view, is do you think it adequately recognises naval service today? It may not have in the past. Or do you hear from your members and people putting in claims at the
20 moment, that there are still obstacles?

MR KLAEHN: There are still obstacles, Commissioner. There are still obstacles. It's not clear. Not, you know, like, everyone has spoken about plain language in all that there. So if it was plain language it would
25 probably be a lot better, understandable. And advocates that we've spoken to too are saying the same thing. One person will put a claim in and the next person will put another claim in similar to that one. This person will get it, the other person won't get it.

30 **COMMISSIONER FITZGERALD:** Is that – they're obviously – the Department delegates are acting in accordance with those statements of principle and they're fairly prescriptive, aren't they?

MR KLAEHN: Yes, they are, yes.

35

COMMISSIONER FITZGERALD: So what do you think – why do you think a veteran, a naval veteran is being – why are they being differentiated? Why are they being treated differently?

40 **MR KLAEHN:** Well, they don't understand the jobs that they're doing. I believe it's - - -

COMMISSIONER FITZGERALD: Yes, that's - - -

45 **MR KLAEHN:** Yes, I believe that - - -

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MS YENCH: Or the advocates.

MR KLAEHN: Or the advocates. I do believe that DVA up here have gone to visit Army bases and all that there, to learn what they do. To go on a naval ship and learn what they do, is virtually impossible. You know, they've got so many hoops to jump over and all that there, and workplace health and safety, well, today they just couldn't do it.

MS YENCH: I think a lot of the issue also is that advocates are trained online, and as we all know sometimes you can gloss over things as you're reading through. I think if we had face-to-face advocacy training and possibly even some paid advocates, it would be of benefit to members.

COMMISSIONER FITZGERALD: And as you would have heard Richard mention before, we will be looking at the Robert Cornall report, which we hope the government makes public soon, and he obviously has recommendations around advocacy and some of those issues. Can I just deal with the second one, and then Richard might have some questions. It's this issue of Centrelink. Now, that's not our proposal, as you know. That's currently what DVA is doing. So DVA is closing some of its own offices and I understand the entry point for some is now Centrelink. As you would have heard from the Secretary in the public hearing in Sydney – sorry, in Canberra, there is a fair bit of outsourcing going to take place to the Department of Human Services. Now, they're not our proposals but we recognise that some back office functions can be done by other agencies. We have a slightly different model, as you know. But what's your concern about the use of Centrelink in any way, shape or form?

MR KLAEHN: We will oppose it.

COMMISSIONER FITZGERALD: Yes, but why?

MR KLAEHN: Our members – why? Because the members feel that you've just got to go in there and line up in the queue, and, you know, fair dinkum, you've got – if you've been to Centrelink offices you've got a few bogans in there and all that there. So it's degrading for them to be all clumped together in that system. And we feel that they're sort of just saying, okay, you're veterans, just join the queue and we'll get to you when we're good and ready.

MS YENCH: And I think they're already overloaded anyway.

MR KLAEHN: Yes.

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MS YENCH: Centrelink are overloaded.

COMMISSIONER FITZGERALD: So are your members required to access Centrelink service at the front entry here in Brisbane or Queensland at the moment, or is that something that you think might be forced on you?

MR KLAEHN: I think it probably will be forced on us.

COMMISSIONER FITZGERALD: But not currently?

MR KLAEHN: Not currently, no.

MS YENCH: No.

COMMISSIONER FITZGERALD: No. And just in relation to that, the notion of veterans' hubs and what-have-you, they're not an entry point for DVA but as you know from Townsville and others, there are some – people are saying there should be some soft entry points for people to get advice from DVA and so on and so forth. Do you have a particular view about those sorts of initiatives?

MS YENCH: I would definitely support the hubs. When I was putting in my own claim to DVA, my point of contact was Hobart, and I was living in Townsville at the time. I went to the RSL in Townsville, my advocate was an ex-Army advocate who didn't understand a lot of the Navy issues.

COMMISSIONER FITZGERALD: Right.

MS YENCH: So definitely hubs are the thing, but also you've got to have advocates who are, for example, ex-Navy, doing ex-Navy paperwork, and the same with the Army. Army does Army. Airforce does Air Force.

COMMISSIONER SPENCER: So do you think that those skills are able to be learnt? I understand what you're saying and we've visited bases of all three services, and I appreciate they're very different in character and the nature of the work is very different. But from an advocate's point of view, do you think it's the obligation of DVA or whoever it is, to educate the advocate so that they can deal with all three services, or do you think that's just asking too much?

MR KLAEHN: No, I think it's – it would help. And not only if they did that it would help themselves as well, you know. Most of our members are quite happy with DVA up here in Queensland. It seems to be different

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to what it is down south. We seem to be unique up here. We get along very well with DVA up here. We are always kept informed – we've always been informed of what's going on.

5 **MS YENCH:** I also think that if you had your advocates looking after specifically that service, it would prevent a lot of time-wasting in DVA when you put in a submission and then find, not, it's rejected because something hasn't been included, and it may be just the nature that they haven't understood what your service might have been about.

10

COMMISSIONER SPENCER: Trevor and Helen, you've mentioned item number 6 in your recommendations provide financial assistance to ESOs, ensuring their ability to represent veterans, family interests and, secondly, develop a comprehensive suite of wellbeing services. So just
15 going to the suite of wellbeing services, so we've commented and you've commented on the hub proposal. What other services do you think would be valued and you would look to be supported by the Department?

MS YENCH: Well, certainly transitioning. Transitioning at the moment,
20 I'll give you an example, the President and I went to HMAS Moreton and spoke to 130 reservists two or three weeks ago. Those people had never – some of them had never heard of this draft Productivity Commission, and most of them didn't know about White Cards. All right. So we need some sort of information on transitioning. We need to be able to provide
25 some sort of employment for people coming out of the forces. So I think any funding around that sort of thing would be excellent.

COMMISSIONER SPENCER: Trevor, any thoughts as well on that, or to add to that?

30

MR KLAEHN: Yes. With the transitioning, coming out, I think what would be a good idea, Centrelink has got one where you go and work for a company for a week or two weeks to learn. I think that should be – I think Veterans Affairs should look into something similar to that. Get some of
35 these businesses online, and say, "Okay, this bloke here was an electrician in the Navy. Can he do two or three weeks of you so he can learn the different systems that an electrician in civvy life has got, compared to Navy." And things like that.

40 You've got engineers, you know, that work in the engine room, let them come out and get into an organisation where they can do on-job training for a couple of weeks. So the businessman or the employer can see, "Hey, well, this bloke is keen, he has got good ethics, we'll give him a go." And things like that, you know, it would help a lot. The veteran is leaving the
45 service saying, "Well, I'm worthy, this bloke is going to give me a go, so

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I'll do my best." And people who have got some injury or disability, put them into the scheme as well, and pick out the jobs that will suit them without hurting them anymore. I think that would be a good system to work to.

COMMISSIONER SPENCER: As, you know, we're supportive of that notion of really working out who needs assistance, what kind of assistance. We had in our discussion with Gerry earlier about the enhanced role we can see for ESOs and also a more strategic view of this by the Department informed by ESOs and other organisations of their frontline experience and how that can best meet the needs.

I had a discussion at the coffee break which highlighted the point that for a number of veterans, their transitioning will be a light touch is all that's needed. They're on their way, they know what they want to do. They're – and good evidence, of course, they go on to have very successful future lives, so the trajectory is good. Although sometimes it starts well but then there are complications or concerns later. But it's often about working out and being thoughtful and strategic about who are those people who are really in tough times, and how do we make sure that they get the services they need.

ESOs and others have a terrific role to play in that space, we think, because they're often trusted and have the peer to peer relationships that it's very hard for government to have at that particular time. I just wanted to bring you back to a comment you made to – focusing on the female veterans. You've noted female veterans in particular. Do you have any comments about how the system should better respond to the particular needs of female veterans?

MS YENCH: I can only speak for my own personal situation, I guess. When I was discharged from the Navy I spent 11 years as a communicator, and then a further five years in the reservists. My particular role was as a communicator, and that meant reading of Morse code. There's no job in the civilian life that equates to that. So when I first got out, I really didn't know what I was going to do. Even though I was newly married and had a child, I just couldn't see anything that I could possibly do that was going to earn me any money.

What I eventually did, after having another child, I was volunteering in the classrooms in schools, and so then I decided, well that's what I'll do. So I went back to university and gained an education degree, and became a teacher for the next 21 years. So I was lucky that I was able to then find something that I had a passion for, but it didn't equate to anything that I had done in the Navy, other than the fact that I was a chief petty officer

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who was in charge of quite a few people. So eventually my teaching career led to a deputy principal's role and again that sort of role from the Navy was transferred to what I could do in a civilian life.

5 **COMMISSIONER SPENCER:** So during transition, as we've commented several times, being assisted to think through what the possibilities and opportunities may be. As Trevor said, sometimes even the experience of seeing what that might look like, that's an important part. Because we do know that in the ADF, of course, return to duty is
10 very, very important. But once having separated from service, the notion of work, it has been shown by evidence to be extremely important in terms of people's wellbeing. Sometimes that's not possible, as we know and, therefore, it's about meaningful life and what assists the veteran to be able to achieve that.
15
I just wanted to – and you may want to comment on this but I've just noticed in your last point you've said – you've mentioned 86 proposed "removals". And we've heard this figure before that we're "removing" 86 benefits, and that had us intrigued because we're not intending to do that.
20 But, Robert, you may want to - - -

COMMISSIONER FITZGERALD: Look, I just want to clarify.

COMMISSIONER SPENCER: Yes.
25
COMMISSIONER FITZGERALD: It has come up in a number of ESO submissions. A particular ESO did a word check, and what they did is they found the word "remove" 86 or 87 times, including where it says, "do not remove," and including duplication where it's the same
30 recommendation repeated in different parts. So I just want to assure you, it never was, never is that we are moving anything like 86. It's actually a very small number.

What we have said in relation to allowances, that some of those we think
35 could be paid out, some of those should be incorporated into an increased benefit payment, and some of them we actually think are probably for the chop. But it's only a very small number of those. So I just wanted to clarify Richard's point is that is simply a figure that is being used, and it has misled many ESOs. There was simply a word check by somebody
40 and it misrepresents what we've actually put. So I just clarify that. Not criticise but clarify.

MS YENCH: Right.

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COMMISSIONER FITZGERALD: So just be careful when you do word checks. That's good. Is there any final comment that you would like to make?

5 **MS YENCH:** I think the most important thing is being able to transition people. We're having quite a bit of difficulty being able to get the member who was transitioning from the Navy to be able to find out from us, as an ESO, what is available to them, and perhaps lead them to an advocate. Again, a lot of them don't know what they might be entitled to
10 through injuries that they've sustained during their service time.

COMMISSIONER FITZGERALD: You said – a question just arising from that – that I think, Trevor, you mentioned you thought the Navy was particularly – I'm not quite sure if you used the word "secretive" but - - -
15

MR KLAEHN: Yes.

