Rod Thompson
Advocate Level 4

Dear Members,

As time is short and we all have other commitments, there will be a significant amount of information overload so I intend where possible to simplify the issues and then later apply the appropriate legislative language with the input of the members.

Sadly, DVA have provided us with ONE DAY to discuss the complexities of the VEA, SRCA/DRCA, MRCA and the Comsuper implications. The first order of business was to engage with the VVFA to ensure we have a united block at the forum. This has been done and it appears the VVFA and ADSO are on the same page in regard the one-day forum they agree that the agenda proposed by DVA is a joke, it is quite clear that DVA currently have no interest is listening as indicated by the attached agenda they are doing all the talking.

Item 1. Ensuring that all ESO's and groups involved are if at all possible on the same page – Allan

Item 2. Identifying areas of legislation that are problematic or ambiguous in nature

Item 3. Establishing a framework based on the VEA to effectively amalgamate all 4 legislations' in a practical and cost-effective manner.

Example Section 199 MRCA and associated sections pertaining to SRDP or MRCA TPI

Amending and incorporating areas of 199 MRCA and S24 VEA will provide a template for caring for significantly disabled veterans through all stages of life. Suggested formula to incorporate aspects of MRCA section 199 into Section 24 (1) (c). The alone clause can be fairly and simply addressed in line with case law and the beneficial provisions pertaining to the VEA.

1. If a veteran has significant impairment from non-service related injuries a GARP assessment should be undertaken on the non-accepted conditions alone, and if that assessment places the non-accepted condition at 70% GR under GARP 5 using the lifestyle rating applied to the veteran at his / her most recent PI assessment. Then it should be taken that s24 (1) (c) is not met if the non-accepted condition is assessed at more than 70% of the general rate indicating it of itself would legislatively be considered to be of itself alone preventing the veteran undertaking remunerative work as defined at s24 1 (a) (i) & (b). A veteran who fails at s24 may be considered under S22 (3) (b) if the age factor was removed

2. The 8 hour test s24 (1) (b) VEA should be amended in line with section 199 (1) (d) MRCA increasing work capability from 8 hours to 10 hours per week.

3. The age restriction at 65 at s24 (1) (aab) should be raised to 70.

4. If a veteran is medically discharged for any illness or injuries noted on the final medical board it should be said that liability under the legislation has been established for those noted conditions. Claims for un noted conditions / sequella conditions should be considered under the current claims processing system.

5. Subsequent to 4 above if that veteran is deemed by those noted / accepted conditions to be at 50 MRCA / 70 VEA /50 WPI SRCA / DRCA the veteran should be offered under section 25 VEA Temporary Payment Special Rate for the first 12 months post discharge with a comprehensive assessment from his / her treating specialists to be undertaken approximately 12 months post discharge for reassessment and rehabilitation recommendations and reports (medical only).

6. To enable the MRCA Rehabilitation Element which is far stronger than that of the VEA it is suggested that MRCA Chapter 3 Rehabilitation sections 37-53 (pages 16-26) replace Instrument 2015 No. R11 - Veterans Vocational Rehabilitation Scheme (VVRS) **page 26 with link.**

7. Providing the provision for lump sum payments under the VEA. The ability for a lump sum pension advance already exists - VEA The advance payment eligible amount is the sum of the maximum basic rate of service pension that applies to the person (i.e. single, partnered, illness separated) and the amount (if any) by which the person's pension supplement exceeds the minimum pension supplement amount. For people not receiving a service pension this is calculated as if they were receiving the pension. This can simply be amended and extended to enable the advance of Pension at a % or the whole amount of the awarded percentage of the general rate of pension.

   Examples: Veteran aged 40 is assessed at 100 % of the general rate VEA receives **$488.40** per fortnight = **$12,698.40** per annum which would equate to if multiplied out to retirement age 70 a lump sum figure of **$380,952** with the pension returning at the deemed retirement age as a tax-free pension. This is also cost neutral as the 100% of the general rate would have to be paid in any circumstances. As this is part of an existing compensation arrangement the acuity tables will not be required.

- 199 Persons who are eligible to make a choice under this Part

(1) A person is eligible to make a choice under this Part if the Commission is satisfied that the person meets the following criteria (the eligibility criteria):

(a) at least one of the following applies:

(i) the person is receiving compensation worked out under Division 2 of Part 4 as a result of one or more service injuries or diseases;

(ii) the amount, under section 126, of the person's compensation for a week, as a result of one or more service injuries or diseases, is nil or a negative amount;

(iii) the person has been paid a lump sum under section 138 in respect of the person's incapacity for work as a result of one or more service injuries or diseases;

(b) as a result of the injuries or diseases, the person has suffered an impairment that is likely to continue indefinitely;

(c) the Commission has determined under Part 2 that the person's impairment constitutes at least 50 impairment points;

(d) the person is unable to undertake remunerative work for more than 10 hours per week, and rehabilitation is unlikely to increase the person's capacity to undertake remunerative work.

(2) The Commission must, as soon as practicable after becoming satisfied that a person meets the eligibility criteria, make the person a written offer of a choice under this Part. The offer must specify the date on which the offer is made.

200 Choice to receive Special Rate Disability Pension

(1) A person who is offered the choice under this Division can choose to receive a Special Rate Disability Pension instead of compensation worked out under Division 2 of Part 4.

(2) A person who makes the choice cannot change it.

(3) However, a person to whom the Commonwealth is no longer liable to pay a Special Rate Disability Pension under section 209 is taken not to have chosen to receive the Pension.

Note: This means that the person might still be entitled to compensation worked out under Division 2 of Part 4 or under the Return to Work Scheme in section 210.

201 When the choice is to be made

(1) A person who is offered the choice under this Part and who wishes to make the choice must do so within 12 months after the date on which the offer was made.

(2) The Commission may, either before or after the end of that period, extend the period within which the person must make the choice if the Commission is satisfied that:

(a) there was a delay in the person receiving the offer under subsection 199(2); or

(b) the person did not receive the offer.

202 Other requirements for the choice

(1) The Commission may, in writing, approve a form for the purposes of this section.

(2) A person must make the choice in writing in accordance with the form.

(3) Before making the choice, the person must obtain financial advice from a suitably qualified financial adviser in respect of the choice.

Note: The person might be entitled to compensation for the cost of the financial advice under section 205.

203 Determinations by Commission

(1) The Commission must determine that the Commonwealth is liable to pay a Special Rate Disability Pension to a person instead of compensation worked out under Division 2 of Part 4 if:

(a) the person is offered the choice under this Part; and

(b) the person makes the choice to receive the pension within the period applicable under section 201 and in accordance with section 202; and

(c) the Commission is satisfied that the person meets the eligibility criteria on the day on which the person makes the choice.

(2) The Commission must determine that a person is to continue to receive compensation worked out under Division 2 of Part 4 if:

(a) the person is offered a choice under this Part; and

(b) either:

(i) the person does not make the choice within the period applicable under section 201 and in accordance with section 202; or

(ii) the Commission is satisfied that the person does not meet the eligibility criteria on the day on which the person makes the choice.

(3) If the Commission makes a determination under subsection (1) in relation to a person, a Special Rate Disability Pension is payable to the person instead of compensation worked out under Division 2 of Part 4 from the day on which the Commission becomes aware of the person's choice.

204 Offsets

(1) The maximum weekly amount of a Special Rate Disability Pension that could be payable to a person is reduced in accordance with this section.

Permanent impairment compensation

(2) There is a reduction that is made by reference to amounts payable or paid to the person under Part 2 (permanent impairment). However, a payment received for eligible young

persons, financial advice, legal advice or energy supplement under that Part does not reduce the maximum weekly amount of Special Rate Disability Pension that could be payable to the person.

(3) The maximum weekly amount of a Special Rate Disability Pension that could be payable to a person is reduced by the sum of:

(a) any weekly amounts that are being paid to the person under Part 2; and

(b) if the person has chosen to convert all or part of one or more weekly amounts that were payable to the person under that Part to lump sums—those weekly amounts or those parts of those weekly amounts.

(4) Subsection (3) applies to a person to whom section 389 or 402 applies as if the person were being paid the weekly amounts under Part 2 that the person would be paid if that section did not apply to the person.

Note: Section 389 provides that compensation under Part 2 is not payable to a person who chooses to institute proceedings for damages against the Commonwealth. Under section 402, compensation under this Act is not payable to a person who recovers damages from a third party.

Commonwealth superannuation

(5) There is a reduction if the person:

(a) has retired voluntarily, or has been compulsorily retired, from his or her work; and

(b) receives either or both a pension or lump sum under a Commonwealth superannuation scheme as a result of the retirement.

(6) The amount of the reduction under subsection (5) is 60% of the reduction that would apply to the person under section 134, 135 or 136 if the person were receiving compensation worked out under Division 2 of Part 4.

Relationship with subsection 415(4)

(7) This section does not limit the application of subsection 415(4) in relation to a Special Rate Disability Pension.

Note: Subsection (7) has the effect that if the maximum weekly amount of a Special Rate Disability Pension is reduced in accordance with this section, that amount may be further reduced in accordance with subsection 415(4).

204A Overpayment if payment of lump sum under section 138

(1) This section applies if the Commission makes a determination under subsection 203(1) in relation to a person where subparagraph 199(1)(a)(iii) applies.

(2) An amount, equal to so much of the lump sum under section 138 as is worked out in accordance with a legislative instrument made by the Commission under this subsection, is taken to be an amount of compensation that should not have been paid to the person.

Note 1: Section 415 allows the Commission to recover that amount as a debt due to the Commonwealth and allows that amount to be deducted from an amount that is payable under this Act.

Note 2: Section 1228 of the Social Security Act 1991 provides that amount is recoverable under that Act by means of deductions from payments under that Act.

Note 3: Section 205 of the Veterans' Entitlements Act 1986 provides that amount is recoverable under that Act by means of deductions from payments under that Act.

205 Compensation for cost of financial advice and legal advice

Financial advice

(1) The Commonwealth is liable to pay compensation for the cost of financial advice obtained by a person if:

(a) the person obtains financial advice from a suitably qualified financial adviser as mentioned in subsection 202(3); and

(b) a claim for compensation in respect of the person has been made under section 319.

Legal advice

(2) The Commonwealth is liable to pay compensation for the cost of legal advice obtained by a person if:

(a) the legal advice was obtained from a practising lawyer; and

(b) the legal advice was obtained in respect of the choice the person may make under this Part; and

(c) a claim for compensation in respect of the person has been made under section 319.

206 Amount of financial advice and legal advice compensation

Financial advice

(1) The Commission must determine the amount of compensation under subsection 205(1) for the cost of the financial advice that it considers reasonable.

Legal advice

(2) The Commission must determine the amount of compensation under subsection 205(2) for the cost of the legal advice that it considers reasonable.

Limit

(3) The sum of the total amount of compensation under subsections 205(1) and (2) in respect of the person must not exceed $2,400.

Note: The amount of $2,400 is indexed under section 404.

(4) The amount of $2,400 applies both to financial advice and legal advice under this Part and financial advice and legal advice under Part 2 if the day on which the offer under this Part was made, and the day specified in the first notice given to the person under section 76, are the same.

207 Whom the compensation is payable to

(1) Compensation under section 205 for the cost of financial advice or legal advice is payable to:

(a) the person who made the claim for compensation; or

(b) if that person so directs:

(i) the person who gave the advice; or

(ii) any other person who incurred the cost of the advice.

Note: A special rule applies if a trustee is appointed under section 432.

(2) An amount paid to the person who gave the advice discharges any liability of any other person for the cost of the advice to the extent of the payment.

208 Persons who are imprisoned

The Commonwealth is not liable to pay a Special Rate Disability Pension to a person for any period during which the person is imprisoned in connection with his or her conviction of an offence.

209 Ceasing to meet certain criteria

The Commonwealth is no longer liable to pay a Special Rate Disability Pension to a person if the Commission is satisfied that:

(a) the person's impairment as a result of all of the service injuries or diseases from which the person suffers constitutes fewer than 50 impairment points; or

(b) the person is able to undertake remunerative work for more than 10 hours per week.

209A Energy supplement for Special Rate Disability Pension

(1) The Commonwealth is liable to pay an energy supplement to a person for a day if:

(a) Special Rate Disability Pension:

(i) is payable to the person for the day; or

(ii) would be payable to the person for the day apart from section 204 and paragraph 398(3)(b); and

(b) the person resides in Australia on the day; and

(c) on the day the person either:

(i) is in Australia; or

(ii) is temporarily absent from Australia and has been so for a continuous period not exceeding 6 weeks.

Note: Section 424L may affect the person's entitlement to the energy supplement.

(2) The daily rate of the supplement is 1/7 of $10.75.

SIMPLIFICATION This section can be subsumed into the VEA section 24 with some alterations and amendments to S24 highlighted in red and blue below

• 24 Special rate of pension

(1) This section applies to a veteran if:

(aa) the veteran has made a claim under section 14 for a pension, or an application under section 15 for an increase in the rate of the pension that he or she is receiving; and

(aab) the veteran had not yet turned 65 (sub – 70) when the claim or application was made; and

(a) either:

(i) the degree of incapacity of the veteran from war caused injury or war caused disease, or both, is determined under section 21A to be at least 70% or has been so determined by a determination that is in force; or (Baseline MRCA 50 impairment points = 70% DP VEA)

(ii) the veteran is, because he or she has suffered or is suffering from pulmonary tuberculosis, receiving or entitled to receive a pension at the general rate; and

(b) the veteran is totally and permanently incapacitated, that is to say, the veteran's incapacity from war caused injury or war caused disease, or both, is of such a nature as, of itself alone, to render the veteran incapable of undertaking remunerative work for periods aggregating more than 8 (sub 10 hours) hours per week; and

Section 199 MRCA

iii) the person has been paid a lump sum under section 138 in respect of the person's incapacity for work as a result of one or more service injuries or diseases;

(b) as a result of the injuries or diseases, the person has suffered an impairment that is likely to continue indefinitely;

(c) the Commission has determined under Part 2 that the person's impairment constitutes at least 50 impairment points;

(c) the veteran is, by reason of incapacity from that war caused injury or war caused disease, or both, alone, prevented from continuing to undertake remunerative work that the veteran was undertaking and is, by reason thereof, suffering a loss of salary or wages, or of earnings on his or her own account, that the veteran would not be suffering if the veteran were free of that incapacity; and

(d) section 25 does not apply to the veteran.

(2) For the purpose of paragraph (1)(c):

(a) a veteran who is incapacitated from war caused injury or war caused disease, or both, shall not be taken to be suffering a loss of salary or wages, or of earnings on his or her own account, by reason of that incapacity if:

(i) the veteran has ceased to engage in remunerative work for reasons other than his or her incapacity from that war caused injury or war caused disease, or both; or

(ii) the veteran is incapacitated, or prevented, from engaging in remunerative work for some other reason; and

(b) where a veteran, not being a veteran who has attained the age of 65 years, who has not been engaged in remunerative work satisfies the Commission that he or she has been genuinely seeking to engage in remunerative work, that he or she would, but for that incapacity, be continuing so to seek to engage in remunerative work and that that incapacity is the substantial cause of his or her inability to obtain remunerative work in which to engage, the veteran shall be treated as having been prevented by reason of that incapacity from continuing to undertake remunerative work that the veteran was undertaking.

(2A) This section applies to a veteran if:

(a) the veteran has made a claim under section 14 for a pension, or an application under section 15 for an increase in the rate of the pension that he or she is receiving; and

(b) the veteran had turned 65 before the claim or application was made; and

(c) paragraphs (1)(a) and (1)(b) apply to the veteran; and

(d) the veteran is, because of incapacity from war caused injury or war caused disease or both, alone, prevented from continuing to undertake the remunerative work (last paid work) that the veteran was last undertaking before he or she made the claim or application; and

(e) because the veteran is so prevented from undertaking his or her last paid work, the veteran is suffering a loss of salary or wages, or of earnings on his or her own account, that he or she would not be suffering if he or she were free from that incapacity; and

(f) the veteran was undertaking his or her last paid work after the veteran had turned 65; and (SUB 70)

(g) when the veteran stopped undertaking his or her last paid work, the veteran had been undertaking remunerative work for a continuous period of at least 10 years that began before the veteran turned 65; and

(h) section 25 does not apply to the veteran.

(2B) For the purposes of paragraph (2A)(e), a veteran who is incapacitated from war caused injury or war caused disease or both, is not taken to be suffering a loss of salary or wages, or of earnings on his or her own account, because of that incapacity if:

(a) the veteran has ceased to engage in remunerative work for reasons other than his or her incapacity from that war caused injury or war caused disease, or both; or

(b) the veteran is incapacitated, or prevented from engaging in remunerative work for some other reason.

(3) This section also applies to a veteran who has been blinded in both eyes as a result of war caused injury or war caused disease, or both.

(4) Subject to subsections (5), (5A) and (6), the rate at which pension is payable to a veteran to whom this section applies is $919.40 per fortnight.

(5) Subject to subsections (5A) and (6), the rate at which pension is payable to a veteran to whom section 115D applies (veterans working under rehabilitation scheme) is the reduced amount worked out using the following formula:

(5A) If:

(a) section 115D applies to a veteran because of subsection 115D(1A); and

(b) the veteran is engaged in remunerative work of more than 8 hours, but less than 20 hours, per week as a result of undertaking a vocational rehabilitation program under the Veterans' Vocational Rehabilitation Scheme;

then, subject to subsection (6) of this section, the rate at which pension is payable to the veteran is the higher of the following amounts:

(c) the amount worked out under subsection (5) of this section;

(d) the amount under subsection 23(4).