COMMISSIONER FITZGERALD: - - - I will use that. What did you actually mean by that?
20

MR KLAEHN: Well, the last commander down at Moreton, Commander MacDonald, was very active with the Naval Association, and we were getting on really good with him, and he was helping us out and doing his thing. So we thought, well, we'll put this motion to him. We
25 were like one room, probably once a week, down on base, to talk to the blokes who were transitioning. And not many sailors transition in Brisbane, they mainly do it out of Sydney. But the ones that do up here, we like to talk to them for an hour, give them an idea about what they're entitled to, what they can have and what they can't have.
30

He thought it was a great idea. He put it to Admiral Noonan down south, and he just knocked it on the head. So, you know, there's nothing there at all. We tried even – we've just got into the Naval News that goes right throughout the fleet, of advertising. That has drawn a few more into it.
35 But over the whole, I think we've got to get over the Navy's secret thing. You know, they just seem to be very protective of what they do, and even I think DVA have made the comment too that Navy is very hard to deal with, getting information out of them. I don't know what it is.

40 **COMMISSIONER FITZGERALD:** We have heard that – and, again, I can't verify this, but we have heard that Navy is the more difficult of the three services to transition from.

MR KLAEHN: Yes.
45

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COMMISSIONER FITZGERALD: I want to be clear that we can't verify that, but that's certainly feedback we get. And there's some structural issues that might give rise to that, so we will be trying to address that in our transition recommendations.

MR KLAEHN: Yes, and the other thing too I just wanted to bring up is we've probably lost more sailors to suicide over the last few years because of the lengthy drawbacks with their claims. And they're not young sailors too. They're in their 50s and 40s as well. Because they get to a certain stage and they just throw their arms up and say, "Well, bugger it."

COMMISSIONER FITZGERALD: Yes.

MR KLAEHN: You know, and a couple of weeks ago I was dealing with a mate who's 66, 68, going through cancer, and it eventually got into his blood and he passed away two weeks ago. But he was halfway through DVA getting everything done. And there are many more veterans like that, young and old. The girls who come out after doing 10 years, they joined the Navy at 17, come out at 27. One girl came to us and she didn't know about the Medicare card, didn't know you had to have one. Things like that. They weren't told. The lack of – information going to young men and women in the Navy is very minimal. Unless you ask, they don't tell you sort of thing there. So that's the thing we've got to try and get through. And, like you say, many other people have said Navy is very hard to deal with.

COMMISSIONER FITZGERALD: All right. Thank you very much.

MR KLAEHN: Thank you.

COMMISSIONER FITZGERALD: Much appreciate. We'll now break for 45 minutes and resume at 1 o'clock precisely. Thank you.

LUNCHEON ADJOURNMENT **[12.16 pm]**

RESUMED **[1.00 pm]**

COMMISSIONER FITZGERALD: We'll resume and thank you for being here this afternoon. The first day it's full, the second morning is a bit less full. By the afternoon, it's empty, so it's – so we're grateful that there are some people here. David Petersen, please.

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UNIDENTIIFIED SPEAKER: Robert, just before you start, do you mind telling me, did the Defence Force Welfare Associate appear?

COMMISSIONER FITZGERALD: Yesterday.

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UNIDENTIIFIED SPEAKER: Yesterday?

COMMISSIONER FITZGERALD: Yes. They had two people representing them yesterday, so that's good. So we're into the home stage
10 so, David, if you can give your name and – your full name and whether you represent any organisation. Thanks.

MR PETERSEN: It's David Peterson, and I don't represent any organisation.

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COMMISSIONER FITZGERALD: Good. David, just as you know the drill, if you can just give us a short presentation?

MR PETERSEN: Sure. I served 11 years in the Australian regular
20 Army, including a deployment to Afghanistan in 2012. In 2017 I was medically discharged as a direct result of my service in Afghanistan. My discharge diagnoses were PTSD, anxiety, depression and alcohol abuse. My medical discharge was potentially avoidable. Today I appear in a private capacity and my comments and insights into this draft report
25 should not be considered the views of any other individual, entity or organisation.

COMMISSIONER FITZGERALD: Sure.

30 **MR PETERSEN:** However, for context, I am employed fulltime as a project manager for a Veteran Suicide Prevention program here in Brisbane, and I'm also the president of an RSL subbranch, perhaps the youngest president of a subbranch in Australia. I feel that I have a robust understanding of the veteran rehabilitation and compensation system, as
35 both a client and a service delivery provider.

Since the establishment of the Repatriation Commission through the Australian Soldiers Repatriation Act 1917, Australia has changed for the better. In 1917 Australia did not have a welfare system that our volunteer
40 citizen soldiers could return home to be supported by. Thankfully, the government of the day acknowledged that veterans required a dedicated system to care and support for them, and their unique needs, regardless of the costs. The requirements of mass mobilisation and the subsequent repatriation of volunteer citizen soldiers is entirely different to the present

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day challenges faced by a modern and professional Australian Defence Force.

The concept of repatriation simply does not exist anymore. The lines between peacetime, peacekeeping, peacemaking, combat and training are often blurred, and entangled with each other. Units are held at high readiness for combat, and the state of readiness requires challenging, frequent and often dangerous training. Today our highly professional soldiers, sailors and airmen are expected to go from their living room to combat and potentially back in just a matter of hours, not the months of sea voyages that preceded and followed our first world war soldiers' combat.

The unique nature of military service is such that individuals forego their rights to place Australia's interests first, up to and including death. It is because of this unique nature of service that Australians willingly go into combat and that that combat potentially results in their death, injury or illness. However, in 19 years of combat in Afghanistan, the number of battle casualties requiring medical evacuation is approximately 500. The vast majority of rehabilitation and compensation requirements from ex-ADF members, is not as a direct and immediate result of close combat with the enemy.

My injuries from Afghanistan did not occur overnight. It was a slow and insidious onset. I failed my psychologist screening on return to Al Minhad Air Base. I was not allowed to return to work until I was deemed psychologically suitable to return to work. So what did I do on the advice of my boss? I told them I was okay so that I could go back to work. That decision, a decision that I made under the advice of my commander at the time, was a decision that has had negative impacts on my life, on my family, on my kids, and ultimately on the Commonwealth.

My commander provided his advice with no consideration to the whole of life cost of that decision to lie in my psychological assessment. That is wrong and requires change within the ADF. The ADF, who is the Commonwealth's agent for a veteran's health and wellbeing whilst they are serving, should be incentivised and penalised for not effectively managing the investment made by the Commonwealth on financial, capability and personnel levels.

Presently the ADF has no penalty imposed on it for the poor choices that negatively impact on the health and wellbeing of service members, and will only achieve cultural change when both incentives and penalties are imposed. When leaders are held accountable. Time and time again service members who could receive early intervention or treatment for

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minor, and at the time short-term injuries, do not do so due to cultural pressures within the ADF, just like I could have.

Only when leaders within the ADF encourage, support and require injuries to be managed quickly, inexpensively and at the earliest possible level, will the cost of compensation and rehabilitation for veterans be reduced whilst simultaneously improving the wellness of service members and veterans alike. When the Commonwealth can analyse the whole of life cost incurred by its decisions, can service members and veterans be provided with the best possible health and wellbeing.

Carl Von Clausewitz said, "War is a continuation of politics by other means." Well, veteran compensation and rehabilitation is the cost of war by other means. The government deserves to know the likely cost in blood and treasure when they deploy and employ the Australian Defence Force in our national interest. Part of the cost to the Commonwealth is the whole of life cost of veteran rehabilitation and compensation, 12 or 13 billion dollars per annum.

We need to stop the snowball of rehabilitation and compensation within our service members and veteran populations. Look across both population groups. We need to change the culture within the entire Defence portfolio, and we need to both incentive and penalise those who mistreat the Commonwealth's investment in its personnel. The big opportunities here are the upstream costs, not the downstream costs. I would like to highlight the fallacy within the RSL Queensland analogy of a professional sports team and the term tactical athlete.

If RSL Queensland's analogy is to be considered true, then does that organisation believe that the teams prior to worker's compensation schemes and duty of care to its employees, be it athletes, are higher performing and healthier than today's teams who do operate in that condition. Or did the introduction of worker's compensation schemes, or duty of care to its employees, see the introduction of targeted, outcome-focused and professional approaches to both team and individual talent management?

Tactical athletes are treated very differently between – within the ADF, to that within a sports team. We know this. We have tactical athletes who are also professional athletes, particularly in women's sport. Ask them if they are treated better or worse in the ADF, versus professional teams. I believe that only when leaders within Defence are held accountable, and they are incentivised and/or penalised will we achieve better outcomes.

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A possible aid in the reduction of the whole of life cost to the Commonwealth whilst simultaneously increasing the wellness of veterans is through the adoption of a Silver Card. The current provisions and eligibility to a Gold Card should be retained to target service-related health needs of the most vulnerable injured and unwell veterans. I agree with the Productivity Commission's comments within the draft report regarding the Gold Card not sitting well within the key underlying principles of a future scheme.

I also note that I will become eligible for a Gold Card due to my qualifying service. I also agree that the White Card is a well-targeted and appropriate vehicle for funding future healthcare without the administrative and bureaucratic burden of proving liability. I currently hold a White Card. Veterans who have qualifying service or veterans with a service-related injury or illness that has been approved and accepted by the Commonwealth, could be provided with a Silver Card. In effect, a tiered system of healthcare cards that would provide taxpayer funded private health insurance to veterans to encourage a lifetime of wellness.

This would reduce the burden on the Commonwealth later in life when an eligible veteran receives a Gold Card through the reduction in severity and acuity of chronic health conditions when it is most cost-effective to treat them, early, quickly and simply. As proposed, a tiered healthcare card provides support to veterans to achieve their best possible health whilst maintaining a level of personal responsibility. This would be supported by the Commonwealth, say, contributing the premium and the veteran contributing the out of pocket expenses for items that are not covered under other healthcare card schemes, such as the White Card.

Thank you for this opportunity to make an oral submission to this important and once in a generational chance to fix what is a disjointed, fragmented and overly bureaucratic system to support Australia's veterans. I have no further comments.

COMMISSIONER FITZGERALD: Good. Thank you very much. If I could just ask a couple of questions, and then Richard will. Just if I can concentrate on the incentives in relation to the ADF. So your comments are very clear that you believe that in order to bring about change within the ADF, both incentives and penalties need to be imposed. Now, you will have heard throughout these public hearings and elsewhere, that many older veterans are not in favour of having additional incentives. And you've heard the arguments for that. So I was just wondering whether you – what your response to those other sorts of comments around the fact that imposing a premium on ADF or, in fact, holding ADF to more

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account, would in fact somehow or other affect their operational aspects? You don't hold that view.

MR PETERSEN: The requirement to hold forces at readiness will incur cost, there's no doubt about that. That is the unique nature of military service. You know, people will be killed, injured or become ill as a result of their service, be it in peacetime, peacekeeping, peacemaking or combat. However, the fallacy in that argument is that by having a suitable occupational health and safety system in place, those two things are incompatible. And I cannot see how with a healthcare system that is deliberately designed to care for people who have been damaged as a result of their unique nature of service, that jumping out of planes, you know, there is inherent risks in those things.