(6) If section 25A applies to a veteran, the rate at which pension is payable to the veteran is the rate per fortnight specified in subsection (4), (5) or (5A) of this section, reduced in accordance with section 25A.

24A Continuation of rates of certain pensions

(1) Subject to subsections (1A) and (2), if the Commonwealth is or becomes liable to pay a pension to a veteran at the rate applicable under section 23 or 24, that rate continues, while a pension continues to be payable to the veteran, to apply to the veteran unless:

(a) the decision to apply that rate of pension to the veteran would not have been made but for a false statement or misrepresentation made by a person;

(b) in the case of a veteran to whom section 23 applies:

(i) the veteran is undertaking or is capable of undertaking remunerative work of a particular kind for 50% or more of the time (excluding overtime) ordinarily worked by persons engaged in work of that kind on a full time basis; or

(ii) in a case where subparagraph (i) is inapplicable to the work which the veteran is undertaking or is capable of undertaking—the veteran is undertaking or is capable of undertaking that work for 20 or more hours per week; or

(c) in the case of a veteran to whom section 24 applies—the veteran is undertaking or is capable of undertaking remunerative work for periods aggregating more than 8 hours per week.

(1A) However, subsection (1) does not prevent a rate applicable under subsection 24(4), (5) or (5A) from being reduced to give effect to subsection 24(6).

(2) Paragraphs (1)(b) and (c) do not apply to a veteran if the veteran is undertaking a rehabilitation program under the Veterans' Vocational Rehabilitation Scheme or section 115D applies to the veteran.

• 25 Temporary payment at special rate

(1) Where the Commission is satisfied that:

(a) a veteran is temporarily incapacitated from war caused injury or war caused disease, or both; and

(b) if the veteran were so incapacitated permanently, the veteran would be a veteran to whom section 24 applies;

the Commission shall determine the period during which, in its opinion, that incapacity is likely to continue and this section applies to the veteran in respect of that period.

(2) Where this section applies to a veteran in respect of a period, the rate at which pension is payable to the veteran in respect of that period is the rate that would have been applicable under subsection 24(4), (5), (5A) or (6) if section 24 applied to the veteran.

(3) The Commission may, under this section:

(a) determine a period that commenced before the date on which the determination is made; and

(b) determine a period in respect of a veteran that commenced or commences upon the expiration of a period previously determined by the Commission under subsection (1) in respect of the veteran.

25A Offsetting certain payments made under the Safety, Rehabilitation and Compensation (Defence related Claims) Act 1988

(1) This section applies to a veteran:

(a) to whom section 23, 24 or 25 applies; or

(b) who is granted a loss of earnings allowance under section 108;

in respect of the incapacity of the veteran from a war caused injury or a war caused disease if the veteran has received an amount of compensation, whether before or after the commencement of this section, under section 24, 25 or 27 of the Safety, Rehabilitation and Compensation (Defence related Claims) Act 1988 for that injury or disease, or any other injury or disease, in relation to some other incapacity of the veteran.

(2) That amount of compensation is to be converted to a fortnightly amount in accordance with advice from the Australian Government Actuary.

(3) The rate at which:

(a) a pension is payable to the person under section 23, 24 or 25; or

(b) a loss of earnings allowance under section 108 is payable to the person;

apart from this section, is reduced, but not below zero, by the fortnightly amount worked out under s22 General rate of pension and extreme disablement adjustment

(1) This section applies to a veteran who is being paid, or is eligible to be paid, a pension under this Part, other than a veteran to whom section 23, 24 or 25 applies.

(2) Subject to this Division, the rate at which pension is payable to a veteran to whom this section applies in respect of the incapacity of the veteran from war caused injury or war caused disease, or both, is the rate per fortnight that constitutes the same percentage of the general rate as the percentage determined by the Commission in accordance with section 21A to be the degree of incapacity of the veteran from that war caused injury or war caused disease, or both, as the case may be.

(3) For the purposes of this section, the maximum rate per fortnight is $338.94 per fortnight.

(4) Where:

(a) either:

(i) the degree of incapacity of a veteran from war caused injury or war caused disease, or both, is determined under section 21A to be 100% or has been so determined by a determination that is in force; or

(ii) a veteran is, because he or she has suffered or is suffering from pulmonary tuberculosis, receiving or entitled to receive a pension at the maximum rate per fortnight specified in subsection (3);

(b) the veteran has attained the age of 65;

(c) the veteran has an impairment rating of at least 70 points and a lifestyle rating of at least 6 points, each determined in accordance with the approved Guide to the Assessment of Rates of Veterans' Pensions; and

(d) the veteran is not receiving a pension at a rate provided for by section 23, 24 or 25;

the rate at which pension is payable to the veteran is $510.40 per fortnight.

(5) For the purpose of subsection (4), a veteran who has been granted a pension at a rate specified in subsection (3) or provided for by section 23, 24 or 25 shall be taken to be receiving a pension at the rate specified in, or provided for by, the provision concerned even if:

(a) the rate has been reduced, or the pension is not payable, because of section 26, 30C, 30D or 74;

(b) amounts are being deducted from the pension under section 30P, 79 or 205; or

(c) the pension has been suspended under subsection 31(6).ubsection (2) of this section.

• 22 General rate of pension and extreme disablement adjustment

(1) This section applies to a veteran who is being paid, or is eligible to be paid, a pension under this Part, other than a veteran to whom section 23, 24 or 25 applies.

(2) Subject to this Division, the rate at which pension is payable to a veteran to whom this section applies in respect of the incapacity of the veteran from war caused injury or war caused disease, or both, is the rate per fortnight that constitutes the same percentage of the general rate as the percentage determined by the Commission in accordance with section 21A to be the degree of incapacity of the veteran from that war caused injury or war caused disease, or both, as the case may be.

(3) For the purposes of this section, the maximum rate per fortnight is $338.94 per fortnight.

(4) Where:

(a) either:

(i) the degree of incapacity of a veteran from war caused injury or war caused disease, or both, is determined under section 21A to be 100% or has been so determined by a determination that is in force; or

(ii) a veteran is, because he or she has suffered or is suffering from pulmonary tuberculosis, receiving or entitled to receive a pension at the maximum rate per fortnight specified in subsection (3);

(b) the veteran has attained the age of 65;

(c) the veteran has an impairment rating of at least 70 points and a lifestyle rating of at least 6 points, each determined in accordance with the approved Guide to the Assessment of Rates of Veterans' Pensions; and

(d) the veteran is not receiving a pension at a rate provided for by section 23, 24 or 25;

the rate at which pension is payable to the veteran is $510.40 per fortnight.

(5) For the purpose of subsection (4), a veteran who has been granted a pension at a rate specified in subsection (3) or provided for by section 23, 24 or 25 shall be taken to be receiving a pension at the rate specified in, or provided for by, the provision concerned even if:

(a) the rate has been reduced, or the pension is not payable, because of section 26, 30C, 30D or 74;

(b) amounts are being deducted from the pension under section 30P, 79 or 205; or

(c) the pension has been suspended under subsection 31(6).

Chapter 3—Rehabilitation

Part 1—General provisions

Division 1—Simplified outline of this Chapter

37 Simplified outline of this Chapter

This Chapter provides for the following for certain current and former members suffering a service injury or disease:

(a) rehabilitation programs;

(b) assistance in finding suitable defence or civilian work;

(c) assistance in moving from defence service to civilian life.

The capacity for rehabilitation of a person with a service injury or disease is assessed under Part 2. If the person is capable of rehabilitation, he or she may be required to undertake a rehabilitation program under that Part.

Part 2 also provides for rehabilitation for certain persons who have made a claim for acceptance of liability by the Commission for a service injury or disease, where the claim has not been determined.

Under Part 3, a person who is undertaking a rehabilitation program, or a person who cannot undertake a program, can have his or her home or place of work etc. altered or an aid or appliance provided.

All members and former members who are incapacitated for service or work are assisted in finding suitable work under Part 4.

A case manager is appointed under Part 5 to assist a Permanent Forces member, a continuous full-time Reservist or a part-time Reservist move to civilian life if the person is likely to be discharged from the Defence Force.

Division 2—Aim of rehabilitation

38 Aim of rehabilitation

The aim of rehabilitation is to maximise the potential to restore a person who has an impairment, or an incapacity for service or work, as a result of an injury or disease to at least the same physical and psychological state, and at least the same social, vocational and educational status, as he or she had before the injury or disease.

Division 3—Definitions

39 Definition of *rehabilitation authority*

(1) The Chief of the Defence Force is a ***rehabilitation authority*** for the purposes of this Chapter.

(2) The Commission is a ***rehabilitation authority*** for the purposes of this Chapter.

(3) The ***rehabilitation authority*** for a person at a time is:

(a) subject to paragraph (aa), the Chief of the Defence Force for a time when the person:

(i) is a Permanent Forces member, a continuous full-time Reservist or a part-time Reservist; and

(ii) has not been identified by or on behalf of the Chief of the Defence Force as being likely to be discharged from the Defence Force for medical reasons; or

(aa) if the Commission, after considering advice from the Chief of the Defence Force, determines, in writing, that the Commission is to be the rehabilitation authority for a specified person at a specified time—the Commission for that time; or

(b) the Commission for any other time.

(4) A determination made under paragraph (3)(aa) is not a legislative instrument.

40 Rule if rehabilitation authority for a person changes

(1) This section applies if a person's rehabilitation authority (the ***original rehabilitation authority***) changes to another rehabilitation authority (the ***new rehabilitation authority***) because of section 39.

(2) If:

(a) under subsection 44(2), the person requests the original rehabilitation authority to carry out an assessment of the person's capacity for rehabilitation; and

(b) the rehabilitation authority changes before the assessment begins;

the person's request is taken to have been made to the new rehabilitation authority.

(3) A determination of the original rehabilitation authority that is in force immediately before the rehabilitation authority changes has effect as a determination of the new rehabilitation authority. The new rehabilitation authority is responsible for giving effect to the determination.

41 Other definitions

(1) In this Chapter:

approved program provider means:

(a) a person or body that is an approved program provider for the purposes of the *Safety, Rehabilitation and Compensation Act 1988*; or

(b) a person nominated in writing by a rehabilitation authority, being a person the rehabilitation authority is satisfied has appropriate skills and expertise to design and provide rehabilitation programs.

approved rehabilitation program means a rehabilitation program determined under section 51 for a person by the person's rehabilitation authority.

rehabilitation program means a program that consists of or includes any one or more of the following:

(a) medical, dental, psychiatric and hospital services (whether on an in-patient or out-patient basis);
(b) physical training and exercise;
(c) physiotherapy;
(d) occupational therapy;
(e) vocational assessment and rehabilitation;
(f) counselling;
(g) psycho-social training.

vocational assessment and rehabilitation consists of or includes any one or more of the following:

(a) assessment of transferable skills;
(b) functional capacity assessment;
(c) workplace assessment;
(d) vocational counselling and training;
(e) review of medical factors;
(f) training in resume preparation, job-seeker skills and job placement;
(g) provision of workplace aids and equipment.

• Part 2—Rehabilitation programs

Division 1—Application of Part

42 Simplified outline of this Part

This Part applies to a person who is incapacitated for service or work, or who is impaired, as a result of a service injury or disease.

Most decisions under this Part are made by the person's rehabilitation authority. The rehabilitation authority is either the Chief of the Defence Force or the Commission.

The rehabilitation authority, either on its own initiative or on the person's request, carries out an initial assessment of the person's capacity for rehabilitation. The person might be required to undergo an examination (paid for by the Commonwealth) as part of the assessment. (Compensation can be paid for costs incurred in travelling to the examination.)

Once the assessment is done, the rehabilitation authority decides if the person should undertake a rehabilitation program (provided by an approved program provider). In certain cases, the rehabilitation authority can stop or vary the program once it has begun.

A person's right to compensation can be suspended if the person fails to undergo an examination or fails to undertake the program as required.

This Part also provides for rehabilitation for certain persons who have made a claim for acceptance of liability by the Commission for a service injury or disease, where the claim has not been determined.

43 Persons to whom this Part applies

Commission has accepted liability for service injury or disease

(1) This Part applies to a person at a time if, at that time:
   (a) the person is incapacitated for service or work, or has an impairment, as a result of a service injury or disease; and
   (b) the Commission has accepted liability for the injury or disease.

(2) To avoid doubt, this Part applies to a person who is incapacitated or impaired as a result of an aggravated injury or disease even if the incapacity or impairment resulted from the original injury or disease and not from the aggravation or material contribution.

Claim for acceptance of liability for service injury or disease not determined

(3) This Part also applies to a person if:
   (a) the person has made a claim of a kind referred to in paragraph 319(1)(a); and
   (b) the Commission has not determined the claim; and

(c) the person is included in a class of persons determined in an instrument under subsection (4); and

(d) the Commission has determined, in writing, that this Part applies to the person.

(4) The Commission may, by legislative instrument, determine a class of persons for the purposes of paragraph (3)(c).

(5) A determination under paragraph (3)(d) is not a legislative instrument.

Division 2—Assessment of a person's capacity for rehabilitation

44 When an assessment may or must be carried out

Assessments on rehabilitation authority's initiative

(1) The rehabilitation authority for a person to whom this Part applies may, on its own initiative, carry out an initial assessment or a further assessment of the person's capacity for rehabilitation.

Requests for assessments

(2) A person to whom this Part applies may request his or her rehabilitation authority to carry out an initial assessment or a further assessment of his or her capacity for rehabilitation.

(3) The rehabilitation authority:

(a) must carry out an initial assessment; and

(b) may carry out a further assessment;

if the person requests the rehabilitation authority to do so.

Requirement to carry out assessment before ceasing or varying a program

(4) The rehabilitation authority must carry out an assessment before ceasing or varying a rehabilitation program under section 53.

45 What may be done as part of an assessment

(1) This section applies if the person's rehabilitation authority carries out an assessment under section 44 of the person's capacity for rehabilitation.

(2) The rehabilitation authority may seek the assistance of a person the authority is satisfied has suitable qualifications or expertise to provide assistance.

(3) The rehabilitation authority may take into account any relevant information of which it is aware.

(4) The rehabilitation authority may require the person to undergo an examination under section 46.

46 Requirements for examinations

(1) This section applies if the person's rehabilitation authority requires the person to undergo an examination.

(2) The examination is to be carried out by an examiner nominated by the rehabilitation authority whom the authority is satisfied has suitable qualifications or expertise to carry out the examination.

(3) The examiner must give a written report of the examination to the rehabilitation authority. The report must include:

(a) an assessment of the person's capacity for rehabilitation; and

(b) if the person has a capacity for rehabilitation—the kinds of rehabilitation from which the person would benefit; and

(c) any other information relating to the provision of a rehabilitation program for the person that the rehabilitation authority requires.

(4) The Commonwealth is liable to pay the cost of conducting the examination.

47 Compensation for journey and accommodation costs

The Commonwealth is liable to pay compensation for any costs reasonably incurred if:

(a) the costs are incurred:

(i) in making a necessary journey in connection with the examination; or

(ii) in remaining, for the purpose of the examination, at a place to which the person has made a journey for that purpose; and

(b) a claim for compensation in respect of the person has been made under section 319.

Note: This section might be affected by section 50 or 52 (failure to undergo examination or rehabilitation program).

48 Amount of compensation for journey and accommodation costs

(1) The amount of compensation that the Commonwealth is liable to pay under section 47 is the amount determined by the rehabilitation authority to be the amount reasonably incurred in making the journey or remaining at the place.

(2) In determining the amount, the rehabilitation authority must have regard to:

(a) the means of transport available to the person for the journey; and

(b) the route or routes by which the person could have travelled; and

(c) the accommodation available to the person.

49 Whom the compensation is payable to

(1) Compensation under section 47 for costs reasonably incurred is payable to:

(a) the person who made the claim for compensation; or

(b) if that person so directs:

(i) the person who provided services in connection with the journey or accommodation; or

(ii) any other person who incurred the cost of services in connection with the journey or accommodation.

Note: A special rule applies if a trustee is appointed under section 432.

(2) A payment under section 47 to a person who provided services in connection with the journey or accommodation discharges any liability of any other person for the cost of those services to the extent of the payment.

50 Consequences of failure to undergo an examination

(1) If the rehabilitation authority for a person requires the person to undergo an examination under section 45 and the person:

(a) refuses or fails to undergo the examination; or

(b) in any way obstructs the examination;

the rehabilitation authority may determine that the person's right to compensation (but not the person's right to treatment or compensation for treatment under Chapter 6) under this Act is suspended until the examination takes place.

Note: Subsection (6) provides that this section does not apply to a person to whom this Part applies because of subsection 43(3) (claim for acceptance of liability not determined).

(2) A determination under subsection (1) must not be made in relation to a refusal or failure to undergo the examination if, before the time fixed for the examination, the person gives to the rehabilitation authority evidence of a reasonable excuse for the refusal or failure.

(3) The rehabilitation authority must determine that the suspension under subsection (1) is terminated from a date determined by the rehabilitation authority if, within 14 days after the date fixed for the examination, the person gives to the rehabilitation authority evidence of a reasonable excuse for the refusal, failure or obstruction.

(4) If a determination under subsection (1) is made by a delegate of the rehabilitation authority, the rehabilitation authority must ensure that any determination terminating the suspension under subsection (3) also made by a delegate of the rehabilitation authority is made by a delegate other than a delegate who was involved in making the determination under subsection (1).

(5) If a person's right to compensation is suspended under subsection (1), compensation is not payable during or in respect of the period of the suspension.

(6) This section does not apply to a person to whom this Part applies because of subsection 43(3) (claim for acceptance of liability not determined).