COMMISSIONER FITZGERALD: Sure.

MR PETERSEN: Commanders must accept those risks as well. The Commonwealth does already accept those risks because we let them do that. But at the moment there is no consideration to the lifetime cost of that decision.

COMMISSIONER FITZGERALD: Sure.

MR PETERSEN: So only when the Chief of Defence Force can no longer buy another tank, because he broke too many soldiers or she broke too many soldiers, will that leader actually be incentivised to go and do something upstream. And too often they're not incompatible. You know, the tactical athlete analogy is perfect. We allow people to go onto the sporting field and become injured in the pursuit of the final or the game or the points. But it doesn't mean we don't provide for their health and wellbeing in other areas, and prepare them actually better.

So that the analogy is always, well, if we train them softer they'll break. Well, sports team today are far better than they were in the past, because they have these systems in place that prepares them for combat better, and incentivises them to do that. And when a commander doesn't do that, they become penalised in some way that's appropriate and not detrimental to Australia's national interests.

COMMISSIONER FITZGERALD: So we've been on a large number of bases, including Kapooka which is the Army training base, and the Air Force training base in Wagga. But in relation to Kapooka they would say to us that there has been significant changes to the way in which they train young military personnel. And it's a very different system that was in place even just a decade ago. The second thing people would say to us is

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the very big change has been the imposition of the workplace health and safety legislation in 2011.

That is universally accepted by both those in the military and the Departments. But you were discharged in 2017 and you're relating to us a very recent set of experiences. So when the commander asked you to misrepresent the position in that assessment, roughly what year are we talking about?

MR PETERSEN: 2013.

COMMISSIONER FITZGERALD: 2013. So can you just tell us from your point of view whether or not you have seen, prior to your discharge, any significant improvement in relation to one, the prevention of unnecessary injury, some injury is unavoidable. The second part is the way in which commanders and others responded to the reporting of those injuries.

MR PETERSEN: Injuries within Defence are highly under-represented. We know that because when veterans leave they start claiming. They don't claim beforehand. And this is why the system of repatriation is somewhat broken, because individuals serve multiple deployments. They might serve on a training operation overseas, and then at – it should be a streamlined sort of handover process that if you're injured in your first year of service it shouldn't affect you negatively if you're rehabilitated correctly.

Just like a football player who gets injured, they put their hand up to say, "I need help here because it's going to impact my career. I need long-term – I need treatment because this will be a problem later." And so they're incentivised to actually do that. So by putting these mechanisms in place, we would be able to reduce the life cost, and it also would improve capability. We would have more soldiers to put on the battlefield than less. In terms of your question regarding - - -

COMMISSIONER FITZGERALD: Reporting.

MR PETERSEN: - - - reporting, deployments are hard to come by in the current setting. No one wants to be the broken person and so, therefore, people under-report and they are not incentivised to report. There is no benefit in reporting. There's only cost, both in administrative and also in an appearance that you're doing unsafe training. I served in Kapooka in 2010. I was a platoon commander there. I had 40, 50, 60 recruits at one time. We had a box checking activity, but in all reality it was – we were

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just doing what we were told to do and we just did that. There was no ability to be sort of innovative in terms of health and safety of trainees.

I would not like to mischaracterise my commanders. You know, it wasn't some deceitful, let's game the system to get you back to work. It was just cultural. That's just what you did. It wasn't a big deal. Just like it was cultural to send me on three months leave with a prescription for, you know, benzo drugs to look after me for the next three months. That was just cultural, what we did.

COMMISSIONER FITZGERALD: My final question, then, Richard, just in relation to your own discharge, you were discharged medically in 2017. Could you just describe in very brief terms the nature of that transition for you at that time?

MR PETERSEN: I was a very unwell man when I was discharged. Very unwell. I needed to get out of the military as soon as possible because of the ongoing effect on me in that setting. And I did everything I could to get out of the military as quickly as possible. My discharge was a high risk activity. You know, someone who was considered so unwell that they couldn't remain in the military, was allowed to just be cast off. I received my discharge notification in an email from the Defence Force, and at the time I was living on a cattle station because I had to get as far away from Defence as possible.

It was an aggravating aspect to my mental health. In terms of career transition and the like, I don't have a single certificate for my time in the military. I don't have a single qualification for my time. I spent 11 years, I was a captain on discharge. I have allegedly qualifications but if I now email the Army to seek those qualifications, they say, you know, "It's not our problem, you're no longer a serving member, we can't get them for you." So, you know, I know it's not a widely held position, people aren't coming here and saying these things to you.

COMMISSIONER FITZGERALD: Sure.

MR PETERSEN: You're having – you know, when you speak to Defence they say, "No, we've got a great system and we've improved it." In my capacity elsewhere, I see this same story time and time and time again. Veterans who just get out and just go about their own business because that's what they've been told to do their whole life. Just get on with it.

They got on with it in the military and now they've returned to civilian life, they just get on with it and stop fighting the system. You know, don't

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fight the green, is the saying in the Army. But the reality is that unless you have, you know, the ticket printed before you get out, it's not there. In fact, I got – after my discharge I got chased for overpaid wages for several months whilst living effectively homeless.

COMMISSIONER SPENCER: David, you mentioned something earlier that we're focused on in our report, and we've been almost universally – you're the exception – one of the few exceptions of people who have come back, and this is the whole of life cost. And as you know, we've said unless you're tracking the whole of life consequences and costs of that, you don't have the analysis, the insight, to be able to understand the impact of things which maybe should not have happened at the prevention end, and in terms of better management right at the beginning of this process.

It has been put to us time and time again that, well, that's not going to have any incentive for change, it is what it is. But you've highlighted it and you've said, no, no, you think it will be meaningful. So do you want to just give us a bit more of your thinking, why you have some confidence about that?

MR PETERSEN: Imagine when the National Security Committee of cabinet meets, and they say, "We want to deploy 1,000 soldiers to Afghanistan in 2001, you know, or 2006." Kevin Rudd. We want to return our forces to Afghanistan. We're going to achieve this task. We're going to have this many people, this many planes, this many ships. Well, off our previous experience on a similar style operation, the ongoing cost per annum for our veteran rehabilitation and compensation system is this. That's just a factor to be factored into all the other costs, operational costs, that are already presented to government.

I think it's okay for government to say for us to go and do this, it's going to cost us X amount of dollars for the life of these veterans, and that's a higher cost and we're willing to pay that. We know that sending soldiers into combat will cost us X amount per veteran for the rest of their life. That is something that the government should know, and it's mind-boggling that they don't currently know that cost. How do we get to a point where you spend 12 or 13 billion dollars a year on healthcare but have no causation related to that? It's scandalous.

What would be much better would be to say we've considered all the costs in front of us, the loss of life, injuries, illness, the ongoing costs, and we still think that this is a great decision. I think that's something that government should be made available, and that's where the Minister of Defence Personnel and veterans in the Defence portfolio provides that

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advice to government. Just like the Minister for Defence Material currently provides advice to government that if you want to buy this submarine it's going to cost you this much money, and for the life of that system it's going to cost you this much to maintain every year. The fact the Minister of Personnel cannot do that, is outrageous.

COMMISSIONER FITZGERALD: All right. Thanks, David. Can I just go to the silver card proposal? Can you talk us through a little bit more about how you see that working? So we've currently got the Gold Card and the White Card, as you described earlier. So how would the Silver Card work?

MR PETERSEN: So my proposal – and noting that it is part of the RSL Victoria submission – the – I'm from Victoria.

COMMISSIONER FITZGERALD: Yes.

MR PETERSEN: I flew up for this. Noting the concept is if I develop a chronic health problem, which I'm likely to do – I have PTSD, that is well-proven to have chronic health condition effects on me in a physical sense, and my life expectancy is less as a result of that. When I turn 70 or receive the Gold Card through a process earlier, the government then takes full responsibility for my healthcare costs. And the government should be incentivising me to reduce my healthcare costs when I do receive that Gold Card, not because of the cost-saving measure; because it means I'm less sick. I'm less broken, I'm less ill.

That's what the Commonwealth is incentivised about really at the end of the day. So something like, I've got a sore shoulder, it's not really working quite well. Is it related to my service? Is it not? Maybe not. I carried a pack, walked lots of kilometres. You know, I've hurt my shoulder in the past. Maybe not, but when I get that Gold Card it becomes a Commonwealth problem. So surely they would be incentivised to reduce my pain and suffering now at 32, versus I wait until the day I get my Gold Card, and then go straight to the ortho, bang, you've got to pay for my healthcare costs.

So something like if they were to pay premium health insurance for me over my life, prior to receiving that – I already get free care for those conditions that are covered by the White Card, but for all those other healthcare costs, they would cover that. And that mirrors the system we have in place for the general community. The general community is if you want to have healthcare above and beyond that provided by Medicare, we provide it through self-funded private health insurance.

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Well, the government could fund a system like this. And, therefore, you know, I went to a GP and said, "My shoulder's not quite right. Is it or isn't it Defence-related? Don't know but let's look after it right now, here and now, so that it doesn't become a longer-term problem." So I would have some costs associated with that. I have no problem paying for my own healthcare. I currently pay for premium healthcare for myself and my family.

COMMISSIONER SPENCER: Right. So does that touch on an issue which we raised in an information request in our paper, and that was the co-contribution idea? And some people have said, "No, no, no, you know, the – it should all be fully paid for." But then we run into the other issue that people say, 'Yes, but the fee schedule that's out there means that you've got a card but you can't get the contribution." So we were looking at a co-contribution in terms of having choice.

So it comes back to an issue you're raising, and that is giving both responsibility and opportunity to the individual to determine, well, what – my service-related conditions are met but in terms of other healthcare needs I have, I will have choice about who I will go to and whether I will pay additional fees to go and see a specialist. In fact, we've heard some veterans and they do that already anyway.

MR PETERSEN: I do it already.

COMMISSIONER SPENCER: Yes.

MR PETERSEN: So I strongly and, you know, in my report or my submission I strongly support the current arrangements for the Gold Card. But Dr Khoo, who presented yesterday, from the Psychiatry College, you know, his point is 100 per cent factual. You know, people can't get into mental health and other health providers because the fee schedule is not sufficient. So there's no point throwing the baby out with the bathwater. The Gold Card and the White Card system is a very, very useful system, but the fee schedule needs to be increased.

However, for those who fall in between the bracket – so I will become eligible for the Gold Card, so you will be paying for my healthcare costs when I get the Gold Card, whether by age or earlier precedents, I should have some agency in how my healthcare goes in that period in between. So it's really targeting those middle grounds. Those who don't have, you know, the 50 – 40, 30 points towards permanent incapacity, who could then have some agency in how they actually went about and treated that. Surely it's going to save costs downstream, surely. The government

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already agrees that it does save costs downstream because it reduces the burden on the Medicare system.

COMMISSIONER FITZGERALD: Right. So, I mean, the whole direction of our report in relation to health issues and rehabilitation issues seems, in fact, to support your view, and that is that it is about health outcomes, improving the health and wellbeing of people, not simply waiting around to get a benefit. And, of course, the government recognise that in the introduction of the MRCA in 2004.