Division 3—Provision of rehabilitation programs

51 Rehabilitation authority may determine that a person is to undertake a rehabilitation program

(1) The rehabilitation authority for a person to whom this Part applies may determine that the person is to undertake a rehabilitation program specified in the determination if an assessment has been made under section 44 of the person's capacity for rehabilitation.

(2) In making a determination under subsection (1) in respect of the person, the person's rehabilitation authority is to have regard to the following:

(a) any written report in respect of the person under subsection 46(3);

(b) any reduction in the future liability of the Commonwealth to pay or provide compensation if the program is undertaken;

(c) the cost of the program;

(d) any improvement in the person's opportunity to be engaged in work after completing the program;

(e) the person's attitude to the program;

(f) the relative merits of any alternative and appropriate rehabilitation program;

(g) any other matter the rehabilitation authority considers relevant.

(3) If the rehabilitation authority for a person makes a determination under subsection (1) that a person is to undertake a rehabilitation program, the rehabilitation authority must make arrangements with an approved program provider for the provision of the program for the person.

Note: The person might also be entitled to have his or her home altered or aids or appliances provided under Part 3.

(4) For the purposes of designing or providing a rehabilitation program:

(a) the rehabilitation authority or approved program provider concerned may seek the assistance of persons with suitable qualifications or expertise in the design or provision of rehabilitation programs; and

(b) the rehabilitation authority or approved program provider concerned may take into account any relevant information of which it is aware or that is brought to its attention.

(5) The cost of a rehabilitation program provided for a person under this section is to be paid by the Commonwealth.

52 Consequences of failure to undertake a rehabilitation program

(1) If the rehabilitation authority for a person requires the person to undertake a rehabilitation program under section 51, and the person refuses or fails to undertake the rehabilitation program, the rehabilitation authority may determine that the person's right to compensation (but not the person's right to treatment or compensation for treatment under Chapter 6) under this Act is suspended until the person undertakes the rehabilitation program.

Note: Subsection (6) provides that this section does not apply to a person to whom this Part applies because of subsection 43(3) (claim for acceptance of liability not determined).

(2) A determination under subsection (1) must not be made in relation to a refusal or failure to undertake the rehabilitation program if, before the date fixed for starting the

rehabilitation program, the person gives to the rehabilitation authority evidence of a reasonable excuse for the refusal or failure.

(3) The rehabilitation authority must determine that the suspension under subsection (1) is terminated from a date determined by the rehabilitation authority if, within 14 days after the date fixed for starting the rehabilitation program, the person gives to the rehabilitation authority evidence of a reasonable excuse for the refusal or failure.

(4) If a determination under subsection (1) is made by a delegate of the rehabilitation authority, the rehabilitation authority must ensure that any determination terminating the suspension under subsection (3) also made by a delegate of the rehabilitation authority is made by a delegate other than a delegate who was involved in making the determination under subsection (1).

(5) If a person's right to compensation is suspended under subsection (1), compensation is not payable during or in respect of the period of the suspension.

(6) This section does not apply to a person to whom this Part applies because of subsection 43(3) (claim for acceptance of liability not determined).

53 Cessation or variation of a rehabilitation program

(1) This section applies if:
  (a) the rehabilitation authority for a person has made a determination under subsection 51(1) that the person is to undertake a rehabilitation program; and
  (b) an approved program provider has commenced providing the rehabilitation program.

(2) The rehabilitation authority may, on its own initiative or on written application by the person, determine that:
  (a) the rehabilitation program cease; or
  (b) the rehabilitation program be varied.

(3) Before making a determination under subsection (2), the rehabilitation authority must:
  (a) undertake an assessment under section 44 of the person's capacity for rehabilitation; and
  (b) consult the person about the proposed determination.

• Veterans' Vocational Rehabilitation Scheme

Instrument 2015 No. R11

made under subsection 115B(1) of the

Veterans' Entitlements Act 1986

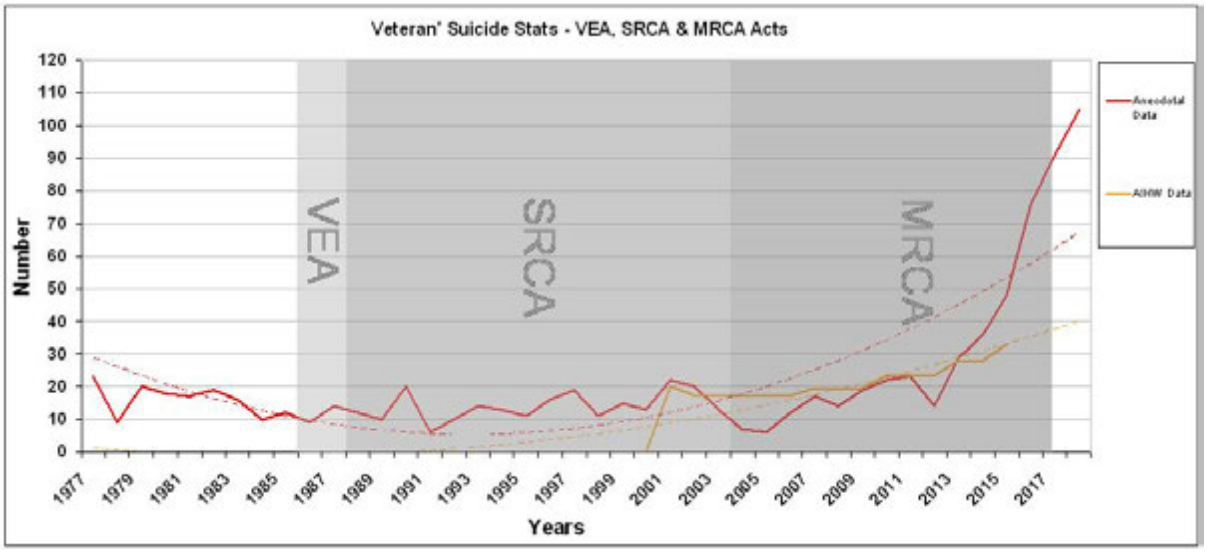
Compilation No. 1

Compilation date: 20 March 2016

Includes amendments up to: F2016L00248

Registered: 6 April 2016

https://www.legislation.gov.au/Series/F2015L01263



This factsheet summarises the key findings from the 2016 DVA Client Satisfaction Survey. In total, 3,002 randomly selected veterans participated in the telephone survey conducted in November-December 2016. DVA actively targeted veterans of all ages for this survey, across Australia. A higher number of veterans aged under 45 years were interviewed (compared to the client population) in an effort to improve understanding of satisfaction amongst this group. In this factsheet, survey results have been aligned to reflect the DVA client population. Key Insights The survey results show 83% of veterans are satisfied with DVA overall, 6 percentage points below the result of the last survey in 2014. Older veterans remain more positive about DVA's service delivery compared to younger veterans. This is partly explained by younger veterans' higher levels of interaction with DVA in relation to claims for benefits and services. The results of this survey will inform DVA's efforts to transform the delivery of services to veterans and their families. Respondent Characteristics 53% 47% NT

https://www.dva.gov.au/sites/default/files/files/consultation%20and%20grants/2016%20CSS%20Factsheet.PDF

3.11.3 Payment of Lump Sum Advance

DOCUMENT
Print version Send email

Last amended: 5 March 2013

Advance payment eligible amount

VEA ?
The advance payment eligible amount is the sum of the maximum basic rate of service pension that applies to the person (i.e. single, partnered, illness separated) and the amount (if any) by which the person's pension supplement exceeds the minimum pension supplement amount. For people not receiving a service pension this is calculated as if they were receiving the pension.

Amount of lump sum advance payment

VEA ?
The result of the following process is the maximum advance payable:

Step	Action
1	Work out 3/52 of the person's advance payment eligible amount.
2	Work out the annual rate at which pension was payable to the person on the last payday before they applied for an advance payment (excluding any remote area allowance, minimum pension supplement and clean energy supplement).

3	Work out the smaller of the result of Step 1 and: • for service pensioners and ISS recipients – 7.5% of the result of Step 2 • otherwise – 13 times the fortnightly rate of pension payable to the person.
4	From the result of step 3 subtract: • any advance payments paid in the previous 13 fortnights • any other advance payments that have not been fully repaid.
5	Round the result of step 4 to the nearest cent (rounding 0.5 cents upwards).

A pensioner can request any amount of lump sum advance providing it is less than the[glossary:advance:] payment [glossary:maximum amount:] and greater than the[glossary:advance:] payment [glossary:minimum amount.:]

Minimum amount of advance payment

VEA ?
The minimum advance payable is 1/52 of the person's [glossary:advance:] payment[glossary:eligible amount:].

Frequency of lump sum advance

There is no direct limit on the number of lump sum advance payments. In practice, due to the operation of the minimum and maximum amounts, up to three lump sum advances can be granted in any 13 week period.

Service Pensioners or ISS recipients who also receive Disability Pension

Where an individual has two payments which make them eligible for a lump sum advance, they are entitled to receive a lump sum advance based on whichever payment gives the higher advance amount.

Example of a lump sum advance for a person receiving service pension and disability pension

Anne is a single person who receives fortnightly service pension payment of $530.60 (including pension supplement but excluding clean energy supplement) and a 15% disability pension payment of $64.89 (excluding clean energy supplement). She applies for an advance of $800. A delegate of the Commission determines that she meets all of the eligibility criteria. She has not received any advances in the past 13 fortnights. Based on her service pension (excluding the minimum supplement and clean energy supplement) her maximum lump sum advance is $975 ([$530.60 – 30.60] x 1.95). Based on her disability pension her maximum lump sum advance is $843.57 ($64.89 x 13). As the service pension advance is higher, but is less than the maximum single advance of $1,005.75, that amount will be her maximum advance. Her minimum

advance is $381.05. Based on her service pension, she can receive an advance of $800, but she will not be eligible for another advance for the next thirteen fortnights, as her maximum advance less the $800 advance is lower than the minimum advance payment amount.

http://clik.dva.gov.au/compensation-and-support-policy-library/part-3-income-support-eligibility/311-lump-sum-advance/3113-payment-lump-sum-advance

Sincerely

Rod Thompson
Advocate (Level 4)

Rod Thompson
Advocate Level 4

Dear Members,

As time is short and we all have other commitments, there will be a significant amount of information overload so I intend where possible to simplify the issues and then later apply the appropriate legislative language with the input of the members.

Sadly, DVA have provided us with ONE DAY to discuss the complexities of the VEA, SRCA/DRCA, MRCA and the Comsuper implications. The first order of business was to engage with the VVFA to ensure we have a united block at the forum. This has been done and it appears the VVFA and ADSO are on the same page in regard the one-day forum they agree that the agenda proposed by DVA is a joke, it is quite clear that DVA currently have no interest is listening as indicated by the attached agenda they are doing all the talking.

Item 1. Ensuring that all ESO's and groups involved are if at all possible on the same page – Allan

Item 2. Identifying areas of legislation that are problematic or ambiguous in nature

Item 3. Establishing a framework based on the VEA to effectively amalgamate all 4 legislations' in a practical and cost-effective manner.

Example Section 199 MRCA and associated sections pertaining to SRDP or MRCA TPI

Amending and incorporating areas of 199 MRCA and S24 VEA will provide a template for caring for significantly disabled veterans through all stages of life. Suggested formula to incorporate aspects of MRCA section 199 into Section 24 (1) (c). The alone clause can be fairly and simply addressed in line with case law and the beneficial provisions pertaining to the VEA.

1. If a veteran has significant impairment from non-service related injuries a GARP assessment should be undertaken on the non-accepted conditions alone, and if that assessment places the non-accepted condition at 70% GR under GARP 5 using the lifestyle rating applied to the veteran at his / her most recent PI assessment. Then it should be taken that s24 (1) (c) is not met if the non-accepted condition is assessed at more than 70% of the general rate indicating it of itself would legislatively be considered to be of itself alone preventing the veteran undertaking remunerative work as defined at s24 1 (a) (i) & (b). A veteran who fails at s24 may be considered under S22 (3) (b) if the age factor was removed

2. The 8 hour test s24 (1) (b) VEA should be amended in line with section 199 (1) (d) MRCA increasing work capability from 8 hours to 10 hours per week.

3. The age restriction at 65 at s24 (1) (aab) should be raised to 70.

4. If a veteran is medically discharged for any illness or injuries noted on the final medical board it should be said that liability under the legislation has been established for those noted conditions. Claims for un noted conditions / sequella conditions should be considered under the current claims processing system.

5. Subsequent to 4 above if that veteran is deemed by those noted / accepted conditions to be at 50 MRCA / 70 VEA /50 WPI SRCA / DRCA the veteran should be offered under section 25 VEA Temporary Payment Special Rate for the first 12 months post discharge with a comprehensive assessment from his / her treating specialists to be undertaken approximately 12 months post discharge for reassessment and rehabilitation recommendations and reports (medical only).

6. To enable the MRCA Rehabilitation Element which is far stronger than that of the VEA it is suggested that MRCA Chapter 3 Rehabilitation sections 37-53 (pages 16-26) replace Instrument 2015 No. R11 - Veterans Vocational Rehabilitation Scheme (VVRS) **page 26 with link.**

7. Providing the provision for lump sum payments under the VEA. The ability for a lump sum pension advance already exists - VEA The advance payment eligible amount is the sum of the maximum basic rate of service pension that applies to the person (i.e. single, partnered, illness separated) and the amount (if any) by which the person's pension supplement exceeds the minimum pension supplement amount. For people not receiving a service pension this is calculated as if they were receiving the pension. This can simply be amended and extended to enable the advance of Pension at a % or the whole amount of the awarded percentage of the general rate of pension.

   Examples: Veteran aged 40 is assessed at 100 % of the general rate VEA receives **$488.40** per fortnight = **$12,698.40** per annum which would equate to if multiplied out to retirement age 70 a lump sum figure of **$380,952** with the pension returning at the deemed retirement age as a tax-free pension. This is also cost neutral as the 100% of the general rate would have to be paid in any circumstances. As this is part of an existing compensation arrangement the acuity tables will not be required.

- 199 Persons who are eligible to make a choice under this Part

(1) A person is eligible to make a choice under this Part if the Commission is satisfied that the person meets the following criteria (the eligibility criteria):

(a) at least one of the following applies:

(i) the person is receiving compensation worked out under Division 2 of Part 4 as a result of one or more service injuries or diseases;

(ii) the amount, under section 126, of the person's compensation for a week, as a result of one or more service injuries or diseases, is nil or a negative amount;

(iii) the person has been paid a lump sum under section 138 in respect of the person's incapacity for work as a result of one or more service injuries or diseases;

(b) as a result of the injuries or diseases, the person has suffered an impairment that is likely to continue indefinitely;

(c) the Commission has determined under Part 2 that the person's impairment constitutes at least 50 impairment points;

(d) the person is unable to undertake remunerative work for more than 10 hours per week, and rehabilitation is unlikely to increase the person's capacity to undertake remunerative work.

(2) The Commission must, as soon as practicable after becoming satisfied that a person meets the eligibility criteria, make the person a written offer of a choice under this Part. The offer must specify the date on which the offer is made.

200 Choice to receive Special Rate Disability Pension

(1) A person who is offered the choice under this Division can choose to receive a Special Rate Disability Pension instead of compensation worked out under Division 2 of Part 4.

(2) A person who makes the choice cannot change it.

(3) However, a person to whom the Commonwealth is no longer liable to pay a Special Rate Disability Pension under section 209 is taken not to have chosen to receive the Pension.

Note: This means that the person might still be entitled to compensation worked out under Division 2 of Part 4 or under the Return to Work Scheme in section 210.

201 When the choice is to be made

(1) A person who is offered the choice under this Part and who wishes to make the choice must do so within 12 months after the date on which the offer was made.

(2) The Commission may, either before or after the end of that period, extend the period within which the person must make the choice if the Commission is satisfied that:

(a) there was a delay in the person receiving the offer under subsection 199(2); or

(b) the person did not receive the offer.

202 Other requirements for the choice

(1) The Commission may, in writing, approve a form for the purposes of this section.

(2) A person must make the choice in writing in accordance with the form.

(3) Before making the choice, the person must obtain financial advice from a suitably qualified financial adviser in respect of the choice.

Note: The person might be entitled to compensation for the cost of the financial advice under section 205.

203 Determinations by Commission

(1) The Commission must determine that the Commonwealth is liable to pay a Special Rate Disability Pension to a person instead of compensation worked out under Division 2 of Part 4 if:

(a) the person is offered the choice under this Part; and

(b) the person makes the choice to receive the pension within the period applicable under section 201 and in accordance with section 202; and

(c) the Commission is satisfied that the person meets the eligibility criteria on the day on which the person makes the choice.

(2) The Commission must determine that a person is to continue to receive compensation worked out under Division 2 of Part 4 if:

(a) the person is offered a choice under this Part; and

(b) either:

(i) the person does not make the choice within the period applicable under section 201 and in accordance with section 202; or

(ii) the Commission is satisfied that the person does not meet the eligibility criteria on the day on which the person makes the choice.

(3) If the Commission makes a determination under subsection (1) in relation to a person, a Special Rate Disability Pension is payable to the person instead of compensation worked out under Division 2 of Part 4 from the day on which the Commission becomes aware of the person's choice.

204 Offsets

(1) The maximum weekly amount of a Special Rate Disability Pension that could be payable to a person is reduced in accordance with this section.

Permanent impairment compensation

(2) There is a reduction that is made by reference to amounts payable or paid to the person under Part 2 (permanent impairment). However, a payment received for eligible young

persons, financial advice, legal advice or energy supplement under that Part does not reduce the maximum weekly amount of Special Rate Disability Pension that could be payable to the person.