But the veteran community is deeply divided, as you know, in relation to those matters, but we take on board your view that it is actually – it's self-evidently true that if you can help people to remain well, that is good for them and it is good for the community. How we achieve that is now the great challenge. So, look, thank you very much for that, David, we appreciate that. And, as you say, that Silver Card proposal, just to be clear, is in fact the same Silver Card proposal we heard from RSL Victoria. Is that correct? Or your variation?

MR PETERSEN: I may have been involved in the consultation process at RSL Victoria. Check the dates on mine, and their submission.

COMMISSIONER FITZGERALD: No, that's all right.

MR PETERSEN: I'm in first.

COMMISSIONER FITZGERALD: Duly noted. Duly noted. Thank you very much for that. Good.

MR PETERSEN: Thank you.

COMMISSIONER FITZGERALD: If I could have John Heney. John, if you could give your full name and if you represent an organisation, the name of that?

MR HENEY: My name's John Heney. I live here in Southport on the Gold Coast, and I'm just an ex-veteran, you know.

COMMISSIONER FITZGERALD: So if you can just give us some of your key points you would like us to take into account?

MR HENEY: I joined the Navy in 1968. I suffered, like, mental and physical abuse in that period of time, in that 12 months. And back then, like, the Navy had like a code of silence where you were sort of threatened if you said anything, you know. And over the 49 years it has been since

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I've served in the Navy, I've had, like – I had an operation where we had a thing called the gauntlet, you know, that happened every week, over there in Leeuwin. And basically what happened, the culture over there was, like, the longer that you were in – served, like, as a junior recruit, okay, the more power you had.

So the other intakes that were in longer, they would pull this gauntlet every week, every – maybe twice a week, in the middle of the night, you know, and you had to run through that gauntlet. And they got their pillowcases full of hard stuff, like boots and irons and, you know, irons and stuff like that, and they'd smash it into you. And I copped a blow to the chest, my left chest. And went from Leeuwin to HMAS Watson to do a radar course, and a friend of mine advised me that I had to go see a doctor because the lump in my chest grew from, like, the size of a fingernail to the size of an orange, you know.

And they immediately, after – the day I finished the course, they transported me to hospital and cut it out. Now, that – when I was discharged from the Navy they said that – I was threatened that if anything was said about that or anything else that happened while I was serving, I would be brought back to face military consequences, you know. So for 49 years I kept my mouth shut and said nothing. Okay.

In the meantime, that 49 years, I had spasmodic pain every now and then in that particular area, and just recently I applied to DVA for compensation for that, and was – had mixed phone calls from DVA at that time, like welfare people would say, "You're under age and there won't be any problem," and it was like a rollercoaster ride. You know, like, you get excited and then the next minute you're down in the dumps, right, because in the end DVA knocked it back twice. And the other thing that happened – so I'm a bit lost as where to go now, you know what I mean?

So it's – you hear all this different information all over the place. And but the other thing that happened was that my first son was born disabled, you know. And I – back – that was in 1975, and basically he had heart – cardiovascular disease, and Down syndrome and all that sort of stuff. And I – the doctors in Melbourne that diagnosed his condition said that it came from one of us, me or my wife, you know. And I totally believe because there have been no history of that happening in her family or my family, ever, that it happened through some cause of serving in the Navy.

And what used to happen was we used to chip paint on the deck, you know, in front of high powered radio masts and stuff like that. And I've done a bit of research on it and that can affect, you know, chromosomes and that sort of stuff. And I'm at the point now where I don't know where

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to go. You know, like there's – like I've been knocked back twice for the first problem, and it's just like – and that leads to depression and all that sort of stuff. You know what I mean? So that's, yes, how it has happened.

COMMISSIONER FITZGERALD: Firstly, I should say that I'm very familiar with the abuse that occurred at Leeuwin, and I would imagine that the Defence Force no longer denies that such abuse occurred. It has been subject to multiple investigations, and there would have been a significant number of individuals who were injured as a consequence of sexual, physical and other abuse at that facility. So the question is not whether or not the abuse occurred at that facility but is DVA saying that related to you, you're unable to identify that your injuries or your illnesses today are related to that period of time?

MR HENEY: Yes. They said that – their final report, like, just a couple of months ago, like, when they denied the accountability was, like, that it's something to do with puberty, you know what I mean? And I don't believe that. I mean, that's like – we got smacked in the chest and that every second day, you know what I mean? So my thing is that, like the Navy can actually say whatever they want, whether it's true or not. You know what I mean?

COMMISSIONER FITZGERALD: When did you first put in your claim, John?

MR HENEY: Well, it started, like, two years ago.

COMMISSIONER FITZGERALD: So you waited a very long period of time before you put the claim in?

MR HENEY: Because of the threat of the Navy saying that, you know, you keep your mouth shut, you know. And it took me that long to find out whether my other recruit guys that I joined with, I didn't – we – you know, you just kept your mouth shut and you didn't say anything, you know.

COMMISSIONER FITZGERALD: And what changed for you two years ago?

MR HENEY: Well, Facebook, you know, like, it's talking to some guys that I – as – who I joined the Navy with 50 years ago, you know, and what – listened to their stories and all that sort of stuff, and then sort of woke up, you know, yes.

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COMMISSIONER FITZGERALD: And when you started to think about putting in a claim, did you contemplate getting an advocate or contacting one of the ESOs?

5 **MR HENEY:** Yes, I went – first of all, I went to a doctor and got an assessment from him, and then I went to the local advocate, you know, at Southport RSL, and just followed it up from there, you know.

COMMISSIONER FITZGERALD: But did you use an advocate
10 within the ESOs?

MR HENEY: Yes.

COMMISSIONER FITZGERALD: You have?

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MR HENEY: Yes.

COMMISSIONER FITZGERALD: And, I'm sorry, I may have missed it but who was the advocate? Which organisation?

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MR HENEY: Southport RSL.

COMMISSIONER FITZGERALD: Sorry, Southport RSL.

25 **MR HENEY:** Yes.

COMMISSIONER FITZGERALD: And has that advocate been of assistance to you, to be able to try and deal with these claims? Notwithstanding the fact that they've been denied, was that process
30 helpful to you?

MR HENEY: Yes. But one of the things I've said before, like, you know, like, being in the Navy, these advocates are Army, Air Force and stuff like that. So they basically left a few things out, do you know what I
35 mean? Like, do you know what I mean? Like, they didn't understand exactly what was going on.

COMMISSIONER FITZGERALD: So did anybody at the RSL or elsewhere sort of suggest you might go to, like, to the Naval Association
40 of Australia or something like that, that had a greater understanding of naval veterans?

MR HENEY: No.

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COMMISSIONER FITZGERALD: When you spoke to DVA, did you speak to DVA directly at any stage?

MR HENEY: Well, yes, I went to Broadbeach and that.

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COMMISSIONER FITZGERALD: Did they give you any advice as to who might be able to support you in putting the claim in?

MR HENEY: They – yes, well, what happened was that once it got
10 knocked back for the second time, I went to see the DVA at Broadbeach, and he suggested an advocate down at Currumbin, you know, who dealt with the – you know, the administrative tribunal, you know. And I went to see him, and he was an expert and that, and he said, "There's no point."

15 **COMMISSIONER FITZGERALD:** So he said there's no point?

MR HENEY: No point in doing it because I was just getting knocked back again, and it will cost you money.

20 **COMMISSIONER FITZGERALD:** And on what basis did he think that would happen or why did he think that would happen?

MR HENEY: Well, he said that he has had cases like that before where – see, what happened was, like, in 1970 there was legislation that came
25 through that said any time before 1970 you only had six months to claim some complaint, you know.

COMMISSIONER FITZGERALD: So did your advocate indicate to you that you had missed some form of time limit?

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MR HENEY: Yes. Yes.

COMMISSIONER FITZGERALD: We've heard about that by the Naval Association actually, just prior to lunch.

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COMMISSIONER SPENCER: John, you mentioned earlier how it's impacting on your own health and wellbeing at the moment. Have you – are you aware of Open Arms? Have you had a chance to access any support or services through Open Arms, the counselling service?

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MR HENEY: Yes, I went to – I went and saw them for three months, and then I'm still seeing them on and off now. But that – see, I'm under a shrink, like, a psychologist at the moment, only because with Open Arms they can't write a report. They're not allowed to write a report to submit

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that to DVA. Okay. That's why I'm going to a shrink at the moment because I get him to write a report and put in another claim.

COMMISSIONER FITZGERALD: Well, just in relation to that, have you been – are you eligible for a White Card?

MR HENEY: I've got a White Card, yes. That was based on the fact that, like, I did the hearing test and then they brought in the mental bit, you know.

COMMISSIONER FITZGERALD: So in relation to the – as you say, the mental bit, are you putting in a claim in relation to your mental health?

MR HENEY: I will, yes.

COMMISSIONER FITZGERALD: But you haven't put that in at the moment?

MR HENEY: Not at the moment.

COMMISSIONER FITZGERALD: The previous two claims you put in have been in relation to your physical illness or injuries?

MR HENEY: Yes.

COMMISSIONER FITZGERALD: That's all right.

MR HENEY: Which has had, like, an impact on my whole life really, you know, like work situations and stuff like that. Do you know what I mean? Like – yes.

COMMISSIONER FITZGERALD: Sure. I'm presuming that at the time you discharged from the Navy, did you discharge under a medical discharge regime, or did you just discharge voluntarily?

MR HENEY: Just voluntarily.

COMMISSIONER FITZGERALD: Would it be correct to say that at that time there was very little support in that transition for you?

MR HENEY: Nothing.

COMMISSIONER FITZGERALD: Can I just ask this, you lived in this sort of fear of whatever the Commander said to you about the ramifications of reporting this abuse.

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MR HENEY: Yes.

COMMISSIONER FITZGERALD: And I've heard that from many
5 people in another role that I've had. When you look back on that fear,
why do you think it lived with you for so long? Why do you think you
had that fear of some sort of retribution for over 40 years?

MR HENEY: Well, I mean, I joined when I was, like, 16 so I was still a
10 kid, you know.

COMMISSIONER FITZGERALD: Yes.

MR HENEY: Basically whatever the Navy said was true, you know. So
15 that threat at the end, like, okay, I get brought back and charged and stuff
like that, it meant something. You know what I mean? So it stuck with
me for that long, you know. It wasn't until I met, like, the other guys that
I joined with, online, that I woke up. It's like, you know what I mean,
like, so what they were saying and what they've done and all that sort of
20 stuff. And that's still happening today. You know, like, one guy will get
X amount of money, and the next guy will get nothing. You know what I
mean? So there's no – I think the trouble with DVA, there's no really
standard practice. You know what I mean? Like, they – I don't know.
It's just all over the place, you know.
25

COMMISSIONER FITZGERALD: Any other final points you would
like to make, John?