(3) The maximum weekly amount of a Special Rate Disability Pension that could be payable to a person is reduced by the sum of:

(a) any weekly amounts that are being paid to the person under Part 2; and

(b) if the person has chosen to convert all or part of one or more weekly amounts that were payable to the person under that Part to lump sums—those weekly amounts or those parts of those weekly amounts.

(4) Subsection (3) applies to a person to whom section 389 or 402 applies as if the person were being paid the weekly amounts under Part 2 that the person would be paid if that section did not apply to the person.

Note: Section 389 provides that compensation under Part 2 is not payable to a person who chooses to institute proceedings for damages against the Commonwealth. Under section 402, compensation under this Act is not payable to a person who recovers damages from a third party.

Commonwealth superannuation

(5) There is a reduction if the person:

(a) has retired voluntarily, or has been compulsorily retired, from his or her work; and

(b) receives either or both a pension or lump sum under a Commonwealth superannuation scheme as a result of the retirement.

(6) The amount of the reduction under subsection (5) is 60% of the reduction that would apply to the person under section 134, 135 or 136 if the person were receiving compensation worked out under Division 2 of Part 4.

Relationship with subsection 415(4)

(7) This section does not limit the application of subsection 415(4) in relation to a Special Rate Disability Pension.

Note: Subsection (7) has the effect that if the maximum weekly amount of a Special Rate Disability Pension is reduced in accordance with this section, that amount may be further reduced in accordance with subsection 415(4).

204A Overpayment if payment of lump sum under section 138

(1) This section applies if the Commission makes a determination under subsection 203(1) in relation to a person where subparagraph 199(1)(a)(iii) applies.

(2) An amount, equal to so much of the lump sum under section 138 as is worked out in accordance with a legislative instrument made by the Commission under this subsection, is taken to be an amount of compensation that should not have been paid to the person.

Note 1: Section 415 allows the Commission to recover that amount as a debt due to the Commonwealth and allows that amount to be deducted from an amount that is payable under this Act.

Note 2: Section 1228 of the Social Security Act 1991 provides that amount is recoverable under that Act by means of deductions from payments under that Act.

Note 3: Section 205 of the Veterans' Entitlements Act 1986 provides that amount is recoverable under that Act by means of deductions from payments under that Act.

205 Compensation for cost of financial advice and legal advice

Financial advice

(1) The Commonwealth is liable to pay compensation for the cost of financial advice obtained by a person if:

(a) the person obtains financial advice from a suitably qualified financial adviser as mentioned in subsection 202(3); and

(b) a claim for compensation in respect of the person has been made under section 319.

Legal advice

(2) The Commonwealth is liable to pay compensation for the cost of legal advice obtained by a person if:

(a) the legal advice was obtained from a practising lawyer; and

(b) the legal advice was obtained in respect of the choice the person may make under this Part; and

(c) a claim for compensation in respect of the person has been made under section 319.

206 Amount of financial advice and legal advice compensation

Financial advice

(1) The Commission must determine the amount of compensation under subsection 205(1) for the cost of the financial advice that it considers reasonable.

Legal advice

(2) The Commission must determine the amount of compensation under subsection 205(2) for the cost of the legal advice that it considers reasonable.

Limit

(3) The sum of the total amount of compensation under subsections 205(1) and (2) in respect of the person must not exceed $2,400.

Note: The amount of $2,400 is indexed under section 404.

(4) The amount of $2,400 applies both to financial advice and legal advice under this Part and financial advice and legal advice under Part 2 if the day on which the offer under this Part was made, and the day specified in the first notice given to the person under section 76, are the same.

207 Whom the compensation is payable to

(1) Compensation under section 205 for the cost of financial advice or legal advice is payable to:

(a) the person who made the claim for compensation; or

(b) if that person so directs:

(i) the person who gave the advice; or

(ii) any other person who incurred the cost of the advice.

Note: A special rule applies if a trustee is appointed under section 432.

(2) An amount paid to the person who gave the advice discharges any liability of any other person for the cost of the advice to the extent of the payment.

208 Persons who are imprisoned

The Commonwealth is not liable to pay a Special Rate Disability Pension to a person for any period during which the person is imprisoned in connection with his or her conviction of an offence.

209 Ceasing to meet certain criteria

The Commonwealth is no longer liable to pay a Special Rate Disability Pension to a person if the Commission is satisfied that:

(a) the person's impairment as a result of all of the service injuries or diseases from which the person suffers constitutes fewer than 50 impairment points; or

(b) the person is able to undertake remunerative work for more than 10 hours per week.

209A Energy supplement for Special Rate Disability Pension

(1) The Commonwealth is liable to pay an energy supplement to a person for a day if:

(a) Special Rate Disability Pension:

(i) is payable to the person for the day; or

(ii) would be payable to the person for the day apart from section 204 and paragraph 398(3)(b); and

(b) the person resides in Australia on the day; and

(c) on the day the person either:

(i) is in Australia; or

(ii) is temporarily absent from Australia and has been so for a continuous period not exceeding 6 weeks.

Note: Section 424L may affect the person's entitlement to the energy supplement.

(2) The daily rate of the supplement is 1/7 of $10.75.

SIMPLIFICATION This section can be subsumed into the VEA section 24 with some alterations and amendments to S24 highlighted in red and blue below

• 24 Special rate of pension

(1) This section applies to a veteran if:

(aa) the veteran has made a claim under section 14 for a pension, or an application under section 15 for an increase in the rate of the pension that he or she is receiving; and

(aab) the veteran had not yet turned 65 (sub – 70) when the claim or application was made; and

(a) either:

(i) the degree of incapacity of the veteran from war caused injury or war caused disease, or both, is determined under section 21A to be at least 70% or has been so determined by a determination that is in force; or (Baseline MRCA 50 impairment points = 70% DP VEA)

(ii) the veteran is, because he or she has suffered or is suffering from pulmonary tuberculosis, receiving or entitled to receive a pension at the general rate; and

(b) the veteran is totally and permanently incapacitated, that is to say, the veteran's incapacity from war caused injury or war caused disease, or both, is of such a nature as, of itself alone, to render the veteran incapable of undertaking remunerative work for periods aggregating more than 8 (sub 10 hours) hours per week; and

Section 199 MRCA

iii) the person has been paid a lump sum under section 138 in respect of the person's incapacity for work as a result of one or more service injuries or diseases;

(b) as a result of the injuries or diseases, the person has suffered an impairment that is likely to continue indefinitely;

(c) the Commission has determined under Part 2 that the person's impairment constitutes at least 50 impairment points;

(c) the veteran is, by reason of incapacity from that war caused injury or war caused disease, or both, alone, prevented from continuing to undertake remunerative work that the veteran was undertaking and is, by reason thereof, suffering a loss of salary or wages, or of earnings on his or her own account, that the veteran would not be suffering if the veteran were free of that incapacity; and

(d) section 25 does not apply to the veteran.

(2) For the purpose of paragraph (1)(c):

(a) a veteran who is incapacitated from war caused injury or war caused disease, or both, shall not be taken to be suffering a loss of salary or wages, or of earnings on his or her own account, by reason of that incapacity if:

(i) the veteran has ceased to engage in remunerative work for reasons other than his or her incapacity from that war caused injury or war caused disease, or both; or

(ii) the veteran is incapacitated, or prevented, from engaging in remunerative work for some other reason; and

(b) where a veteran, not being a veteran who has attained the age of 65 years, who has not been engaged in remunerative work satisfies the Commission that he or she has been genuinely seeking to engage in remunerative work, that he or she would, but for that incapacity, be continuing so to seek to engage in remunerative work and that that incapacity is the substantial cause of his or her inability to obtain remunerative work in which to engage, the veteran shall be treated as having been prevented by reason of that incapacity from continuing to undertake remunerative work that the veteran was undertaking.

(2A) This section applies to a veteran if:

(a) the veteran has made a claim under section 14 for a pension, or an application under section 15 for an increase in the rate of the pension that he or she is receiving; and

(b) the veteran had turned 65 before the claim or application was made; and

(c) paragraphs (1)(a) and (1)(b) apply to the veteran; and

(d) the veteran is, because of incapacity from war caused injury or war caused disease or both, alone, prevented from continuing to undertake the remunerative work (last paid work) that the veteran was last undertaking before he or she made the claim or application; and

(e) because the veteran is so prevented from undertaking his or her last paid work, the veteran is suffering a loss of salary or wages, or of earnings on his or her own account, that he or she would not be suffering if he or she were free from that incapacity; and

(f) the veteran was undertaking his or her last paid work after the veteran had turned 65; and (SUB 70)

(g) when the veteran stopped undertaking his or her last paid work, the veteran had been undertaking remunerative work for a continuous period of at least 10 years that began before the veteran turned 65; and

(h) section 25 does not apply to the veteran.

(2B) For the purposes of paragraph (2A)(e), a veteran who is incapacitated from war caused injury or war caused disease or both, is not taken to be suffering a loss of salary or wages, or of earnings on his or her own account, because of that incapacity if:

(a) the veteran has ceased to engage in remunerative work for reasons other than his or her incapacity from that war caused injury or war caused disease, or both; or

(b) the veteran is incapacitated, or prevented from engaging in remunerative work for some other reason.

(3) This section also applies to a veteran who has been blinded in both eyes as a result of war caused injury or war caused disease, or both.

(4) Subject to subsections (5), (5A) and (6), the rate at which pension is payable to a veteran to whom this section applies is $919.40 per fortnight.

(5) Subject to subsections (5A) and (6), the rate at which pension is payable to a veteran to whom section 115D applies (veterans working under rehabilitation scheme) is the reduced amount worked out using the following formula:

(5A) If:

(a) section 115D applies to a veteran because of subsection 115D(1A); and

(b) the veteran is engaged in remunerative work of more than 8 hours, but less than 20 hours, per week as a result of undertaking a vocational rehabilitation program under the Veterans' Vocational Rehabilitation Scheme;

then, subject to subsection (6) of this section, the rate at which pension is payable to the veteran is the higher of the following amounts:

(c) the amount worked out under subsection (5) of this section;

(d) the amount under subsection 23(4).

(6) If section 25A applies to a veteran, the rate at which pension is payable to the veteran is the rate per fortnight specified in subsection (4), (5) or (5A) of this section, reduced in accordance with section 25A.

24A Continuation of rates of certain pensions

(1) Subject to subsections (1A) and (2), if the Commonwealth is or becomes liable to pay a pension to a veteran at the rate applicable under section 23 or 24, that rate continues, while a pension continues to be payable to the veteran, to apply to the veteran unless:

(a) the decision to apply that rate of pension to the veteran would not have been made but for a false statement or misrepresentation made by a person;

(b) in the case of a veteran to whom section 23 applies:

(i) the veteran is undertaking or is capable of undertaking remunerative work of a particular kind for 50% or more of the time (excluding overtime) ordinarily worked by persons engaged in work of that kind on a full time basis; or

(ii) in a case where subparagraph (i) is inapplicable to the work which the veteran is undertaking or is capable of undertaking—the veteran is undertaking or is capable of undertaking that work for 20 or more hours per week; or

(c) in the case of a veteran to whom section 24 applies—the veteran is undertaking or is capable of undertaking remunerative work for periods aggregating more than 8 hours per week.

(1A) However, subsection (1) does not prevent a rate applicable under subsection 24(4), (5) or (5A) from being reduced to give effect to subsection 24(6).

(2) Paragraphs (1)(b) and (c) do not apply to a veteran if the veteran is undertaking a rehabilitation program under the Veterans' Vocational Rehabilitation Scheme or section 115D applies to the veteran.

• 25 Temporary payment at special rate

(1) Where the Commission is satisfied that:

(a) a veteran is temporarily incapacitated from war caused injury or war caused disease, or both; and

(b) if the veteran were so incapacitated permanently, the veteran would be a veteran to whom section 24 applies;

the Commission shall determine the period during which, in its opinion, that incapacity is likely to continue and this section applies to the veteran in respect of that period.

(2) Where this section applies to a veteran in respect of a period, the rate at which pension is payable to the veteran in respect of that period is the rate that would have been applicable under subsection 24(4), (5), (5A) or (6) if section 24 applied to the veteran.

(3) The Commission may, under this section:

(a) determine a period that commenced before the date on which the determination is made; and

(b) determine a period in respect of a veteran that commenced or commences upon the expiration of a period previously determined by the Commission under subsection (1) in respect of the veteran.

25A Offsetting certain payments made under the Safety, Rehabilitation and Compensation (Defence related Claims) Act 1988

(1) This section applies to a veteran:

(a) to whom section 23, 24 or 25 applies; or

(b) who is granted a loss of earnings allowance under section 108;

in respect of the incapacity of the veteran from a war caused injury or a war caused disease if the veteran has received an amount of compensation, whether before or after the commencement of this section, under section 24, 25 or 27 of the Safety, Rehabilitation and Compensation (Defence related Claims) Act 1988 for that injury or disease, or any other injury or disease, in relation to some other incapacity of the veteran.

(2) That amount of compensation is to be converted to a fortnightly amount in accordance with advice from the Australian Government Actuary.

(3) The rate at which:

(a) a pension is payable to the person under section 23, 24 or 25; or

(b) a loss of earnings allowance under section 108 is payable to the person;

apart from this section, is reduced, but not below zero, by the fortnightly amount worked out under s22 General rate of pension and extreme disablement adjustment

(1) This section applies to a veteran who is being paid, or is eligible to be paid, a pension under this Part, other than a veteran to whom section 23, 24 or 25 applies.

(2) Subject to this Division, the rate at which pension is payable to a veteran to whom this section applies in respect of the incapacity of the veteran from war caused injury or war caused disease, or both, is the rate per fortnight that constitutes the same percentage of the general rate as the percentage determined by the Commission in accordance with section 21A to be the degree of incapacity of the veteran from that war caused injury or war caused disease, or both, as the case may be.

(3) For the purposes of this section, the maximum rate per fortnight is $338.94 per fortnight.

(4) Where:

(a) either:

(i) the degree of incapacity of a veteran from war caused injury or war caused disease, or both, is determined under section 21A to be 100% or has been so determined by a determination that is in force; or

(ii) a veteran is, because he or she has suffered or is suffering from pulmonary tuberculosis, receiving or entitled to receive a pension at the maximum rate per fortnight specified in subsection (3);

(b) the veteran has attained the age of 65;

(c) the veteran has an impairment rating of at least 70 points and a lifestyle rating of at least 6 points, each determined in accordance with the approved Guide to the Assessment of Rates of Veterans' Pensions; and

(d) the veteran is not receiving a pension at a rate provided for by section 23, 24 or 25;

the rate at which pension is payable to the veteran is $510.40 per fortnight.

(5) For the purpose of subsection (4), a veteran who has been granted a pension at a rate specified in subsection (3) or provided for by section 23, 24 or 25 shall be taken to be receiving a pension at the rate specified in, or provided for by, the provision concerned even if:

(a) the rate has been reduced, or the pension is not payable, because of section 26, 30C, 30D or 74;

(b) amounts are being deducted from the pension under section 30P, 79 or 205; or

(c) the pension has been suspended under subsection 31(6).ubsection (2) of this section.

• 22 General rate of pension and extreme disablement adjustment

(1) This section applies to a veteran who is being paid, or is eligible to be paid, a pension under this Part, other than a veteran to whom section 23, 24 or 25 applies.

(2) Subject to this Division, the rate at which pension is payable to a veteran to whom this section applies in respect of the incapacity of the veteran from war caused injury or war caused disease, or both, is the rate per fortnight that constitutes the same percentage of the general rate as the percentage determined by the Commission in accordance with section 21A to be the degree of incapacity of the veteran from that war caused injury or war caused disease, or both, as the case may be.

(3) For the purposes of this section, the maximum rate per fortnight is $338.94 per fortnight.

(4) Where:

(a) either:

(i) the degree of incapacity of a veteran from war caused injury or war caused disease, or both, is determined under section 21A to be 100% or has been so determined by a determination that is in force; or

(ii) a veteran is, because he or she has suffered or is suffering from pulmonary tuberculosis, receiving or entitled to receive a pension at the maximum rate per fortnight specified in subsection (3);

(b) the veteran has attained the age of 65;

(c) the veteran has an impairment rating of at least 70 points and a lifestyle rating of at least 6 points, each determined in accordance with the approved Guide to the Assessment of Rates of Veterans' Pensions; and

(d) the veteran is not receiving a pension at a rate provided for by section 23, 24 or 25;

the rate at which pension is payable to the veteran is $510.40 per fortnight.

(5) For the purpose of subsection (4), a veteran who has been granted a pension at a rate specified in subsection (3) or provided for by section 23, 24 or 25 shall be taken to be receiving a pension at the rate specified in, or provided for by, the provision concerned even if:

(a) the rate has been reduced, or the pension is not payable, because of section 26, 30C, 30D or 74;

(b) amounts are being deducted from the pension under section 30P, 79 or 205; or

(c) the pension has been suspended under subsection 31(6).

Chapter 3—Rehabilitation

Part 1—General provisions

Division 1—Simplified outline of this Chapter

37 Simplified outline of this Chapter

This Chapter provides for the following for certain current and former members suffering a service injury or disease:

(a) rehabilitation programs;

(b) assistance in finding suitable defence or civilian work;

(c) assistance in moving from defence service to civilian life.

The capacity for rehabilitation of a person with a service injury or disease is assessed under Part 2. If the person is capable of rehabilitation, he or she may be required to undertake a rehabilitation program under that Part.

Part 2 also provides for rehabilitation for certain persons who have made a claim for acceptance of liability by the Commission for a service injury or disease, where the claim has not been determined.

Under Part 3, a person who is undertaking a rehabilitation program, or a person who cannot undertake a program, can have his or her home or place of work etc. altered or an aid or appliance provided.

All members and former members who are incapacitated for service or work are assisted in finding suitable work under Part 4.

A case manager is appointed under Part 5 to assist a Permanent Forces member, a continuous full-time Reservist or a part-time Reservist move to civilian life if the person is likely to be discharged from the Defence Force.

Division 2—Aim of rehabilitation

38 Aim of rehabilitation

The aim of rehabilitation is to maximise the potential to restore a person who has an impairment, or an incapacity for service or work, as a result of an injury or disease to at least the same physical and psychological state, and at least the same social, vocational and educational status, as he or she had before the injury or disease.

Division 3—Definitions

39 Definition of *rehabilitation authority*

(1) The Chief of the Defence Force is a ***rehabilitation authority*** for the purposes of this Chapter.

(2) The Commission is a ***rehabilitation authority*** for the purposes of this Chapter.

(3) The ***rehabilitation authority*** for a person at a time is:

(a) subject to paragraph (aa), the Chief of the Defence Force for a time when the person:

(i) is a Permanent Forces member, a continuous full-time Reservist or a part-time Reservist; and

(ii) has not been identified by or on behalf of the Chief of the Defence Force as being likely to be discharged from the Defence Force for medical reasons; or

(aa) if the Commission, after considering advice from the Chief of the Defence Force, determines, in writing, that the Commission is to be the rehabilitation authority for a specified person at a specified time—the Commission for that time; or

(b) the Commission for any other time.

(4) A determination made under paragraph (3)(aa) is not a legislative instrument.

40 Rule if rehabilitation authority for a person changes

(1) This section applies if a person's rehabilitation authority (the ***original rehabilitation authority***) changes to another rehabilitation authority (the ***new rehabilitation authority***) because of section 39.

(2) If:

(a) under subsection 44(2), the person requests the original rehabilitation authority to carry out an assessment of the person's capacity for rehabilitation; and

(b) the rehabilitation authority changes before the assessment begins;

the person's request is taken to have been made to the new rehabilitation authority.

(3) A determination of the original rehabilitation authority that is in force immediately before the rehabilitation authority changes has effect as a determination of the new rehabilitation authority. The new rehabilitation authority is responsible for giving effect to the determination.

41 Other definitions

(1) In this Chapter:

approved program provider means:

(a) a person or body that is an approved program provider for the purposes of the *Safety, Rehabilitation and Compensation Act 1988*; or

(b) a person nominated in writing by a rehabilitation authority, being a person the rehabilitation authority is satisfied has appropriate skills and expertise to design and provide rehabilitation programs.

approved rehabilitation program means a rehabilitation program determined under section 51 for a person by the person's rehabilitation authority.

rehabilitation program means a program that consists of or includes any one or more of the following:

(a) medical, dental, psychiatric and hospital services (whether on an in-patient or out-patient basis);
(b) physical training and exercise;
(c) physiotherapy;
(d) occupational therapy;
(e) vocational assessment and rehabilitation;
(f) counselling;
(g) psycho-social training.

vocational assessment and rehabilitation consists of or includes any one or more of the following:

(a) assessment of transferable skills;
(b) functional capacity assessment;
(c) workplace assessment;
(d) vocational counselling and training;
(e) review of medical factors;
(f) training in resume preparation, job-seeker skills and job placement;
(g) provision of workplace aids and equipment.

• Part 2—Rehabilitation programs

Division 1—Application of Part

42 Simplified outline of this Part

This Part applies to a person who is incapacitated for service or work, or who is impaired, as a result of a service injury or disease.

Most decisions under this Part are made by the person's rehabilitation authority. The rehabilitation authority is either the Chief of the Defence Force or the Commission.

The rehabilitation authority, either on its own initiative or on the person's request, carries out an initial assessment of the person's capacity for rehabilitation. The person might be required to undergo an examination (paid for by the Commonwealth) as part of the assessment. (Compensation can be paid for costs incurred in travelling to the examination.)

Once the assessment is done, the rehabilitation authority decides if the person should undertake a rehabilitation program (provided by an approved program provider). In certain cases, the rehabilitation authority can stop or vary the program once it has begun.

A person's right to compensation can be suspended if the person fails to undergo an examination or fails to undertake the program as required.

This Part also provides for rehabilitation for certain persons who have made a claim for acceptance of liability by the Commission for a service injury or disease, where the claim has not been determined.

43 Persons to whom this Part applies

Commission has accepted liability for service injury or disease

(1) This Part applies to a person at a time if, at that time:
   (a) the person is incapacitated for service or work, or has an impairment, as a result of a service injury or disease; and
   (b) the Commission has accepted liability for the injury or disease.

(2) To avoid doubt, this Part applies to a person who is incapacitated or impaired as a result of an aggravated injury or disease even if the incapacity or impairment resulted from the original injury or disease and not from the aggravation or material contribution.

Claim for acceptance of liability for service injury or disease not determined

(3) This Part also applies to a person if:
   (a) the person has made a claim of a kind referred to in paragraph 319(1)(a); and
   (b) the Commission has not determined the claim; and

(c) the person is included in a class of persons determined in an instrument under subsection (4); and

(d) the Commission has determined, in writing, that this Part applies to the person.

(4) The Commission may, by legislative instrument, determine a class of persons for the purposes of paragraph (3)(c).

(5) A determination under paragraph (3)(d) is not a legislative instrument.

Division 2—Assessment of a person's capacity for rehabilitation

44 When an assessment may or must be carried out

Assessments on rehabilitation authority's initiative

(1) The rehabilitation authority for a person to whom this Part applies may, on its own initiative, carry out an initial assessment or a further assessment of the person's capacity for rehabilitation.

Requests for assessments

(2) A person to whom this Part applies may request his or her rehabilitation authority to carry out an initial assessment or a further assessment of his or her capacity for rehabilitation.

(3) The rehabilitation authority:

(a) must carry out an initial assessment; and

(b) may carry out a further assessment;

if the person requests the rehabilitation authority to do so.

Requirement to carry out assessment before ceasing or varying a program

(4) The rehabilitation authority must carry out an assessment before ceasing or varying a rehabilitation program under section 53.

45 What may be done as part of an assessment

(1) This section applies if the person's rehabilitation authority carries out an assessment under section 44 of the person's capacity for rehabilitation.

(2) The rehabilitation authority may seek the assistance of a person the authority is satisfied has suitable qualifications or expertise to provide assistance.

(3) The rehabilitation authority may take into account any relevant information of which it is aware.

(4) The rehabilitation authority may require the person to undergo an examination under section 46.

46 Requirements for examinations

(1) This section applies if the person's rehabilitation authority requires the person to undergo an examination.

(2) The examination is to be carried out by an examiner nominated by the rehabilitation authority whom the authority is satisfied has suitable qualifications or expertise to carry out the examination.

(3) The examiner must give a written report of the examination to the rehabilitation authority. The report must include:

(a) an assessment of the person's capacity for rehabilitation; and

(b) if the person has a capacity for rehabilitation—the kinds of rehabilitation from which the person would benefit; and

(c) any other information relating to the provision of a rehabilitation program for the person that the rehabilitation authority requires.

(4) The Commonwealth is liable to pay the cost of conducting the examination.

47 Compensation for journey and accommodation costs

The Commonwealth is liable to pay compensation for any costs reasonably incurred if:

(a) the costs are incurred:

(i) in making a necessary journey in connection with the examination; or

(ii) in remaining, for the purpose of the examination, at a place to which the person has made a journey for that purpose; and

(b) a claim for compensation in respect of the person has been made under section 319.

Note: This section might be affected by section 50 or 52 (failure to undergo examination or rehabilitation program).

48 Amount of compensation for journey and accommodation costs

(1) The amount of compensation that the Commonwealth is liable to pay under section 47 is the amount determined by the rehabilitation authority to be the amount reasonably incurred in making the journey or remaining at the place.

(2) In determining the amount, the rehabilitation authority must have regard to:

(a) the means of transport available to the person for the journey; and

(b) the route or routes by which the person could have travelled; and

(c) the accommodation available to the person.

49 Whom the compensation is payable to

(1) Compensation under section 47 for costs reasonably incurred is payable to:

(a) the person who made the claim for compensation; or

(b) if that person so directs:

(i) the person who provided services in connection with the journey or accommodation; or

(ii) any other person who incurred the cost of services in connection with the journey or accommodation.

Note: A special rule applies if a trustee is appointed under section 432.

(2) A payment under section 47 to a person who provided services in connection with the journey or accommodation discharges any liability of any other person for the cost of those services to the extent of the payment.

50 Consequences of failure to undergo an examination

(1) If the rehabilitation authority for a person requires the person to undergo an examination under section 45 and the person:

(a) refuses or fails to undergo the examination; or

(b) in any way obstructs the examination;

the rehabilitation authority may determine that the person's right to compensation (but not the person's right to treatment or compensation for treatment under Chapter 6) under this Act is suspended until the examination takes place.

Note: Subsection (6) provides that this section does not apply to a person to whom this Part applies because of subsection 43(3) (claim for acceptance of liability not determined).

(2) A determination under subsection (1) must not be made in relation to a refusal or failure to undergo the examination if, before the time fixed for the examination, the person gives to the rehabilitation authority evidence of a reasonable excuse for the refusal or failure.

(3) The rehabilitation authority must determine that the suspension under subsection (1) is terminated from a date determined by the rehabilitation authority if, within 14 days after the date fixed for the examination, the person gives to the rehabilitation authority evidence of a reasonable excuse for the refusal, failure or obstruction.

(4) If a determination under subsection (1) is made by a delegate of the rehabilitation authority, the rehabilitation authority must ensure that any determination terminating the suspension under subsection (3) also made by a delegate of the rehabilitation authority is made by a delegate other than a delegate who was involved in making the determination under subsection (1).

(5) If a person's right to compensation is suspended under subsection (1), compensation is not payable during or in respect of the period of the suspension.

(6) This section does not apply to a person to whom this Part applies because of subsection 43(3) (claim for acceptance of liability not determined).

Division 3—Provision of rehabilitation programs

51 Rehabilitation authority may determine that a person is to undertake a rehabilitation program

(1) The rehabilitation authority for a person to whom this Part applies may determine that the person is to undertake a rehabilitation program specified in the determination if an assessment has been made under section 44 of the person's capacity for rehabilitation.

(2) In making a determination under subsection (1) in respect of the person, the person's rehabilitation authority is to have regard to the following:

(a) any written report in respect of the person under subsection 46(3);

(b) any reduction in the future liability of the Commonwealth to pay or provide compensation if the program is undertaken;

(c) the cost of the program;

(d) any improvement in the person's opportunity to be engaged in work after completing the program;

(e) the person's attitude to the program;

(f) the relative merits of any alternative and appropriate rehabilitation program;

(g) any other matter the rehabilitation authority considers relevant.

(3) If the rehabilitation authority for a person makes a determination under subsection (1) that a person is to undertake a rehabilitation program, the rehabilitation authority must make arrangements with an approved program provider for the provision of the program for the person.

Note: The person might also be entitled to have his or her home altered or aids or appliances provided under Part 3.

(4) For the purposes of designing or providing a rehabilitation program:

(a) the rehabilitation authority or approved program provider concerned may seek the assistance of persons with suitable qualifications or expertise in the design or provision of rehabilitation programs; and

(b) the rehabilitation authority or approved program provider concerned may take into account any relevant information of which it is aware or that is brought to its attention.

(5) The cost of a rehabilitation program provided for a person under this section is to be paid by the Commonwealth.

52 Consequences of failure to undertake a rehabilitation program

(1) If the rehabilitation authority for a person requires the person to undertake a rehabilitation program under section 51, and the person refuses or fails to undertake the rehabilitation program, the rehabilitation authority may determine that the person's right to compensation (but not the person's right to treatment or compensation for treatment under Chapter 6) under this Act is suspended until the person undertakes the rehabilitation program.

Note: Subsection (6) provides that this section does not apply to a person to whom this Part applies because of subsection 43(3) (claim for acceptance of liability not determined).

(2) A determination under subsection (1) must not be made in relation to a refusal or failure to undertake the rehabilitation program if, before the date fixed for starting the

rehabilitation program, the person gives to the rehabilitation authority evidence of a reasonable excuse for the refusal or failure.

(3) The rehabilitation authority must determine that the suspension under subsection (1) is terminated from a date determined by the rehabilitation authority if, within 14 days after the date fixed for starting the rehabilitation program, the person gives to the rehabilitation authority evidence of a reasonable excuse for the refusal or failure.

(4) If a determination under subsection (1) is made by a delegate of the rehabilitation authority, the rehabilitation authority must ensure that any determination terminating the suspension under subsection (3) also made by a delegate of the rehabilitation authority is made by a delegate other than a delegate who was involved in making the determination under subsection (1).

(5) If a person's right to compensation is suspended under subsection (1), compensation is not payable during or in respect of the period of the suspension.

(6) This section does not apply to a person to whom this Part applies because of subsection 43(3) (claim for acceptance of liability not determined).

53 Cessation or variation of a rehabilitation program

(1) This section applies if:
  (a) the rehabilitation authority for a person has made a determination under subsection 51(1) that the person is to undertake a rehabilitation program; and
  (b) an approved program provider has commenced providing the rehabilitation program.

(2) The rehabilitation authority may, on its own initiative or on written application by the person, determine that:
  (a) the rehabilitation program cease; or
  (b) the rehabilitation program be varied.

(3) Before making a determination under subsection (2), the rehabilitation authority must:
  (a) undertake an assessment under section 44 of the person's capacity for rehabilitation; and
  (b) consult the person about the proposed determination.

• Veterans' Vocational Rehabilitation Scheme

Instrument 2015 No. R11

made under subsection 115B(1) of the

Veterans' Entitlements Act 1986

Compilation No. 1

Compilation date: 20 March 2016

Includes amendments up to: F2016L00248

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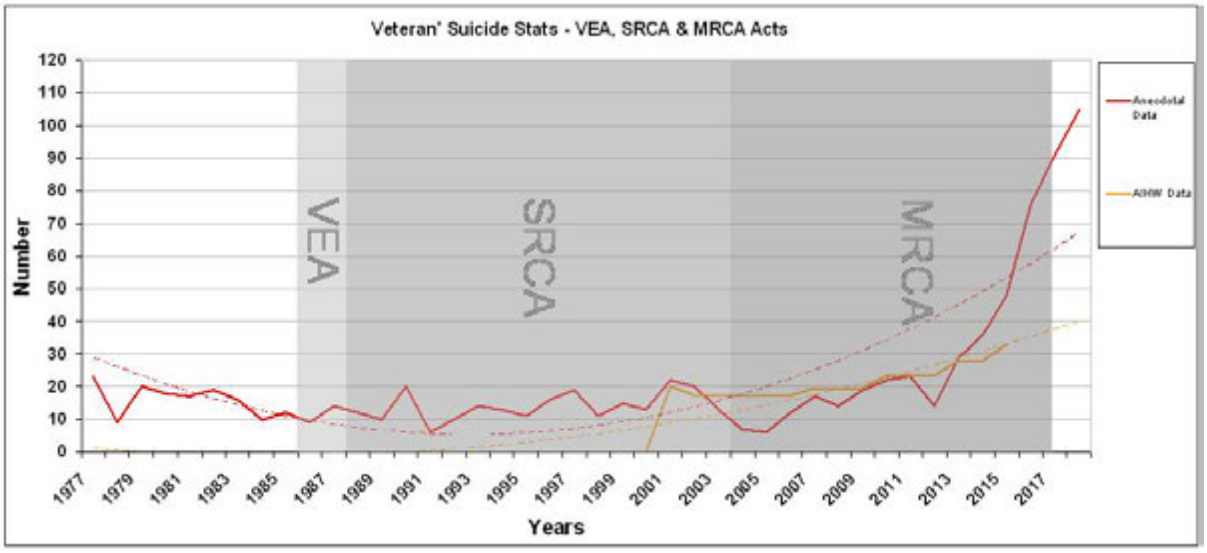

This factsheet summarises the key findings from the 2016 DVA Client Satisfaction Survey. In total, 3,002 randomly selected veterans participated in the telephone survey conducted in November-December 2016. DVA actively targeted veterans of all ages for this survey, across Australia. A higher number of veterans aged under 45 years were interviewed (compared to the client population) in an effort to improve understanding of satisfaction amongst this group. In this factsheet, survey results have been aligned to reflect the DVA client population. Key Insights The survey results show 83% of veterans are satisfied with DVA overall, 6 percentage points below the result of the last survey in 2014. Older veterans remain more positive about DVA's service delivery compared to younger veterans. This is partly explained by younger veterans' higher levels of interaction with DVA in relation to claims for benefits and services. The results of this survey will inform DVA's efforts to transform the delivery of services to veterans and their families. Respondent Characteristics 53% 47% NT

https://www.dva.gov.au/sites/default/files/files/consultation%20and%20grants/2016%20CSS%20Factsheet.PDF

3.11.3 Payment of Lump Sum Advance

DOCUMENT
Print version Send email

Last amended: 5 March 2013

Advance payment eligible amount

VEA ?
The advance payment eligible amount is the sum of the maximum basic rate of service pension that applies to the person (i.e. single, partnered, illness separated) and the amount (if any) by which the person's pension supplement exceeds the minimum pension supplement amount. For people not receiving a service pension this is calculated as if they were receiving the pension.

Amount of lump sum advance payment

VEA ?
The result of the following process is the maximum advance payable:

Step	Action
1	Work out 3/52 of the person's advance payment eligible amount.
2	Work out the annual rate at which pension was payable to the person on the last payday before they applied for an advance payment (excluding any remote area allowance, minimum pension supplement and clean energy supplement).