MR HENEY: Well, yes, that's basically it, you know. But, like, the
30 working conditions that we were on the ship, I definitely – like, from my
heart, think that that what's caused my son's, like, problems. And he died
back in 2003 because it was totally terminal. And the doctors said then
that any other kid would have – would be exactly the same. So, you
know, you think about what happened with the way, you know, the –
35 you're ordered to do work on the ship and stuff like that, anything could
happen, you know. You know, and because my son was going to, like, a
special school, you'd run into kids that were – who were agent orange
kids and all that sort of stuff, every day of the week, you know what I
mean? So, yes, you know, so the whole experience had basically a big
40 impact on my life, you know, like – you know, yes.

COMMISSIONER FITZGERALD: Sure.

MR HENEY: So I'm just hoping that some day it will change. I don't
45 know.

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COMMISSIONER FITZGERALD: Well, the whole report that we've put together, warts and all, are intended to bring about an improvement in the system for veterans.

5

MR HENEY: Yes.

COMMISSIONER FITZGERALD: That's the whole focus. But, as you would be aware, that everyone so far, whilst they disagree with many
10 of our recommendations, agree with the ultimate direction and the goals and objectives. And that's really about the wellness of veterans and their family members, in a way that perhaps was missing and certainly missing when you were at Lewin and subsequently were discharged. So thank you very much for sharing that story with us.

15

MR HENEY: Okay. Thank you.

COMMISSIONER FITZGERALD: Good. Do we have the representatives for the Australian Rehabilitation Providers Association?
20 A galaxy of stars. So you will just need to share those microphones. So can I just get your full names for the record, and the organisation that you represent.

MS KEYS: Sure. So I'm Jacqui Keys. I'm the Director of Work Rehab.
25 I'm also a council member for Queensland for the Australian Rehab Providers Association.

COMMISSIONER FITZGERALD: Good.

30 **MS BUNN:** I'm Julia Bunn. I'm representing Easec Proprietary Limited, an accredited rehab provider to DVA, and I'm also the Queensland Secretary for the Australian Rehab Providers Association.

COMMISSIONER FITZGERALD: Good.

35

MS ELLIS: Thank you. I'm Sue Ellis. I'm the National DVA Account Manager for Work Rehab. I also did three years as the ADF Account Manager for a previous company. And for what it's worth I'm also an ex-wife of someone who served 24 years in the military and was
40 administratively discharged but then subsequently went on and had several medical conditions, PTSD being one of them.

COMMISSIONER FITZGERALD: Good. Thank you.

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MR NELSON: Michael Nelson. I'm the Executive Manager at Work Rehab.

COMMISSIONER FITZGERALD: Good. So I'm not quite sure how
5 you're going to do this, but you've got about 15 minutes to give us some opening comments, and then we will have a conversation.

MS KEYS: We've prepared – the Australian Rehab Providers Association have prepared a summation of their submission, that I'm
10 happy to share with you now.

COMMISSIONER FITZGERALD: Sure.

MS KEYS: And then also on behalf of Work Rehab and EZEC, we've
15 prepared a short submission each. Are you happy if we provide those three, and then we can do questions? Would that make sense?

COMMISSIONER FITZGERALD: Yes, I've got those three. We've got those. But if you – whichever way you wish to do it, but you've got
20 about 15 minutes in that opening phase.

MS KEYS: Okay. So thank you for the opportunity to speak. We've introduced ourselves, so I won't go through that. The position of the Australian Rehabilitation Providers Association or ARPA – I will call it
25 the Association for today – is the industry voice for the Australian workplace rehabilitation industry, representing thousands of independent workplace rehab providers and allied health professionals. The Association believes that giving Defence members and veterans with injuries earlier and more targeted access to independent workplace rehab
30 services, is the best way to secure their safe, timely and sustainable recovery and return to meaningful life and work.

There are currently around 35 rehab providers working with DVA across the country, and this information was provided yesterday by the newly
35 appointed national stakeholder liaison within DVA. The Association is committed to improving the standard and quality of service within the rehab industry, and it's for this very reason that we believe we play a pivotal role to this inquiry and can provide coalface experience and recommendations for the future planning of veteran rehabilitation. We're
40 committed to the wellbeing and rehab of injured workers, and in this instance specifically to that of veterans.

We acknowledge that there are many positives about the current system, however, there are many areas for improvement. The draft report suggests
45 the workplace rehabilitation model as a potential model for veteran rehab

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in the future. And whilst there are many benefits to this model, there are also inherent risks. I won't go into those right now, but if you would like to ask questions I do have some points around that.

The Association agrees that Joint Transition Command has merit, however, this should not necessarily sit with Defence, and we recommend further exploration of the timely engagement model used by ADFRPs and DVA RPs in the transition period in Queensland. The ADFRP does not represent the full potential value that is possible given the resources and costs associated with the program. Further, it has been inappropriately grouped under the medical services delivery model for Garrison Health, which is overwhelmingly a medical model.

Workplace and vocational rehabilitation are best delivered by a psychosocial model. The ADFRP will be better placed outside of Garrison Health, to stand in its own right. Additionally, the decision to subcontract this to only one provider or two to four providers, has considerably eroded choice, quality and performance. The greater the variety of health service providers available, the greater the critical diversity available to ADF members. This should not detract from the government's views to maintain quality and performance.

Procurement models tend to be designed for the benefit of those managing the procurement, rather than the benefit of the client of the service. If we're serious about a veteran-centric model, then this should be underpinned in the procurement stage. The Association prefers a lifetime care, insurance or vocational rehabilitation model of claims management for veterans, rather than a worker's compensation model. What this looks like would require work, and it's highly recommended that rehab providers are included in that.

We support improved data collection and focus on measuring individual outcomes. Importantly, the system needs to have a greater reliance on rehabilitation providers to ensure that veterans are provided with the right support at the time right. In order to do this, the joint transition command and DVA or Veteran Services Commission need to have well-developed relationships with providers underpinned by performance data. With regard to the draft recommendations that relate to the rehabilitation industry, I will briefly mention those.

COMMISSIONER FITZGERALD: Sure.

MS KEYS: 6.1, the Association supports this. A person-centred model must have robust metrics and report on outcomes of rehabilitation. Recommendation 6.2, the Association supports this. While we support

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this, we do this with the following caution. The report infers that better outcomes are achieved by providers supporting serving members compared to the services received by veterans. And that other jurisdictions are streets ahead of DVA in terms of providing holistic and tailored rehabilitation services. It is the position of ARPA that this claim is difficult to determine in the absence of comparable data. We encourage caution with respect to claims around the direct correlation of scheme performance.

It should also be noted that all rehabilitation providers currently working on DVA rehab cases, must be Comcare accredited. That's not an easy feat, in itself, but it provides basic corporate governance. In addition to this, workplace rehabilitation providers who provide service to DVA – and this is a newly introduced scheme – must have all individual staff who are all qualified health professionals in their own right. Must undergo training provided by DVA by way of 11 online modules, which include topics such as understanding military life.

They are then approved by DVA to provide service. So the suggestion that little governance currently exists around rehabilitation with DVA service provision – yes, so currently a rehab provider working in the DVA space actually needs to meet more criteria than in other workplace rehabilitation jurisdictions. This has not always been the case. This is a new thing. Recommendation 6.3, the Association supports greater engagement with DVA and Defence, and the provision of evidence on treatment and client outcomes.

ARPA does not support the recommendation regarding the coordination of rehab services prior to and post discharge in its current form. The current interaction between ADFRP and DVA is underreported in the draft report, and requires further investigation. And, again, I refer to the timely engagement model, that has worked successfully in Queensland. The Association proposes that effective engagement of rehab services is outside the expertise of the functions proposed within the joint transition command, and should remain within the ADFRP and DVA, or VSC.

COMMISSIONER FITZGERALD: Okay.

MS KEYS: Draft recommendation 7.1, the recommended creation of a Joint Transition Command taskforce is supported, and the Association would like to have a presence on this, given our working knowledge. So, in summary, from ARPA our three key points are the relevance of rehab providers in improving outcomes for veterans, and recognising the good aspects of rehabilitation services that currently exist. The importance of having measurable and comparable outcomes as well as maintain

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standards to improve quality service. And the importance of DVA or VSC in coordinating the transition of veterans, as well as managing the post-discharge rehab services.

5 **COMMISSIONER FITZGERALD:** Good.

MS KEYS: So that's the voice of ARPA. Julia, would you like to - - -

MS BUNN: Thank you for this opportunity. I would like to commend
10 you on the research and work you've done so far. This is a very complex system that we work in. I hope my comments will be of some assistance to you in my field of expertise, which is rehab. I'm an occupational therapist, and I'm also the general manager of Easec. We're an accredited rehab provider and I've personally been involved in delivering rehab and
15 return to work services since 1997.

Easec is one of the accredited rehab providers to the DVA rehab program, and previously to the ADF rehab program. We are accredited with the heads of worker's comp authorities under the nationally consistent
20 approval framework for workplace rehab providers. We have experience delivering rehab services at the coalface to many different personal injury insurance systems. Today I intend to briefly summarise the key points from my submission.

25 We are in agreement that the current veterans' compensation and rehab system requires improvement, but whilst embracing the need for review and change, we caution against undoing the success and benefits of the current model. To achieve the goal of wellbeing for veterans over their lifetime, the Commission has recommended that the system needs to be
30 redesigned based on the best practice features of worker's comp, and contemporary social insurance schemes.

It's our belief that a worker's comp model, whilst delivering some of the intended benefits, is too narrow for a veterans' model, and fails to
35 incorporate other contemporary social insurance schemes, such as those found in the community and the disability services sector. We believe that a system that incorporates both an efficiency goal and a social welfare goal is more suited to the unique needs of the veteran population. And my submission provides further recommendation to you regarding the features
40 of a suitable veteran lifetime model.

My submission also provided detail on how rehab services are procured by DVA. The governance around who can provide rehab case management through DVA is strict and clear. The foundation for rehab
45 provider organisations is the Comcare model, which is a mature and well-

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developed accreditation system, with extensive governance and quality assurance requirements upon the organisation. In addition to this are extra measures set by DVA to ensure that the individuals working in our organisations are highly skilled and carry levels of expertise in working with veterans.

In our experience, the requirements of DVA rehab providers are more rigorous than many comparative worker's comp and life insurance rehabilitation systems. ADF rehab is a different model. In 2012 the ADFRP moved away from a workplace rehab model, to a medical management model delivered through the Garrison Health Services contract. This led to the program becoming process-based to meet efficiency goals.

The procurement process resulted in two rehab providers being awarded the ADFRP contracts through Medibank Health Solutions, without any open or competitive process. It's our belief that the current ADFRP service delivery model requires a qualitative review to move towards tailored and evidence-based interventions. We believe that the ADFRP needs to fall outside of the tendered Garrison Health Services, so that the service is managed under a best practice model for workplace rehabilitation.

Under this more suitable model a more diverse choice of rehab services would be available to the ADF as the employer, as is consistent with other contemporary worker's comp schemes. As rehab providers currently working in the DVA and ADF space are required to keep outcomes consistent with our Comcare accreditation, this includes keeping measures of return to work outcomes, cost, durations and durability, whether it be return to work with the pre-injury employer or new employer.