3	Work out the smaller of the result of Step 1 and: • for service pensioners and ISS recipients – 7.5% of the result of Step 2 • otherwise – 13 times the fortnightly rate of pension payable to the person.
4	From the result of step 3 subtract: • any advance payments paid in the previous 13 fortnights • any other advance payments that have not been fully repaid.
5	Round the result of step 4 to the nearest cent (rounding 0.5 cents upwards).

A pensioner can request any amount of lump sum advance providing it is less than the[glossary:advance:] payment [glossary:maximum amount:] and greater than the[glossary:advance:] payment [glossary:minimum amount.:]

Minimum amount of advance payment

VEA ?
The minimum advance payable is 1/52 of the person's [glossary:advance:] payment[glossary:eligible amount:].

Frequency of lump sum advance

There is no direct limit on the number of lump sum advance payments. In practice, due to the operation of the minimum and maximum amounts, up to three lump sum advances can be granted in any 13 week period.

Service Pensioners or ISS recipients who also receive Disability Pension

Where an individual has two payments which make them eligible for a lump sum advance, they are entitled to receive a lump sum advance based on whichever payment gives the higher advance amount.

Example of a lump sum advance for a person receiving service pension and disability pension

Anne is a single person who receives fortnightly service pension payment of $530.60 (including pension supplement but excluding clean energy supplement) and a 15% disability pension payment of $64.89 (excluding clean energy supplement). She applies for an advance of $800. A delegate of the Commission determines that she meets all of the eligibility criteria. She has not received any advances in the past 13 fortnights. Based on her service pension (excluding the minimum supplement and clean energy supplement) her maximum lump sum advance is $975 ([$530.60 – 30.60] x 1.95). Based on her disability pension her maximum lump sum advance is $843.57 ($64.89 x 13). As the service pension advance is higher, but is less than the maximum single advance of $1,005.75, that amount will be her maximum advance. Her minimum

advance is $381.05. Based on her service pension, she can receive an advance of $800, but she will not be eligible for another advance for the next thirteen fortnights, as her maximum advance less the $800 advance is lower than the minimum advance payment amount.

http://clik.dva.gov.au/compensation-and-support-policy-library/part-3-income-support-eligibility/311-lump-sum-advance/3113-payment-lump-sum-advance

Sincerely

Rod Thompson
Advocate (Level 4)

DRAFT DISCUSSION PAPER ON MEDICO-LEGAL REPORTS USED BY DVA UNDER THE VEA, SRCA AND MRCA LEGISLATIONS

PREPARED BY ROD THOMPSON – ADVOCATE LEVEL 4 (APPVA)
NATIONAL ENTITLEMENTS OFFICER
YOUNGER VETERANS OUTREACH PROGRAME

Preamble

Over the past decade or more the Department has engaged the services of Medico-Legal Report Writing Companies for the purpose of Medical Reports that are used to assist in the determination of claims under the VEA, SRCA and more recently MRCA. It is also important to note that COMMSUPER (DFRDB & MSBS) also use the services of these companies as do most State Workers Compensation Boards and Insurance Companies.

There is no doubt that these companies provide a valuable service, all be it at a price to the entities that engage their services. It is not my intention to comment on State Workers Compensation or the Insurance industry as that is outside my scope of expertise and is not relevant to this discussion paper other than their use of Medico-Legal reports as the basis for determining claims.

In the Veterans' Advocacy field I doubt that there would be many files held by ESO's that do not contain at least one Medico-Legal report commissioned by the department at departmental expense. It would not be outrageous to also surmise that approximately 90% of these reports were furnished by Medico-Legal companies and the remainder furnished by LMO's and Treating Specialists. It would be unrealistic to suggest that all reports should be furnished by LMO's or Treating Specialists, as we are all aware that these professionals have practices to run and other patients to see and producing Medico-Legal reports are time consuming and rather low on their list of priorities and rightly so. Subsequently, it is a fact of life that if we want to expedite the claims process the use of Medico-Legal report writing companies is a necessity.

But with that necessity must come some level of responsibility as to the accuracy and validity of these reports. These companies do not provide their services pro bono and receive considerable remuneration for each report. Understanding that the department has an obligation to the Australian Taxpayer to accurately acquit their annual expenditure. Thus, requiring them to ensure that claims made under various legislations are properly assessed on valid medical and legal grounds in line with the appropriate legislation.

Also adding weight to this is the fact that in recent times a number of bogus and fraudulent claims that were previously accepted by the department have been uncovered and prosecuted, understandably placing extra pressure on delegates investigating claims to ensure that everything is above board. This circumstance has somewhat diminished the **"Beneficial Legislation"** clause enshrined in the original Veterans' Entitlement Act. Meaning, unfortunately that the department can no longer take the word of a veteran as to the accuracy of his recollection of a certain event that may have lead to the claimed injury or illness and relies on the services of paid ***"experts"*** to validate the claim.

It is now a normal course of events under both SRCA and MRCA legislations when liability has been accepted for a claimed injury or illness a Permanente Impairment (PI) rating using PIG or GARP must be established to enable the calculation of entitlements for the client. Be that a lump sum payment or fortnightly pension. These assessments are based substantially on Medico-Legal reports sourced from private companies using the American Medical Association (AMA) tables as a guide.

With the introduction of the MRCA legislation in July of 2004 lump sum or compensation payments substantially increased, providing significant financial compensation (still far below the civil bench mark) for service caused injuries and illnesses. Therefore, making the Medico-Legal report pivotal in the determination process, subsequently placing the client's immediate financial future in the hands of a Doctor who may spend as little as 15 minutes with him / her.

This brings me to the point of this paper there are few if any, checks and balances applied to the Medico-Legal Report industry no defined code of conduct or ethics that hold the company liable for inaccurate reports. The department is able to bounce the blame back to the Doctor and absolves itself with the statement ***"you have the right to appeal the decision"***. But the doctor continues to see department referred clients and continues to be paid for inaccurate reports. It should be noted that at end of each report the doctor states that he acknowledges that ***"he / she has read the Expert Witness Code of Conduct and agrees to be bound by it"***. One question I intend to pose below is which code of conduct is that statement in reference to and what are the consequences of breaching it?

Medico-Legal Reports
Facts and Investigations

As stated above Medico-Legal Reports are a fact of life for veterans' and advocates alike it would be a very rare veteran indeed, that has not undergone one of these reports at some stage during their time as a DVA client. Which makes getting these reports right, imperative, not only for the sake of the client's physical, psychological and financial wellbeing, but cutting down departmental expense and delegates workloads. It is a double edged sword, if a report is flawed and inaccurate the delegates decision is more than likely going to be appealed and at some stage during the appeals process a supplementary report will be furnished at departmental expense. In my experience if you appeal a decision based on a flawed medico-legal report and the clients treating doctor supports your contention. It is more than likely the appeal will be successful and the original decision overturned in favour of the client. This process is both stressful and damaging to the client and costly, time and asset consuming for the department.

A number of factors need to be considered when discussing these reports.

- What is the benefit of utilising a medico-legal report company as opposed to requesting the same report from the clients treating specialist.
- If a delegate becomes aware of inaccuracies in a report either by way of the client or personally identifying such inaccuracies. What obligation does the delegate have as to his / her decision in relation to the claim.
- What is an appropriate time frame to conduct a medico-legal examination for single and multiple conditions.
- What supporting evidence i.e. service and civil medical documents, departmental records, x-rays, scans, medication history is the minimum requirement for a balanced report taking into account that the consulting doctor has no previous history with the client.
- Where does the responsibility rest in relation to providing these documents – client or department.
- Does the consulting physician have a responsibility to ascertain what medication and dosage the client has taken prior to the examination.
- Subsequently does the examining doctor then have a responsibility to include in the report that the client's results were tainted and did not reflect the unmediated level of impairment.
- Are the departmental appointment letters sent to clients informing them of the time, place and location of the appointment informative enough.
- What are the rights of clients in relation to the interview process. Are they allowed to record the proceedings or have an independent witness present i.e. spouse/family member/advocate to validate the impartiality of the examination.

- With the point above in mind, taking into account a large percentage of the assessments conducted for the department rely on the AMA tables (some of which are ambiguous at best). What onus is placed on the assessing practitioner to state what methods / equipment was used to formulate his /her findings in relation to the AMA tables.
- Does a delegate have the right to question a report or suggest certain changes to an assessment.
- Does the department pay for flawed reports or is reimbursement requested.

With the above points in mind it is now my intention to examine in detail the whole Medico-Legal process using case studies, original reports, legal references, published reports and papers and personal experiences. Please note that all the information that will be provided below is factual and is not in any way supposition or assumption.

***Please note that no veteran/client will be named directly but if required for purposes of validation requests will be made directly to those concerned for the release of their files held by the Department or ESO's.**

Case 1:

Veteran "**A"** (VEA)

Veteran "A" was a 60 year old Vietnam veteran who worked as a travelling insurance broker. During his operational service in Vietnam he was involved in a motor vehicle accident (MVA) and sustained blunt trauma injuries to his right hip. This injury along with others including PTSD were accepted by the DVA and he was paid disability pension at 80% of the general rate. This situation continued for many years as the veteran was able to work with some interference from his injuries. The injury to the right hip deteriorated to the extent that the veteran required both hips to be replaced. The left hip had deteriorated due to an altered gate compensating for the injured right hip (also accepted by DVA). The veteran subsequently was advised that he would be unable to continue in his position as a travelling insurance broker by his treating specialist as he was unable to climb in and out of his vehicle and the long hours on the road aggravated his hip condition.

The veteran lodged an AFI with a realistic expectation of AGR pension entitlement as he had met all AGR criteria under section 24 of the VEA. The veteran was required to undergo a medico-legal report requested by the assessing delegate. This assessment was undertaken by a doctor working for a medico-legal company and an assessment was made using the GARP tables.

The veteran received a decision some months later increasing his pension to 90% of the general rate on the basis of the medico-legal report. The decision

was appealed, when the 137 report was received it contained the medico-legal report used by the delegate to exclude AGR for the following reasons:

1. The doctor stated that the veteran had little difficulty walking and did not limp.
2. The doctor stated that the veterans' disabilities did not prevent him from continuing work in a sedentary position.
3. The doctor also stated that should the veteran not be able to find employment in his current location he saw no issue with the veteran relocating to an area where employment opportunities were better even though the veteran had reached 60 years of age and had resided in that area for over 10 years.
4. The doctor also raised doubts as to the MVA being the cause of his hip problems even though DVA had investigated and accepted this many years prior.

The facts in this matter were far different:

1. At the time of the interview and assessment the veteran had difficulty walking and used a walking stick. He was one of the few veterans who were transported by jeep during the local ANZAC Day march as he was too disabled to march or walk the distance of the main street some 150 meters. It is also important to note that some 6 weeks after this medico-legal assessment the veteran was admitted to hospital and had both hip replacements redone.
2. The veterans treating specialist was categorical in his opinion that the veteran was unable to continue in his current profession, work that he had been doing for some 20 years. The veterans' employer also stated that he was unable to perform the duties required for his position because of his accepted disabilities and they could no longer hold his position open for him and had to let him go.
3. The veteran had lived in the area for more than 10 years owned a unit and had family living close by. The veteran was 60 years of age had significant disabilities and had little prospect of finding suitable employment locally or further afield.
4. The doctor was not asked to comment on liability issues only to assess the veterans' impairment using the GARP tables. The issue of causation had been investigated and accepted by the department years prior and was supported by service medical documents and previous specialist reports.

This case was successfully appealed and the veteran was granted TPI a supplementary medico-legal report was sourced from the veterans treating specialist at departmental expense.

CASE 2:

Veteran **"B"** (SRCA)

Veteran B was a 63 year old Vietnam veteran who served in the Royal Australian Navy (RAN) from approximately 1964 to 1973 including multiple trips to Vietnam onboard HMAS Sydney. In the late 1990's veteran "B" started suffering mood swings and an increased alcohol intake leading to marital difficulties. He was referred to the VVCS for counselling, during these sessions it was suggested that he may be suffering from PTSD. Subsequently he was advised to lodge a claim (D2582) under the VEA. An initial medico-legal report failed to establish a link to his operational service in Vietnam under the SOP for PTSD and the claim was rightly unsuccessful. Further investigation of the veterans' claim by a new advocate revealed an incident during his pre-Vietnam service when he was posted to HMAS Creswell in 1968 (briefly mentioned in the VEA medico-legal report). Veteran "B" was involved in a rescue / body recovery after a helicopter crash in Jervis Bay (this incident was verified). A claim (D2020) was lodged under SRCA, this claim was also unsuccessful. By this stage the veteran was regularly seeing a Psychiatrist and further details of the veterans' involvement in the helo crash incident were forthcoming and a report supporting the veterans' claim from his treating specialist was forwarded to the departmental review officer.

The review officer affirmed the original decision using the medico-legal report furnished for the VEA claim as part of her decision. Thus creating a catch 22 situation that a medico-legal report that found no link to (operational) VEA service was used to then deny a claim under SRCA where the report clearly defined the clinical onset as being outside the parameters of the VEA, even with supporting letters from the veterans' treating psychiatrist (note no request was sent to the treating specialist for a report). The case was then appealed to the AAT and a further 80+ page medico-legal report was furnished from a forensic psychiatrist (the veteran attended 2 one hour sessions). This report contained over 100 factual errors and misrepresentations relating to the veterans' service, medical and work history. The veterans' Vietnam service was embellished by the report writer to misrepresent the clinical onset to his Vietnam service and support the case of the MRCC. The AAT ordered a supplementary report at the request of the veterans' advocate and detailed the errors in the report supported by a 2 page report from the treating specialist, subsequently the forensic psychiatrist changed his position and agreed with the veterans' treating specialist in relation to clinical onset and causation and the MRCC conceded the case before hearing.

All costs of reports were either born by or reimbursed by the department.

CASE 3:

Veteran **"C"** (SRCA)

Veteran "C" is a 48 year old Gulf War veteran who has dual eligibility under both SRCA and VEA. He is currently in receipt of an AGR pension (VEA). Veteran C requested a reassessment of PI (SRCA) for a number of accepted conditions due to a marked deterioration since previous assessments. Subsequently the veteran was sent to a Medico – Legal Company for orthopaedic assessments on his Lumbar Spine, Left and Right Knees and Right Wrist. A separate medico-legal report was sourced from his treating psychiatrist for his Depressive Disorder (note that this doctor also works for a medico-legal firm). The veteran was informed, as is the norm, by way of departmental letter of the appointments and his responsibilities under the legislation.

The veteran attended the orthopaedic appointment, taking reports, MRI's and X-Rays as requested. During the appointment the veteran felt some unease about the attitude of the doctor conducting the assessment after approximately 40 minutes the assessment concluded. Some months later the veteran received the report in the mail. The report was non-reflective of the veteran's current level of incapacity and contained many factual and medical inconsistencies. The report also included comment on the veterans "Cervical Spine" a condition not claimed by the veteran and no investigation was requested by the department or undertaken by the doctor. Further to this a number of anomalies in relation to the veterans knees were also found in the report such as, no comment was made by the reporting doctor as to the fact that the veteran had undergone surgery on both knees some 3 months prior to the assessment, as the doctor had been handed the surgeons report at the beginning of the assessment along with MRI's (out of date 04) of the spine and x-rays of the right wrist.

The veteran contacted the departmental officer responsible for his claim and expressed his dismay at the report. To her credit the delegate requested that the veteran put his concerns in writing, which he did and subsequently further reports were requested from the veterans treating specialist for the knees and a further medico-legal report from a different company for the lumbar spine.

The veterans PI as per the first medico legal report compared to the second are listed below:

SRCA PI - Lumbar spine	Previous 10% WPI	1st Report 0% WPI	2nd Report 20% WPI
SRCA PI – L & R Knee	10% WPI ea	0% WPI ea	20% WPI ea
SRCA PI – R Wrist	20% WPI	10% WPI	Not Assessed

The difference between the assessments conducted on the same veteran some 4 months apart is astounding also noting that the previous assessments done on the veterans' spine and knees were conducted by the same medico legal company as conducted the first flawed report.

Noting all subsequent reports were conducted at departmental expense.

These brief case outlines are at the worst case scenario end of the scale for medico – legal reports. The bulk of the complaints and issues with these reports are along the lines of incorrect details – Name, Rank, Service, Dates, Units/Ship/Squadron, Age, Marital Status, Disabilities and no reference to medications (specifically pain medication) that could affect the reliability of any functional tests conducted on the day. Some reports obviously confuse patients, details, testing conducted and results. This confusion exists, based on my experience and information provided by Medico-Legal practitioners and Departmental Delegates for the following reasons:

a. Veterans'/clients and examining specialists do no not have a pre-existing repour and veterans'/clients are less likely to be forthcoming with personal details that may be pertinent to an accurate assessment of the claimed disability.
b. Further to (a) above, the examiner having no history with the subject and can rely only on information provided by the department, the subject and their observations on the day.
c. The interview process can be intimidating for the veteran / client, especially for those suffering psychological illnesses and this can create difficulties for the examiner. Especially if the subject becomes agitated and unresponsive due to perceived or real bias.
d. The time frame of an interview can be an issue especially when conducting investigations of multiple disabilities. i.e. 45 minutes may not be adequate for investigation of 2 or more separate injuries. On the other hand the subject's physical health and mental state could also be affected by a prolonged investigation conducted in one session.
e. The responsibility of providing all relevant documents to the examiner is a grey area. Departmental letters sent to veterans' / clients make the assumption that the subject has in his / her possession all the relevant medical data required by the doctor. The doctor, if as is the case in most instances, is not the subjects treating specialist, will not have at his disposal any historical data other than what is supplied by the department and the subject. Conversations with departmental delegates over this issue lead me to believe that due to workload constraints it is uncommon for the delegate to provide all relevant medical documents to the examiner prior to the assessment due to the large amount of time needed to photocopy and collate the appropriate medical information held on file.
f. The use of the American Medical Association (AMA) tables is also a point of conjecture amongst some medical professionals involved in the Medico-Legal field, These tables are at times, best described as ambiguous and in some circumstances unreflective and leave no room for informed medical opinion. Annexe 1.0 (attached) is an example of the negative expert medical opinion raised in relation to the AMA

tables. For the purpose of this paper I will refer to table 9.6 below as it is a more common and regularly used table in the medico-legal process. If a veteran / client is examined using this table for example the difference between 10 % WPI and 20% WPI is theoretically less than 1 degree in range of movement. Examiners use two methods for determining range of movement one is by eye (the touch your toes method) or by using a goniometer. I have personally only ever been assessed using a goniometer (please refer below) on one occasion in five medico-legal assessments for my spinal injury. Also please note that in the case of Veteran **3** above, a goniometer was used for the second assessment the difference being some 18 degrees range of movement which equates to a 20 percent difference under table 9.6 below. Financially this is the difference between no compensation payment and approximately 40,000 + dollars (Under the SRCA legislation).

Medical practitioners, (Physicians, Physician Assistants, Physical Therapists, Athletic Trainers, Chiropractors and Nurse Practitioners) use a goniometer to document initial and subsequent range of motion, at the visits for Occupational injuries, and by disability evaluators to determine a permanent disability. This is to evaluate progress, and also for medico-legal purposes. It is a tool to evaluate Waddell's signs (findings that may indicate symptom magnification.)

Table 9.6: Spine
(Percentage whole person impairment)
Lesions of the sacrum and coccyx should be assessed by using the table which most appropriately reflects the functional impairment. This will usually be Table 9.5.
Lesions of the spine are often accompanied by neurological consequences. These should be assessed using Table 9.4 or 9.5 and the results combined using the combined values table (Appendix 1).

%	Description of level of impairment	
	Cervical spine	**Thoraco-lumbar spine**
0	X-ray changes only.	X-ray changes only.
5	Minor restrictions of movement.	Minor restrictions of movement or crush fracture - compression of 25-50 percent.
10	Loss of half normal range of movement.	Loss of less than half normal range of movement or crush fracture—compression greater than 50 percent.
15	Loss of more than half normal range of movement.	Loss of half normal range of movement.
20	Complete loss of movement.	Loss of more than half normal range of movement.
30		Complete loss of movement.

g. The departmental requests for assessment sent to doctors broadly outline the parameters for assessment, but in my opinion do place enough weight on legislative requirements and precedents. Meaning not enough information is provided to the examining doctor as to what is the minimum legislative requirement (Material Contribution) as described in all legislations and supported by high court decisions such as “Kattenberg” which has been used as a yard stick for some time now. This situation puts the doctor in a difficult position as to his/her assessment and leads to some ambiguity in relation to final Medico-Legal Reports.
h. To my knowledge no uniform guide exists governing the procedures and conduct of Medico-Legal Reporting. A number of professional guides and legal rules are in place (attachments 1.1 and 1.2 refer). This situation applies to both sides of the equation as the practice of “Doctor Shopping” is a well known and a well used process. We are all aware and the above case studies reiterate the fact that medical opinion can differ significantly, and it is not uncommon for the Medico-Legal opinion to be very different from the opinion of the treating specialist and the subject’s medical documents.
i. Departmental delegates have the authority to engage doctors of their choice in regard to medico-legal report s. This is a questionable practice as it places the delegate in a position that could be interoperated as bias if they continue to use a practitioner that appears to furnish reports that are consistently and successfully appealed, is impartiality maintained in this circumstance.
j. Doctors furnishing medico-legal reports very rarely write the reports themselves; they pass notes and findings to a secretary who compiles the report, sometimes months after the initial interview. These reports are also compiled on templates that are used frequently for different subjects and this can result in data not pertaining to the subject being reflected in a report. So when the doctor actually signs the report his memory of the subject and interview may not be as accurate, leading to some of the inconsistencies and factual errors alluded to above.
k. The medico-legal industry is driven by our ever increasingly “litigation” based society. Medico-Legal reports are not compiled as a social service and come at significant cost. This cost is born by one side or the other in an adversarial situation raising the question does this enable an unbiased, impartial assessment or does the phrase that is bandied about frequently in ESO circles “don’t bite the hand that feeds you” carry more weight than it should.

Summary:

Unfortunately there are no easy answers to the questions posed above and it is obvious that Medico-Legal reports are a necessity. But we must bear in mind that the most important issue is the welfare of the veteran / client and their right to due process. A veteran / client may wait for months and sometimes longer for a report to be provided and then a decision in relation to their claim based on that report. In some circumstances the veteran/client may be unable to work and have little or no income to provide for family, basic living expenses, mortgage and other costs of living that we all take for granted. This compounds the stress and pressure already felt by a veteran / client suffering a significant injury / illness creating an avalanche of circumstances beyond their control.

Should the decision not go in favour of the veteran / client based on a flawed report he / she has the right to appeal, but this process is further time consuming and places undue psychological, physical and financial strain on a very vulnerable member of society. Leading, in some cases to marital breakdown, mental breakdown, bankruptcy and other social problems. Subsequently, should the appeal be successful the veteran / client is only compensated for the injury / illness and has no

course of redress for the unwanted consequences caused by the lengthy time frame taken to resolve the problems caused by a decision made using a flawed or inaccurate report.

One suggestion is to make the report writer liable for the unwanted consequences by way of litigation but again, this is costly on many levels and would have little hope of success. As previously stated there are no easy answers to this situation but a bipartisan approach engaging all levels of Government, the DVA , the AMA, Comcare, Medico-Legal Firms, ESO's, Legal Practitioners, Workers Compensation Boards, Insurers and any other relevant body could work to establish legislative guidelines that will benefit both the injured party and his / her employer or their duly appointed representative.

It is ridiculous to think in this day and age that a government department / employer could spend hundreds of thousands of dollars defending a flawed report in the courts system to save as little as few thousand dollars compensation due to an injured employee, when seeking a second opinion could cost as little as a few hundred dollars.

Finally, below I will list a number of personal thoughts based on my experiences as an advocate and a client:

- Time frames for delivery of reports should be established – 30 days from the date of interview would appear reasonable.
- No payment should be made until delivery of a factually correct report – verified by both the client and the department.
- A uniform code of conduct across all legislations should be established for Medico-Legal practitioners.
- Client satisfaction forms should be provided and signed by the veteran / client after each medico-legal assessment. This would help flag possible problems and give all parties the opportunity to resolve any perceived issues in a timely manner.
- All relevant documents should be provided by the requesting authority.
- Minimum and maximum time frames for interviews should be established with scope for further appointments if circumstances so require.
- The cost of proven flawed or factually incorrect reports should be reimbursed to the paying party.
- Delegates should not have the responsibility of sourcing practitioners for reports – departmental contracts engaging practitioners who are agreeable to time frames and guidelines should be established.
- Reports should not be bound solely by the AMA tables alone, some flexibility should be allowed to enable accuracy and correct reflection of the veterans' / client's physical and mental circumstances.
- Possible act of grace payments could be considered should a claim go over a certain time period due to a flawed report and the veteran / client suffer significant financial loss i.e. loss of home, business or other significant loss related directly to the time frame associated with the flawed medico-legal report and the veteran / client's inability to work due to the associated injury. (Only in cases of a successful appeal overturning the flawed report)
- Veterans' / clients should be instructed by departmental letter to cease medication (only when safe to do so) for a time period (taken on sound medical opinion) prior to the medico-legal assessment. This would provide a more accurate assessment of the subject's unmediated (real) state of impairment.
- Delegates / senior managers should be given discretionary powers to order supplementary or further reports should it be bought to their attention that a report is flawed and contains factual errors prior to determining the claim. The cost of these reports should initially be

borne by the department. But should this further report support the findings of the original then the veteran / client should be required to repay the department the cost of the supplementary / further reports. Thus placing some burden of proof on the veteran / client and reducing the likely hood of trivial, baseless and possibly fraudulent claims.

It is my hope that this draft paper will be used by the addressees listed below to add their expert opinions, concerns, thoughts, personal experiences and any other relevant information they deem appropriate. The issues raised above are, in my opinion of the upmost importance as they are at the core of the primary determination process and effect not only the veteran / client on many levels, but also come at a significant cost to the department in terms of finances, staff and asset workloads. Getting the process right the first time can only benefit all concerned and should be a priority for Advocates, Delegates and Doctors alike.

Addressees:

Mr. Alan Thomas – National President APPVA
Mr. Paul Copeland – National Advisor APPVA
Mr. Michael Quinn – Victorian President APPVA and Advocate Level 4
Mr. Tony Alexander - President VSASA and Advocate Level 4
Dr. Bruce Flegg – State Member for Moggill, Minister for Housing and Public Works (Ex-Army Medical Corps)
Ms. Alison Stanley – Deputy Commissioner DVA Queensland
Dr. Jonathan Dywer – Psychologist

Rod Thompson
Advocate (Level 4)
National Entitlements Officer
Younger Veterans Outreach Program
APPVA

Annexes:

1.0 - pages 13 -22	The AMA Guides to the Evaluation of Permanent Impairment and Psychiatric Impairment Assessment by Dr Michael Epstein Consultant Psychiatrist
1.0 – pages 23-24	Reliability of the American Medical Association guides' model for measuring spinal range of motion. Its implication for whole-person impairment rating.Nitschke JE, Nattrass CL, Disler PB, Chou MJ,Ooi KT.
1.1 – pages 25-46	Good Medical Practice A Code of Conduct for Doctors in Australia (8.7 refers to medico-legal)
1.2 – pages 47-48	EXPERT WITNESS CODE OF CONDUCT Supreme Court of NSW (Schedule K, Part 36 Rule 13C(1) and Part 39 Rule 2(1))

ANNEX 1.0

The AMA Guides to the Evaluation of Permanent Impairment and Psychiatric Impairment Assessment

Dr Michael Epstein
Consultant Psychiatrist

I have received the document entitled "Policy review of Comcare's permanent impairment guide. I note that the review has invited submissions.The Policy review has raised a number of issues including the following.

What is the fairest and most equitable basis for assessing the permanent impairment associated with psychological conditions?

For many years I have been involved in psychiatric impairment assessment and I have co-authored the psychiatric impairment guide used in Victoria. I have also lectured on the use of the various guides for assessing psychiatric impairment. I have been trained in the use of the Comcare Guide to the Assessment of the Degree of Permanent Impairment. It is with this background that I have prepared this paper to assist in the policy review.

I have focused on the use of the American Medical Association Guides to the Evaluation of Permanent Impairment -Fourth Edition and its successors, the 5th and 6th Editions.

The American Medical Association Guides to the Evaluation of Permanent Impairment in their successive editions have become an outstanding success and their use has been widespread in America, Australia, and elsewhere. The Guides have provided a standardised method of determining impairment in all organ systems and through successive editions pioneered the use of methods of determining quantifiable and reproducible impairment ratings as a percentage of whole person impairment. They have also provided a method of combining impairments arising from different organ systems.

This success has not been mirrored in the section of The Guides dealing with mental and behavioural impairment. The 2nd Edition had a system that used the basic building blocks of any psychiatric examination, the mental state examination. That method was just workable and with considerable development, an amended version and its successors have been in use in Victoria since 1985. This method has been workable, equitable and without controversy. However that process was abandoned starting with the 3rd Edition This and the next 2 Editions have a system that is unusable. Because of this, every jurisdiction which uses the AMA Guides has been forced to develop some

modification. This has led to a veritable Tower of Babel in terms of methods of assessing psychiatric impairment.

Impairment/Disability

It is important to differentiate between impairment and disability. Impairment is the reduction or loss of a physical/mental function and is a matter for determination by clinicians.

By contrast disability is the reduction in ability arising from an impairment and is a matter for the courts. These definitions have been developed by the World health Organization.

The classical example of the difference is amputation of a little finger. This is a 5% whole person impairment according to the AMA Guides but may lead to 100% disability for a concert pianist and 0% disability for a construction worker.

Why Measure Psychiatric Impairment?

All statutory schemes that provide benefits for claimants such as workers' compensation schemes, transport accident schemes, personal injury schemes, pension and superannuation schemes require some method of measurement of impairment of health. Impairment measurements are used in two ways.

1. To provide a threshold so that claimants with impairments that lie below the threshold cannot proceed.

2. To provide a level of whole person impairment using a percentage to determine the level of benefits provided.

Various legislatures that implement and control these schemes have shown considerable uncertainty and ambivalence about dealing with psychiatric injury. This concern arises from a number of sources. There is some prejudice against the people experiencing a psychiatric injury, at times with disbelief that such injuries occur. There are also concerns that since psychiatric injury is regarded as subjective it is capable of being misused by fraudulent claims, so-called gaming.

Most jurisdictions have developed methods of limiting claims for psychiatric injury. Some jurisdictions simply exclude psychiatric injury from benefits. Other schemes require claimants with a psychiatric injury to meet a higher level of threshold of impairment before they can access the scheme. The third method, used extensively in Australia, is to reject claims for psychiatric injury which are secondary to physical injury, for example depression arising from a chronic back injury. Successful claimants have to demonstrate that they have an injury arising from the incident itself, such as a post traumatic stress disorder. In a number of jurisdictions in Australia the latter two methods are combined.

A reliable means of measuring psychiatric percentage impairment is critical for courts, tribunals, and claimants.

Requirements of Any Method of Psychiatric Impairment Measurement

1. It should measure impairment and not disability. In some methods, which we will see later, disability is used as a surrogate for impairment, this is inappropriate. All

psychiatrists are familiar with assessing a person's mental status. This should be the core of any system of psychiatric impairment.

2. It should be easily and rapidly administered using data arising from the clinical interview. This is preferable to a checklist which is susceptible to cheating by claimants.

3. It should be able to produce a percentage figure which is reliable. The term reliable in this context means that different examiners, seeing the same claimant, come to a similar identical figure for percentage impairment.

4. It should be transparent and readily understood by courts and tribunals and the figures emerging from such a method should make sense. If a method consistently provides claimants who are functioning normally with an impairment of 60%, it would not be credible.

Problems Measuring Psychiatric Impairment

The fundamental problem with measuring psychiatric impairment is that there is no "gold standard". There is no objective measure such as in physical science. There is a means of accurately determining the length of a metre which is reproducible and is the standard throughout the world. Such a situation cannot apply in psychiatry.

Despite the requirement that any method should only measure impairment and leave disability for the courts and tribunals there is inevitably a blurring between impairment and disability, this is difficult to avoid. Inevitably psychiatrists rely on behaviour to inform their opinion. Behaviour is a manifestation of disability. Furthermore any method relies, to a large degree, on self reporting. This causes problems for people who are deliberately misleading the examiner or who, for a variety of reasons, are unable to provide an accurate account of their situation.

Furthermore there is a fundamental absurdity in collapsing a complex pattern of behaviour into a single number. This is inescapable and is a basic problem with psychiatric impairment.

There are also special problems in psychiatric impairment assessment when dealing with the overlap between psychiatric injury and neurological injury and with assessing pain disorders and psychiatric injury.

Methods of Psychiatric Impairment

There are two basic methods of measuring psychiatric impairment.

Method 1 is to assess specific functions and combine these assessments to determine whole person psychiatric impairment. This is the method used in the American Medical Association Guides.

The second method is to group combinations of symptoms assumed to be present at specific levels of impairment. This is the method used by the the ComCare Guides – Chapter 5 and the Diagnostic and Statistical Manual of the American Psychiatric Association 4th Edition Global Assessment of Functioning Scale (GAF).

Fundamental Problems with Chapter 14 of the AMA Guides (Both 4th and 5th Edition)

The method of impairment assessment described in chapter 14 is summarised by a table. The table assesses 4 areas of functioning including *activities of daily living, social functioning, concentration,* and *adaptation*. The impairment for each area lies within one of five classes, ranging from class one, *no impairment* to class five, *extreme impairment*. There is a generalised account of what each of these areas involve but no specific descriptors relevant to each class.

There are two basic problems with this table.

1. Three of the four areas are measures of disability, not impairment. The only measure of impairment is *concentration.* This is a fundamental problem.

2. From an operational point of view there is no method for combining the overall classes. Guide users have no guidance on how to combine the classes.

3. Quite deliberately, the authors have rejected providing percentage impairments.

There are five reasons given for this lack of percentages

1. There are no precise measures of impairment in mental disorders.
2. The use of percentages implies a certainty that does not exist.
3. Percentages are likely to be used inflexibly by adjudicators.
4. No data exists that shows the reliability of the impairment percentages.
5. It would be difficult for Guides users to defend their use in administrative hearings.

This is not seen to be a problem in other parts of the Guides. The chapter on Pain has a means of producing a score with regard to pain and a percentage increment to be added to a physical impairment for pain. The chapter on musculoskeletal systems provide a system of measuring impairment due to pain.

Arguably, pain is even more elusive than psychiatric injury as it is a totally subjective perception. All these concerns still exist and should have been regarded by the authors as a challenge and not as an excuse for their lack of nerve.

Consequences of the Inadequacy of Chapter 14 - the Australian Experience

Most jurisdictions in Australia have recognized that chapter 14 is unusable. This has led to each jurisdiction in Australia developing its own method of determining psychiatric impairment. There are not only differences between the states and the federal jurisdictions but there are also differences within states for determining psychiatric impairment depending whether a person has a workers compensation claim, a transport accident claim or some other claim.