Customer and client measures are also kept. So that's under our Comcare accreditation, it's a requirement. As DVA takes a more holistic approach to rehab than worker's comp insurers, additional measures are currently kept to measure psychosocial outcomes, namely the goal attainment scale and life satisfaction indicators. In our experience DVA is one of the only personal injury compensation jurisdictions to utilise any form of psychosocial outcome measure.

This is innovative and it's to be commended. However, more work is needed to improve the validity and value derived from these outcomes. The DVA rehab providers, like ourselves, have collected this raw data regarding our rehab outcomes. With improved collection and analysis of this information within DVA, we could result in some relative quick wins

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in outcome measurement, and demonstration of the rehab success, which yourselves have noted is currently missing.

COMMISSIONER FITZGERALD: Sorry, we just have to be mindful of the time.

MS BUNN: Okay.

COMMISSIONER FITZGERALD: I know there's another presentation.

MS BUNN: I will speak finally just about transition and then conclude. Management of a member's transition out of the ADF is currently firmly in the hands of the ADF, specifically handled by the DCO, careers transition team. We recognise the potential disconnect between the ADFRP and the DVA rehab program. We recommend that the Commission further explores the timely engagement program which has been successfully providing an effective bridge between the ADF and the DVA for medically discharged members since 2014.

This program is essentially a simple handover of rehab responsibility from the ADF to DVA prior to discharge. This enables a seamless transition between the two rehab programs, and analysis showed improved outcomes and cost savings with this model. The ongoing development and support of this program on a national basis is urgently encouraged. So that program covers those individuals who are medically discharged from the ADF. However, there is a large unquantified group of members who discharged from the ADF through administrative or voluntary channels, who may also require legitimate access to rehab services at some point post discharge.

This group could be considered to have successfully transitioned out of the ADF and may have pre-existing compensable conditions which subsequently aggravate or deteriorate, or latent onset conditions which are not – which do not become apparent or important to the member until well after they have separated from the ADF. It is this group, some of who have spoken just before us today, who we believe require more assistance to access a pathway back into the DVA medical and rehab benefits they are entitled to, and which it is currently set up to cater for.

So, in conclusion, I believe the rehab and transition services currently provided by the ADF and DVA haven't been well-explained or adequately acknowledged in the submissions to the Commission to date. We are returning veterans back to productive lives and work every day. Through sufficient understanding throughout DVA, the ADF and the broader

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government of the rehab models currently used, and a lack of coordinated outcome reporting, the good work currently being provided to veterans has gone unnoticed.

5 Rehabilitating veterans through their lifetime is complex and unlike any other personal injury insurance system I know of. There is noticeable rapid reform taking place within the DVA rehab space, with clear goals and timeframes in line with your recommendations and those that have gone before you. We believe the goals of the Commission regarding
10 rehabilitation can be achieved by allowing the planned reform to the DVA rehab program to be continued and completed.

COMMISSIONER FITZGERALD: Okay.

15 **MS BUNN:** Thank you.

COMMISSIONER FITZGERALD: Have you another person presenting?

20 **MS KEYS:** I will be brief.

COMMISSIONER FITZGERALD: You will need to be brief because we do need to just raise some questions, so if you can just be quite brief.

25 **MS KEYS:** Yes, that's fine. Mine echoes basically the ARPA stance, and Julia's.

COMMISSIONER FITZGERALD: Just if you can move the microphone.

30

MS KEYS: So I'm an occupational therapist as well. My background is a degree in occupational therapy and psychology. I've worked with DVA for the last 10 years, and Work Rehab has worked with DVA for the last eight years. We have supported over 1,000 veterans into meaningful
35 employment and civilian life, and we're currently working with over 400 veterans. We're passionate about this and that's why we're here today. We would like to recognise the good work undertaken by DVA staff in recent years in reforming the system.

40 It does require change and we're happy to be part of that journey. And on that point it's also important to appreciate that since Liz Cosson has become Secretary of DVA there has been a real thrust towards improvement. I just want to acknowledge that. Most of the other points that I have, have been echoed through the ARPA submission and Julia,
45 herself. Yes.

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COMMISSIONER FITZGERALD: So, look, thank you very much for that. Can I just make a couple of comments. We've tried to look at the rehabilitation program both within ADF and DVA, and as you've indicated there, they're different both in terms of procurement and oversight. And so we have two very different models. You've indicated that you have a preference for the DVA model, vis-à-vis the one through the ADF. Can I just deal with ADF for one moment.

You mentioned the Medicare – sorry, Medibank Health Solutions contract. Is that – has the new Bupa contract replicated in broad terms what was in place with Medibank Health Solutions? That is that rehabilitation is part of this one single national contract. Is that correct?

MS BUNN: As far as we're aware. It's still very tightly held under commercial privilege.

COMMISSIONER FITZGERALD: Sure. Well, as far as any of us are aware, so, yes, that's right. Your view – could I just understand the central concern about that model, and I might say we are not in favour of that model, so I hope that became clear in the report. Nevertheless, the government has decided to pursue that agreement, and that agreement is now a contract. But can you just tell me the fundamental concerns you have in relation to the ADF's approach?

MS BUNN: I think the main difficulty with the ADFRP model is that in provision of workplace rehab in Defence, a member's rehabilitation is inextricably linked to their net classification. So it's linked to whether they're fit to deploy or not. So the ability for a workplace rehab provider to effectively implement change in the workplace or to modify work duties, is restricted because a member at the end of a rehab process is either medically fit to deploy or not. So I think that's the key issue related with the ADF model.

COMMISSIONER FITZGERALD: So is it the provision through one single provider who I presume then contracts a whole range of rehabilitation providers, or is it actually what is – is it the actual nature of rehabilitation and the way that is being - - -

MS BUNN: I think it's both.

MS KEYS: Yes, I think it's both as well. I think that there's – you're limiting the choice of the veteran. When one provider is providing all the service, I think it's very difficult, and it has already been proven that they don't have capacity. And from an industry perspective I think we see

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some new graduates that get thrown in the mix to try and provide service to veterans, and that's not good for anybody. And on the flip side, I think Julia is probably better placed to discussed the internal workings of Defence, but the model, itself, from an internal perspective I don't believe works.

I think we're talking about different outcomes really for the veteran. In the worker's compensation model you have the same employer and a new employer situation. So if you're trying to replicate that within Defence, I don't think it's going to work. You're also talking about the psychosocial aspects of the veteran which doesn't exist in a worker's compensation model either. And it also with the medical model, if that's what you're talking about, if it's the model that you're mentioning, they're two different aspects of rehabilitation as well.

COMMISSIONER FITZGERALD: So and if Michael or others wants to comment, just grab the microphone. I can't understand why it's not possible to have a psychosocial model as part of a worker's compensation scheme. Now, let me go back. Our approach is a lifetime model, a model of care and support that travels with the veteran and their families throughout their life. So we are not proposing a worker's compensation model. What we're trying to do is take the best elements of that and social insurance models, and say, how do you fit that within a military compensation scheme or a veteran support scheme, which is what we're calling it, which is in fact lifetime.

So we agree with you on that. We are not suggesting that you take the worker's compensation model which we understand is not the appropriate model. But – and I'm sure Richard will raise this – there are particular practices in that model which do apply and have some attraction to us. But can I come back to this issue. Why would the ADF not embrace a psychosocial approach within their rehabilitation, if that is now regarded as best practice for the wellbeing of a serving or, frankly, a non-serving veteran but in this case a serving veteran?

MS ELLIS: I can answer. So when I was working on the rehab for the ADF, the primary focus is to get the member back up to MEC 1, so they are deployable again. Their psychosocial needs and those needs of the family are not considered. It's only when they've already been deemed medically discharged by the review board. I know that that side of it just does not play out in reality.

COMMISSIONER FITZGERALD: But why is that? Because, again, I'm an outsider, I know nothing about this stuff, although we have had presentations in relation to bio psychosocial approaches in a previous

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hearing, so you're not the first group to raise that. But I just want to understand, from a layman's point of view, would it not be beneficial and would aid the serving personnel to return to duty if those sorts of issues were dealt with? Or am I – is there something that I'm missing in this?

MS ELLIS: No, I think that's absolutely spot on. The caveat there is that if they're not deployable, they are then deemed inappropriate to continue to serve. They don't have the scheme of suitable duties, or they do for a short time but if the member is unable to go from the three or two, and bounce back up to one, it's – you know, they're on a conveyor belt out. So – yes.

COMMISSIONER FITZGERALD: What's the nature of the rehabilitation services that are provided to a person that's on the way out? Does that then allow the rehabilitation provider to take a more holistic approach, including this bio psychosocial approach?

MS ELLIS: In my experience, the ultimate goal is returning to MEC 1.

COMMISSIONER FITZGERALD: Yes.

MS ELLIS: If that does not happen, it is deemed unsuccessful and that conveyor belt is just going, and there – my experience, it was a few years ago, was that all those other aspects were not embraced.

COMMISSIONER FITZGERALD: Even on the pathway to discharge?

MS ELLIS: Absolutely not. Absolutely not, no.

MS BUNN: Can I intervene there? I think that - - -

COMMISSIONER FITZGERALD: Just pull the microphone a little bit in front of you. Yes.

MS BUNN: When a member – it becomes clear that medical discharge is their pathway, the role of the ADFRP is to focus on assisted transition, and that primary is linking the member into the existing support services. Most of those are linking in with civilian medical services, linking in with the community services officered by Defence, through DCO, for example, and through ex-service organisations, and linking in with DVA and Comsuper. So that is the focus of the program, it is psychosocial. But the procurement model is so streamlined that it limits the amount of the psychosocial that's provided in that process.

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COMMISSIONER FITZGERALD: So in relation to the ADF, just for a moment, you're saying to us – and we will look at the submissions in much greater detail – that, in fact, it's – the two elements is the very nature of rehabilitation that is being provided, and the way in which it's being procured.

MS BUNN: Yes. Yes.

COMMISSIONER FITZGERALD: They're the two issues. The third thing, can I just ask, in relation to the ADF rehab, is it more – in one sense it's obviously more focused on a particular outcome, that is return to duty. We understand that. But is the data that's available to actually assess the outcomes, apart from whether a person does return to duty or not, is it adequate? Is it more comprehensive than DVA? And that's a question out of ignorance really.

MS BUNN: I don't believe it's more comprehensive than DVA, but at least what data they have is being captured and measured in some way. DVA's is yet to be captured and reported upon.

COMMISSIONER FITZGERALD: Sure.

MS BUNN: I think, though, that it's useless data. A return to work outcome measure is useless under the ADF, when that outcome is actually determined by a MEC review, not by the effectiveness of the rehab program.

COMMISSIONER FITZGERALD: And how would you do that differently?

MS BUNN: I think it needs to be brought back into the workplace rehabilitation model where the unit decides which rehab providers they use because they get to know the workplace. And they work directly with the rehab provider who is the conduit then back into the medical system and the treatment provision to get their worker back to work.

COMMISSIONER FITZGERALD: And just to be - just push this a little bit, why would it not be the case that the contractor to Garrison Health in the currently Medibank solutions or in the future Bupa, why would they not be able to do that?

MS BUNN: Potentially they could but I think it would be a different contracting model because it's not through the joint health services. It's not a health service, it's an employer workplace based service.

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COMMISSIONER FITZGERALD: Okay. Can I just move to transition and then Richard will obviously have some comments. I should say we had a round table in relation to rehabilitation prior to the draft. And I must say your interpretation of DVA's rehabilitation model is at odds with what we've heard from other providers. Not all other providers and I know you're the big body. But I just want to say that your presentation is very helpful because it sheds a different approach and a different light on it. But I just want to come to transition.

The timely engagement model to which you refer is it the model whereby responsibility or at least in relation to rehabilitation services is provided to DVA 30 days prior to discharge? Is that the model roughly?

MS BUNN: I haven't heard of it described like that.

COMMISSIONER FITZGERALD: So what's the - we had another proposal yesterday that I'll ask you to explain. When you refer to timely engagement model what are you referring to because I may have them confused.

MS ELLIS: Yes. So the timely engagement we've been working with DVA for probably the last six, seven years on the timely engagement and it works brilliantly. The 30 day, I haven't actually heard it called the 30 day, however it is about then that we get notified that someone is due to discharge. And at that point our consultants from the DVA side would actually liaise directly with the ADF rehab providers with the client in the middle and the three of us have - and it works really well.

COMMISSIONER FITZGERALD: So can I then clarify we believe that the transition authority would actually do exactly that. So the transition authority is not a rehabilitation provider. What its sole role is to make sure that a person that's in rehabilitation in the ADF or is in need of rehabilitation is found a provider under the DVA scheme.

MS ELLIS: Yes.

COMMISSIONER FITZGERALD: So it's a means by which you get a coordination across that period of time prior to and post-discharge. So from what you've just said I would have thought, and we'll think about this more fully, that a timely engagement model could well sit within that sort of transition arrangement. And the other thing I should say the transition command that we're looking at would, in fact, have and be manned by not only Defence but DVA, Comsuper and other types of personnel. So I think we've got to explain our model a little bit further.

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MS ELLIS: Could I just add - I probably gave the impression that I sort of didn't see much of the transition sell and experiences. That is because a lot of the members are incredibly ill with complex health issues and they're not able to participate in all these amazing workshops that are available. Certainly our companies are sort of known in the industry for dealing with complex case management. Between our two companies we've got nearly 1,000 cases across Australia.

COMMISSIONER FITZGERALD: Sure.

MS ELLIS: So the timely engagement works. The transition within ADF is a fantastic, fantastic thing if the member is well enough to access it. And we know through experience the vast majority aren't or they don't retain that information because they have significant illnesses and injuries.

COMMISSIONER FITZGERALD: So just before Richard asks a question one of the things we're looking at in the Joint Transition Command, and people have different views about what it should be called and that, is how long that service should be available. So that somebody might well discharge but at the moment once they've gone they can't come back into the Defence area. And our transition approach is to say you can access that for six to 12 months. But again I want to go back to it, there's no reason why a timely engagement model couldn't well sit within that.

MS BUNN: Yes.

MS ELLIS: And there's a fabulous story, I'm hogging the stuff here but I feel quite passionate about it, so the Australian Defence College also have for the 12 months from discharge the veteran is able to go back and actually access their RPL, so the recognition of prior learning. Because, as some of your previous speakers have indicated, that this has been quite difficult, if they have left the service for quite a while. So this is a free service for up to 12 months.

And then as providers we also have our contacts with the organisations who offer this privately. There's some fabulous organisations, I don't know if I'm allowed to mention the one that's linked particularly to the military and aligned services, that's CLET, the College of Law, Education, Training I believe that's called. And they offer a fabulous service, a very fast turnaround as well. So there are some services and even CTAS as well for training. So there are some wonderful opportunities and if the client's very unwell they can defer that 12 months for a further 12 months to be able to access. So there's some real good stuff out there, it's just about communicating that, and it's all being joined up.

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COMMISSIONER SPENCER: Now, look, thanks for that. And, look, Robert's covered I think most of the issues that we were curious about. So, look, I go back to that earlier comment that you made, that you felt we hadn't really appropriately recognised the good work that's underway and so - but, look, I'm struck by the fact that there's - I do have a sense of something special in Queensland. Because you're describing thinking and practice and exploring how this best works based on your experience of the systems that frankly we weren't hearing in other places. So not surprisingly I think it's probably a bit of a mixed report card at this stage but we do take the point that we haven't adequately reflected what's happening at the moment and potentially that we should definitely look at it.

So around the - so just to give a bit context to why we explore this notion of where should this sit, across the transition space, and we've been on many bases as you know and spoken to many people and you do find what I would describe in all aspects of transition bright spots, good things happening, which hold the potential. Quite often when we sort of look at that it's based on an individual or group of people who are providing leadership and champions of change. They're working across boundaries, divisions, whatever, and finding ways to make good things happen. So that's all terrific and I think we'd all applaud that. So obviously we're coming from is to look at but how do we make sure the system doesn't rely on good will and cooperation, so that when people change, you know, what remains and what continues. So that's why we focus on the structural issues about the joint transition command.

So a little bit to what Robert was saying. Just a very firm starting point in that and that is Defence is responsible. Because at the moment there's a lot of cooperation between DVA and Defence and that's terrific but we see that as a structural issue in the future as it has been in the past potentially. So, look, I think what's helpful to us, and it comes back to a point Robert was making is, how do we make sure about all of the transition issues, including rehabilitation, if that's the body where it sits, that it has the capability and expertise. So your submission's very helpful because if we do go down that path what we want to make sure is that that's a body that is fit for those roles and can perform those roles but it's somewhere else at the moment.

So coming back to the timely engagement model, you've indicated that could be rolled out, it hasn't been rolled out. What's the current status of that as far you know from DVA's point of view?

MS BUNN: It's ongoing certainly in Queensland. It's become the norm, so it's no longer even called the timely engagement model. It's to the

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point where it's been piloted, the outcomes have been reported on, and it was due to be rolled out nationally. But anecdotally we've heard that it hasn't effectively been rolled out outside of Queensland.

5 **COMMISSIONER SPENCER:** Do you hear anything about why that might be the case? Because it seems to be more a way of working rather than a costly sort of next step, so it's about people's behaviour and working across the boundaries.

10 **MS BUNN:** Yes, it's well entrenched in that there are, you know, Defence forms called - - -

MS ELLIS: Section 369 I believe.

15 **MS BUNN:** Yes, section 369 transfer of rehabilitation, which is the legal transfer of responsibility, if you like. So it's down to that level of detail and it's just being used as the normal process in Queensland.

COMMISSIONER SPENCER: Yes. But elsewhere I mean, you know,
20 you're reflecting to us, you know, high levels of cooperation.

MS BUNN: Yes.

COMMISSIONER SPENCER: And sort of an entrenched practice
25 now. But elsewhere if you speak to other colleagues - - -

MS BUNN: Could I just - - -

MS ELLIS: No.

30

MS BUNN: Yes, so I spent 18 months in New South Wales after working in the system in Queensland directly after the pilot and even within DVA it was to remain in Queensland. So New South Wales were not aware of this, which was incredibly frustrating because we were having such good
35 success. And our offices are based quite close to some of the bases in New South Wales. So I can't definitively answer why. Even speaking with DVA yesterday the official term timely engagement program is not used. We know that it's simply triggered by the form but as to why I can't provide a clear answer.

40

COMMISSIONER SPENCER: Okay.

MS BUNN: And there was the communication out in October that there has been perhaps a miscommunication and come October last year timely
45 engagement is no more. But there has been an interesting tender that our

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two companies were successful and the case management program it's been renamed WASP, the Wellbeing and Support Program, of which both our companies have clients. One of the referral silos is representing the timely engagement model, which is wonderful. I don't think either of our companies have seen any of those referrals come through. They seem to be more the chronic incredibly ill people. But, yes, so the take is that timely engagement is actually on pause right now.

COMMISSIONER SPENCER: No, I was just going to say just when we believe we understand all acronyms we get a new one. So WASP I noticed that in one of - - -

MS ELLIS: Yes, yes.

COMMISSIONER SPENCER: - - - (indistinct).

MS BUNN: That's the third term.

MS ELLIS: Term in (indistinct).

COMMISSIONER FITZGERALD: Well, DVA is not short of pilots and new terms. They've changed multiple times even in the life of our inquiry. I want to go back to a couple of - just to points, if I can. One of the issues that I think is a problem in the DVA system, but you may say I'm wrong on this, is we can't get any sense that DVA itself understands the outcomes that are being achieved within the rehabilitation service area.

MS BUNN: I think you're absolutely correct.

COMMISSIONER FITZGERALD: So you said to us that through your accreditation you're required to not only have a stringent, you know, and detailed reporting of particular outcomes. And then you said to us that DVA, I understood from you, imposes additional ones and you thought that that was good. But when we've actually got the DVA and other groups the overwhelming sense is they have almost no idea of what the cumulative outcomes are of the whole rehabilitation program and you've disagreed with that.

Now, how is this possible? Because going back to the workers' compensation area we don't see that at all. Workers' compensation providers both government and non-government organisations are one of the key things for them is to actually understand what's happening in terms of outcomes for their clients. Some would say that's driven by money but I would hope to think that it's actually driven by (indistinct).

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But put that aside DVA stands alone in that absence of understanding outcomes. So why is that the case in 2019?

MS BUNN: As a provider to many different compensation systems we're used to keeping that data, recording it, and providing it to the insurer in the method that they request. We do that for DVA as well, we're just not asked to provide it. It's provided on a case by case in closure reports. So we can look at a closure report for a client we've had on a rehab plan for a year and show what their life satisfaction scores were at the beginning of the program, at six months through the program, and at the closure of the program. But I don't believe that data is then - - -

MS ELLIS: Captured and collated.

MS BUNN: - - - captured and collated within DVA. We try individually to report it through to DVA but I don't believe it's then utilised.

MS ELLIS: So on the DVA rehab plans they've got something called goal attainment scoring. You may have heard of that, that is - - -

COMMISSIONER FITZGERALD: Yes, we have.

MS ELLIS: - - - their metrics for capturing positive or neutral goals and outcomes I should say. However, currently a lot of these plans are preset and the goals are set, the activities are set. There is very little room for individuality to demonstrate that whole person approach. And it is very hard to put especially on a psychosocial rehabilitation to actually say this person has got a zero outcome or a plus two.

So as a company, and I'm sure Julia does the same, we have actually spent a lot of time collating the positive outcomes such as, you know, I'm trying to think of an example now, but (indistinct), you know, just family relations.

MS BUNN: Community engagement.

MS ELLIS: Thank you. Community engagement. And then what we would do is we would go in every quarter and provide sort of this united this is what as a team as an external provider but as the delegates together we have achieved this. And there are some amazing, amazing results. Not only the return to work.

COMMISSIONER FITZGERALD: Sure.

MS ELLIS: So it's those qualitative - yes.

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COMMISSIONER FITZGERALD: Michael?

MR NELSON: So just based on my sort of 18 years' experience in the Commonwealth public service I'd suggest to you it's probably because the government hasn't actually asked for it. So what you'll generally get is departments providing information and reporting on things that government asks them to. Where that's not been asked then they're unlikely to probably provide that information.

COMMISSIONER FITZGERALD: But would it be - I mean I understand the rehabilitation scheme in relation to DVA is about a $40 million arrangement. It's not a huge budget but it's not an insignificant budget. I would have thought that any department that is procuring services to the extent of that would want to know whether or not it's actually delivering outcomes beyond the forums and the focus groups and all of those sorts of things.

So whilst you're probably right, and I'm not disagreeing with that, it seems extraordinary to me that you would not want to know whether or not the money is actually achieving outcomes for veterans as well as being good value for money I might just add.

MS KEYS: Can I comment there as well?

COMMISSIONER FITZGERALD: Sure.

MS KEYS: Because I think one of our frustrations as providers, yes, we believe DVA has done a lot of good work in the last few years compared to when I first started working in the scheme. In saying that one of our frustrations is the disparity amongst States. So there are three rehab officers, if you like, that refer to - there's Brisbane, Perth and Adelaide. They all work differently. So as a company we're required to manage different forms for different plans, there are different approvals. So we have to actually train our staff in these different States differently.

Yes, they have just introduced the training modules but there is - the synchronicity is not there. They're also not under a current tender, so we just simply provide service as a provider. There is no contractual arrangement between my business and the department. So we're not required to metrics. We do, we provide qualitative data, outcomes, that can be put into - - -

COMMISSIONER FITZGERALD: Sure.

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MS KEYS: - - - newsletters because we want to sing the successes of the veterans that we help rehabilitate. But you're absolutely right, there are no metrics in there and there's no consistency either.

5 **COMMISSIONER FITZGERALD:** And you've made that point in the earlier - so thank you for that. Do you have any - - -

COMMISSIONER SPENCER: There was just the issue of consumer direct care. I mean that's perhaps more relevant in other areas other than 10 rehabilitation. But I take it from - I've forgotten which submission it was that you think interesting idea but that would need to be looked at, it may have limited application. And, in fact, if I understand correctly if the rehabilitation activities were more in line with what we've been talking about there may be less need for a consumer director care model.

15

But do you have any just quick comments on that as to where some choice of control can come in? Because it strikes me that the (indistinct) like a social model, that you're trying to empower the individual as well as to their own wellbeing and therefore some sort of choice of control through 20 that process seems to have potential. But how do you view that?

MS BUNN: I've got fairly limited comment to make. I've seen it used in other similar systems where a user or an injured individual maybe provided with a choice of three providers and they can go to their website 25 and see who they like and choose them, you know, according to that process.

I've also seen the systems where an injured person can choose a treatment service regardless of whether it's been recommended medically or not. 30 And I question whether that has - how useful that can be based on demonstration of outcomes. So there needs to be I think some level of rigour around the range of providers who are offered whilst then still offering the injured worker, injured person an opportunity for choice.

35 **COMMISSIONER SPENCER:** Right. And there's professional judgments obviously in there that needs to be made by somebody I mean other than the individual, so I guess it's a question of whether within the various treatment options are there choices that are available. I don't know but that's the issue I'm thinking about.

40

COMMISSIONER FITZGERALD: You made a reference to directing us away from a strict version of a workers' compensation arrangement and you mentioned the NDIS. And Richard did a study on the NDIS for the Productivity Commission last year, year before. And so we're fairly 45 familiar with the NDIS but I was just wondering were there any particular

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learnings out of the NDIS or traps that you might just want to alert us to? Now, we are not proposing an NDIS model.

MS BUNN: No.

COMMISSIONER FITZGERALD: But I'm just wondering whether you have any particulate insights.

MS KEYS: I'm not familiar with the NDIS.

MS BUNN: No, I can't comment.

MS KEYS: (Indistinct) submission, yes.

MR NELSON: Like all of these big changes or programs I think the key is in the implementation. So I think any of the issues that have been experienced in the Commonwealth and other areas with NDIS all have been around implementation. So I would suggest that good ideas can fail quite quickly, if not implemented properly.

COMMISSIONER FITZGERALD: No, that's correct. Is there any final very short comments you wish to make and then we'll conclude?

MS KEYS: I think just from the association and from myself we applaud what's being done here. And in essence we've supported most of the recommendations where there are just a few cautions based on our experience working across different schemes as to what would work well. But at the end of the day I think the goal is for the wellbeing of the veteran and a robust scheme that has metrics and data to manage performance around it.

COMMISSIONER FITZGERALD: All right, thank you. And we'll probably be back in touch with your association as we go a little bit further down looking at those rehabilitations. So thank you very much for your collective efforts and - - -

MS ELLIS: Thank you.

COMMISSIONER FITZGERALD: - - - we appreciate that a great deal.

That concludes our formal presentations but if there is anybody in the audience that would like to make a brief presentation now is the opportunity to do so. So is there anybody that would like to make a short

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personal statement? Yes, please. Just pull the microphone a little bit closer to you.

MS MOUNTFORD: Yes.

COMMISSIONER FITZGERALD: That's it, terrific. If you could give me your full name and the name of an organisation, if you represent one.

MS MOUNTFORD: I'm Rosemary Mountford, I work at Redcliffe RSL but I am not representing them and I want to make that definitely clear.

COMMISSIONER FITZGERALD: That's fine, Rosemary.

MS MOUNTFORD: I'm an advocate and a welfare officer and I work directly with veterans each day. I work fulltime there. And some of the stuff I've heard over the last two days and especially today in reality at the coal face we don't see that. The veterans are not seeing it. And I see some really bad cases on basically a daily base.

So what is the veteran? He starts out as 17, maybe 20 year-old very fit, very robust otherwise he's not in the services. He goes in there, he's trained, trained to do a job that he has been employed to do. In that process, in that first initial process, it's set - and I'll say I've been through the process, I have served, so I do understand. They attempt to break you in that first few - couple of months to see whether you're going to be fit for service. It is a process. And the ones who do get through and are not fit for service are quickly weeded out.

Then you go on and it's almost like a Stockholm Syndrome. You are taught not to question and you're taught to like the person that is abusive to you. And Stockholm Syndrome is the closest thing that I can ever relate that to. So these soldiers become dependent on the people above them to care for their needs and express what their belief is. They're not allowed to have an opinion. They are a soldier.

And this is the thing that sets aside Australian soldiers because we are very good at following orders and being able to go into battle and achieve. They are very well trained. That is the purpose of an Army. Our Army also works in Defence of our country but also in the support of disaster. And this is a big thing that is not recognised. The people who are in disaster relief or peacekeeping their service is diminished and not accepted, that they received injuries in those times.

And especially the boys from Banda Aceh. Horrendous, absolutely horrendous injuries there but that was just, you know, something, disaster

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relief, not accepted. So we have this whole thing of they've had to be fit for readiness but some of them get broken in that process but they're so proud they would never say they are broken. And even now they'll come in, they can't sit still, they can't sit in a chair. And you'll say "Are you okay?" "Yeah". And then they'll say "I want to get back into the forces". You're broken. Wait.

A lot of these people are the old dogs and the old salts who are wanting to share the pain that they went through and how they were treated, which was an old guard system. And we still have some of those people in without the new thought processes. So to put in a claim a veteran has to have the evidence and quite often their medical documents are lost. I've got a guy who's missing 15 years of his med docs when he was most damaged. They don't know where they are.

So you've got this whole process. Now, if we're lucky enough to have that, then they've then - we've got to prove that it was treated in the Army, it was diagnosed in the Army but then DVA say, no, it's not related to service. Where is it? Then they have to go through proving it for incapacity. Then they have to go to another doctor to prove that permanent impairment. Then they have to go through another medical examination for CSC. They won't use the same report. I have one fellow he had 80 reports on his psych and they won't accept any of them because they're so different. We have people who are being treated by psychs for up to 10 years, they're sent to an independent one for DVA. They spend an hour with them, no, it can't be that, it's gone.

Same as with orthopaedic surgeons. They might have had multiple operations with an orthopod but the one independent person knocks it on the head and say can't have been because of service. So there's got to be some change in the future in how we approach this. If they have one report and all three share it but even with the three acts. If you've got people who've served from '74 to today they come under the three acts and the three acts don't share the reports. They've got to have - each one has got to have it. It's crazy.

In the English model they actually keep them in until they are fit for civilian life and training them and they pay them to be a soldier until they can be a civilian. So that could be something that we have. I've heard a lot about families and they're talking about the soldier or the sailor or the airman and always referring to them male. We also have a lot of females. And so we've got to look at this new guard that's coming in.

We need to look at - that there are a lot of men and women who are coming back that are very damaged and can't support the family but they

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also can't support the household services that are needed to do but they expect the wife or husband to go out and earn a living, then come home at night and do all the housework as well. So where is the quality in their lives? It's not there. If it's a female they will provide household services for them. If it's a male that's stepping into that role because his wife is having to work out, she is expected to come home, mow the lawn, do all the housework, and do the shopping. But if it's a female that's been broken that's all provided for her. So there's a lot of disparity between sexes where we shouldn't have that.

The men the only ones they get is washing the windows, cleaning the fans, and mowing the lawns. God forbid I wish they would.

COMMISSIONER FITZGERALD: We've only just got a couple of minutes.

MS MOUNTFORD: Yes.

COMMISSIONER FITZGERALD: (Indistinct), please.

MS MOUNTFORD: Yes, yes. So vets at the moment are working towards getting that Gold Card and so they are getting more and more broken and proving how broken they are rather than having a system that works towards getting them better. Rewarding them for engaging and becoming better, the best that they can be even in their brokenness. And I'll finish with that we need to give them a light to work towards rather than a goal to work towards.

I had one yesterday and he can't be engaged because of the extreme nature of his conditions. And the rehab have cut him off and said there is no more rehab that we can engage him with, so that means his PI does not exist. So we need to change this model in the future, so that we can reward rather than they have to be broken to change.

COMMISSIONER FITZGERALD: Thank you very much. And firstly, thank you for having been here the day and a half or the two days, I appreciate that. And we very much hear the sentiments that you've made. I mean our scheme that we're proposing is very much about people trying to move to wellness, if that is possible. And the issue in relation to health cards and we're trying to look at in that context. Its not an attack on the gold card system, which some people think it is. It's actually to say can we have a system that adequately recognises people's service but also has people on a wellness pathway where that is appropriate. But I must say that's proving to be very challenging but we appreciate it.

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And the second thing we're very conscious of - I think the figure at the moment is about 17 per cent of those who've served within our ADF are, in fact, females. So the number of female veterans is growing and their particular needs and aspirations have to be identified and so thank you for
5 raising that issue. So thank you very much for that.

MS MOUNTFORD: Thank you.

COMMISSIONER FITZGERALD: That's terrific. Good, thanks.
10 Anybody would like to make a final comment? Going, going, gone. So it's my duty to just simply adjourn the public hearing until it resumes tomorrow in Townsville. So again, thank you for those that have been with us over the last couple of days and it's been very valuable and very helpful to the Commission. Than you very much.
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MATTER ADJOURNED AT 2.44 pm
UNTIL FRIDAY, 1 MARCH 2019

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