Differing Methods for Measuring Psychiatric Impairment in Australia (see appendix)

Victoria began using the AMA Guides 2nd edition in 1985, a decade or more before other states. At that time chapter 12, Mental and Behavioural Disorders, did provide for measuring mental status and percentages. Subsequently there have been further amendments to this original method and Victoria now uses the Guide to the Evaluation of Psychiatric Impairment for Clinicians (the GEPIC) which has five different classes of impairment with appropriate descriptors for each of the mental functions assessed and a method of combining these to produce a final percentage impairment. Many thousands

of impairment assessments have been done. There have been few concerns about reliability or equity and little controversy.

Most other states who began doing impairment assessment after the publication of the 4th Edition have attempted to use chapter 14 but with significant amendments. These amendments include descriptors of differing levels of impairment for the four areas assessed with appropriate percentages and a means of combining these. The Psychiatric Impairment Rating Scale (the PIRS) developed in New South Wales is one such instance.

Since the PIRS is derived from chapter 14 it measures disability not impairment. It appears to have been specifically designed to meet legislative thresholds and the requirement is that impairment must be attributable to recognized psychiatric conditions. It has subsequently been modified for use in the New South Wales workers compensation system with the addition of more descriptors, the use of employability as part of adaptation and a different method of combining classes. Tasmania also uses the PIRS but ironically, does not provide a percentage rating. Queensland uses the PIRS for assessing psychiatric injury for personal injury claims.

The Northern Territory uses chapter 14 without modification.

In the Commonwealth jurisdictions and some state jurisdictions the methods used have no relationship with the AMA Guides.

Fundamental Criticisms of Chapter 14 of the AMA Guides 4th and 5th Editions

The authors of chapter 14 in the 4th and 5th editions have failed to meet the basic requirements of any system of psychiatric impairment. There is no systematic method to measure impairment. The chapter does not restrict measurement to impairment arising from psychiatric injury. For example, problems with adaptation may relate to a neurological disorder or dementia and not to a psychiatric injury.

The method does not enable a percentage figure to be determined and the method has no inherent reliability. The method is not defensible in court and tribunal settings.

The AMA Guides Sixth Edition

The latest edition is the 6th Edition of the AMA Guides.

This edition appears to have a significant difference in focus. The stated aim in every previous edition was:

to provide a response to a public need for a standardized approach to evaluating medical impairments.

On page 20 of this edition is stated:

The primary purpose of the Guides is to rate impairment to assist adjudicators and others in determining the financial compensation to be awarded to individuals who, as a result of injury or illness, have suffered measurable physical and/or psychological loss.

I have already complained at length about the failure of nerve of the authors of chapter 14 - Mental and Behavioural Disorders of the 4th and 5th Editions. Regrettably, the authors of this chapter in the 6th Edition, have reinforced this impression of timidity. In the two previous editions the authors refused to give any percentages for the reasons described above, this made chapter 14 unusable. In an effort to redress the situation the authors of chapter 14 in the 6th Edition have gone in the opposite direction and have used not one but three different methods, each of which has major flaws but the end result is that there is a percentage impairment established. This is an improvement, but at what a cost!

Ironically, in the first part of the chapter assessors are required to do a mental status examination. As described above, the mental status examination is the basis for the table in the 2nd Edition of the AMA Guides. However findings from the mental state examination then play little part in the method discussed in the 6th Edition.

A Brief Summary of the Methods Described in Chapter 14

The process involves using three scales.

- Brief Psychiatric Rating Scale
- Global Assessment of Functioning Scale
- Psychiatric Impairment Rating Scale

Brief Psychiatric Rating Scale (BPRS) adapted from a recent article

Appropriate for: Patients with major psychiatric disorders, particularly schizophrenia
Administered by: Psychiatrists, psychologists or other trained rater
Time to complete: 15-30 minutes

BPRS Summary

This version of the BPRS is a 24-item scale measuring positive symptoms, general psychopathology and affective symptoms. Some items (eg mannersisms and posturing) can be rated simply on observation of the patient; other items (eg anxiety) involve an element of self-reporting by the patient.

When rating BPRS, it is important to allow unstructured sections in the clinical interview such that conceptual disorganisation in the patient's thought and speech and unusual thought content can be observed.

Each item is rated on a seven-point scale (1=not present to 7=extremely severe)

BPRS Benefits

- Well established - among the most researched instruments used in psychiatry
- Well known - clinicians tend to be familiar with symptom scores and changes
- Sensitive to change - may be used to rate treatment response

- Broad evaluation - allows rating of severity of a number of different symptoms
- Used in many classic studies of new antipsychotics
- Psychometric properties and underlying factor structure is well-established
- Grouping on item scores allow scoring on distinct factors (tension; emotional withdrawal; mannerisms and posturing; motor retardation; uncooperativeness)

BPRS Challenges

- Limited in scope - focus on positive and general psychopathology. Does not focus on negative symptoms. Needs to be utilised in combination with a negative symptom assessment tool, if negative symptomatology is to be captured
- Ambiguous interpretation - there are several ways symptoms are reported (eg. on a scale of 0 to 6 or a scale of 1 to 7); the dual reporting scale must be taken into consideration when interpreting scores
- Use of 1-7 scale - the non-linearity into the scale can complicate interpretation changes over time, particular with regards to response rates.
- The BPRS contains a mixture of symptoms and behaviours in addition to some considerations of "abnormal mental functioning" but where these are present they are reiterative. The 24 items of the BPRS contain multiple aspects of mood/affect impairment but nothing about formal thought disorder or impairment of judgement - surely fundamental aspects of mental functioning.

Furthermore the BPRS has been tweaked beyond its limits. The authors of chapter 14 have added a percentage impairment score derived from who knows where. This is certainly not the product of research and is an innovation by the authors. The maximum score is only 50%, this for someone who is so impaired as to be grossly dysfunctional requiring institutional care!

The Global Assessment of Functioning Scale

The **Global Assessment of Functioning** (**GAF**) is a numeric scale (0 through 100) used by mental health clinicians and physicians to subjectively rate the social, occupational and psychological functioning of adults, e.g., how well or adaptively one is meeting various problems-in-living. The scale is presented and described in the Diagnostic and Statistical Manual of the American Psychiatric Association 4th Edition revised (DSM-IV-TR) on page 32.

91-100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.
81-90 Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.
71-80 If symptoms are present they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning.
61-70 Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
51-60 Moderate symptoms OR any moderate difficulty in social, occupational, or

school functioning.
41-50 Serious symptoms OR any serious impairment in social, occupational, or school functioning.
31-40 Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
21-30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.
11-20 Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
1-10 Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.
0 Not enough information available to provide GAF.

The GAF is a measure of disability. It is intended to measure how well or adaptively one is meeting various problems-in-living. The descriptors are very limited. The authors of chapter 14 have added a so-called GAF Impairment Score which is a means of relating the numbers on the left to a percentage score, a totally subjective exercise. For example a score of between 31-40 which seems to indicate very significant problems is scored at 20% impairment. A person who scores between 1-10 is regarded as having only a 50% impairment. The description provided, brief as it is, seems to indicate a person who is very severely disabled.

The authors of chapter 14 state that

*The Global Assessment of Functioning Scale has been widely used and accepted but has a significant limitation arising from combining level of functioning and symptom severity into one scale. This may lead to a score indicating a high level of impairment for a well functioning person with a single severe symptom. Alternatively, a person may have a life-threatening mental illness and yet may not rate highly on this scale. It is the intention of the authors of this chapter to remedy this problems by using the GAF with the other two scale*s

The authors have not mentioned the problems they have caused by the imposition of their percentage table.

The Psychiatric Impairment Rating Scale

As described above the PIRS is also a measure of disability, the scale relies on self reporting and is vulnerable to gaming. This form of the PIRS involves scoring using six different tables.

- self-care, personal hygiene and activities of daily living
- role functioning, social and recreational activities
- travel
- interpersonal relationships
- concentration, persistence and pace
- resilience and employability

The table regarding concentration, persistence and pace measures impairment, the others are to do with disability. Each of these is scored from 1 to 5. The scores are

arranged in order and the middle two scores are added together. Using a separate table this sum correlates to a specific percentage score.

The percentage scores derived from the BPRS, the GAF and the PIRS are then sorted from low to high, the middle number of the 3 numbers is the final percentage score.

Commentary on Chapter 14

There are significant problems with this method. Not least is the time involved. It is estimated that the BPRS takes between 15-30 minutes, the PIRS involves scoring using six different tables and would probably take a similar period of time. The GAF should derived from the content of the clinical interview and would take it most five minutes. Nevertheless using this method involves a time expenditure of at least 30 minutes and probably longer.

Despite the major drawbacks described above is chapter 14 in the sixth edition an improvement?

One is bemused by the changes from the fourth and fifth edition now seen in the sixth edition. The authors have gone from the sublime to the ridiculous. They have gone from having no method of determining percentages to 3 methods of determining percentages with major questions about whether they are measuring impairment or disability and with real concerns about the means by which they have related particular percentages to particular levels in each of the measures. Despite the obvious advantage in having one AMA guide that can be used by all disciplines nevertheless I cannot endorse this hopeless pastiche.

My own view is that the methods currently used in Australia, chaotic as they are, are better than this.

The method involved is extremely time-consuming, the method involved is appropriate for severe psychiatric illness with regard to the BPRS and the GAF but is not appropriate for most of the psychiatric injuries seen in workers compensation claims.

The GAF and the PIRS are essentially measures of disability and not impairment.

Whatever the reliability of the BPRS and the GAF this reliability has been circumvented by the imposition of arbitrary percentage tables.

Is there a Way Ahead?

The short answer is not yet. The current situation may be confusing, the current chapter, Chapter 5 is very vague and limited in its scope, but the alternatives are worse and less equitable. In Victoria we wish the authors had further developed the method used in the 2nd Edition.

Conclusions

1. The American Medical Association Guides to the Evaluation of Permanent Impairment have provided an effective and efficient means of measuring impairment for all organ systems except for Mental and Behavioural Disorders.

2. The authors of chapter 14 on Mental and Behavioural Disorders in both the 4th and 5th editions have chosen to measure disability rather than impairment and failed to provide percentages related to different levels of impairment.
3. The lack of percentage impairment disadvantages users, claimants, courts, and tribunals.
4. This failure has led to every jurisdiction in Australia developing different methods of measuring psychiatric impairment, leading to a veritable Tower of Babel.
5. All jurisdictions fear that claims for psychiatric injury will overwhelm the funding of any statutory scheme.
6. The consequences of the failure of the authors to do their job has reduced the credibility of psychiatric impairment assessments and has the potential to lead to the exclusion of psychiatric injury from statutory schemes.
7. Chapter 14, Mental and Behavioural Disorders in the AMA Guides 6th edition has used a modified form of the PIRS together with two other scales to produce a clumsy, inequitable and in my view unworkable system for determining percentages for different levels of psychiatric impairment and should not be used in any Comcare Guide.
8. Any guide for assessing psychiatric impairment should be assessing symptoms arising from a mental health disorder or mental illness in a stepwise fashion according to level of severity.
9. Any worthwhile guide to the assessment of psychiatric impairment should not be driven by the need to fit into any specific legislative framework.
10. The current chapter in the Comcare Guides, Chapter 5 – Psychiatric Conditions is very vague and limited in its scope, but the alternatives are worse and less equitable.

Reliability of the American Medical Association guides' model for measuring spinal range of motion. Its implication for whole-person impairment rating.

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Source

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Abstract

STUDY DESIGN:

Repeated measures design for intra- and interrater reliability.

OBJECTIVES:

To determine the intra- and interrater reliability of the lumbar spine range of motion measured with a dual inclinometer, and the thoracolumbar spine range of motion measured with a long-arm goniometer, as recommended in the American Medical Association Guides.

SUMMARY OF BACKGROUND DATA:

The American Medical Association Guides (2nd and 4th editions) recommend using measurements of thoracolumbar and lumbar range of movement, respectively, to estimate the percentage of permanent impairment in patients with chronic low back pain. However, the reliability of this method of estimating impairment has not been determined.

METHODS:

In all, 34 subjects participated in the study, 21 women with a mean age of 40.1 years (SD, +/- 11.1) and 13 men with a mean age of 47.7 years (SD, +/- 12.1). Measures of thoracolumbar flexion, extension, lateral flexion, and rotation were obtained with a long-arm goniometer. Lumbar flexion, extension, and lateral flexion were measured with a dual inclinometer.

Measurements were taken by two examiners on one occasion and by one examiner on two occasions approximately 1 week apart.

RESULTS:

The results showed poor intra- and interrater reliability for all measurements taken with both instruments. Measurement error expressed in degrees showed that measurements taken by different raters exhibited systematic as well as random differences. As a result, subjects measured by two different examiners on the same day, with either instrument, could give impairment ratings ranging between 0% and 18% of the whole person (excluding rotation), in which percentage impairment is calculated using the average range of motion and the average systematic and random error in degrees for the group for each movement (flexion, extension, and lateral flexion).

CONCLUSIONS:

The poor reliability of the American Medical Association Guides' spinal range of motion model can result in marked variation in the percentage of whole-body impairment. These findings have implications for compensation bodies in Australia and other countries that use the American Medical Association Guides' procedure to estimate impairment in chronic low back pain patients.

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10025021
[PubMed - indexed for MEDLINE]

ANNEX 1.2

This code was endorsed by all Australian State and Territory medical boards and the Australian Medical Council. It has been adopted by the Medical Board of Australia after minor revisions to ensure it is consistent with the Health Practitioner Regulation National Law Act 2009 (the National Law). It is issued under s 39 of the National Law.

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1 About this code

1.1 Purpose of the code

Good Medical Practice (the code) describes what is expected of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community. The code was developed following wide consultation with the medical profession and the community. The code is addressed to doctors and is also intended to let the community know what they can expect from doctors. The application of the code will vary according to individual circumstances, but the principles should not be compromised.

This code complements the Australian Medical Association *Code of Ethics*[1] and is aligned with its values, and is also consistent with the *Declaration of Geneva and the International Code of Medical Ethics,*[2] issued by the World Medical Association.

This code does not set new standards. It brings together, into a single Australian code, standards that have long been at the core of medical practice.

The practice of medicine is challenging and rewarding. No code or guidelines can ever encompass every situation or replace the insight and professional judgment of good doctors. Good medical practice means using this judgment to try to practise in a way that would meet the standards expected of you by your peers and the community.

1.2 Use of the code

Doctors have a professional responsibility to be familiar with *Good Medical Practice* and to apply the guidance it contains.

This code will be used:

• To support individual doctors in the challenging task of providing good medical care and fulfilling their professional roles, and to provide a framework to guide professional judgment.

• To assist medical boards in their role of protecting the public, by setting and maintaining standards of medical practice. If your professional conduct varies significantly from this standard, you should be prepared to explain and justify your decisions and actions. Serious or repeated failure to meet these standards may have consequences for your medical registration.

• As an additional resource for a range of uses that contribute to enhancing the culture of medical professionalism in the Australian health system; for example, in medical education; orientation, induction and supervision of junior doctors and international medical graduates; and by administrators and policy makers in hospitals, health services and other institutions.

1.3 What the code does not do

This code is not a substitute for the provisions of legislation and case law. If there is any conflict between this code and the law, the law takes precedence.

This code is not an exhaustive study of medical ethics or an ethics textbook. It does not address in detail the standards of practice within particular medical disciplines; these are found in the policies and guidelines issued by medical colleges and other professional bodies.

While good medical practice respects patients' rights, this code is not a charter of rights.[3]

1.4 Professional values and qualities of doctors

While individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice.

Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy.

Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on their doctors to protect their confidentiality.

Doctors have a responsibility to protect and promote the health of individuals and the community.

Good medical practice is patient-centred. It involves doctors understanding that each patient is unique, and working in partnership with their patients, adapting what they do to address the needs and reasonable expectations of each patient. This includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact on the doctor–patient relationship and on the delivery of health services.
Good communication underpins every aspect of good medical practice.

1 See http://www.ama.com.au/codeofethics
2 See http://www.wma.net/e/policy/c8.htm
3 See the Australian Commission on Safety and Quality in Health Care's Australian Charter of Healthcare Rights (http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/52533CE922D6F58BCA2573AF007BC6F9/$File/17537-charter.pdf)

2

Professionalism embodies all the qualities described here, and includes self-awareness and self-reflection. Doctors are expected to reflect regularly on whether they are practising effectively, on what is happening in their relationships with patients and colleagues, and on their own health and wellbeing. They have a duty to keep their skills and knowledge up to date, refine and develop their clinical judgment as they gain experience, and contribute to their profession.

1.5 Australia and Australian medicine

Australia is culturally diverse. We inhabit a land that, for many ages, was held and cared for by Indigenous Australians, whose history and culture have uniquely shaped our nation. Our society is further enriched by the contribution of people from many nations who have made Australia their home.
Doctors in Australia reflect the cultural diversity of our society, and this diversity strengthens our profession. There are many ways to practise medicine in Australia. The core tasks of medicine are caring for people who are unwell and seeking to keep people well. This code focuses primarily on these core tasks. For the doctors who undertake roles that have little or no patient contact, not all of this code may be relevant, but the principles underpinning it will still apply.

1.6 Substitute decision makers

In this code, reference to the term 'patient' also includes substitute decision makers for patients who do not have the capacity to make their own decisions. This can be the parents, or a legally appointed decision maker. If in doubt, seek advice from the relevant guardianship authority.

3

2 Providing good care

2.1 Introduction

In clinical practice, the care of your patient is your primary concern. Providing good patient care includes:
2.1.1 Assessing the patient, taking into account the history, the patient's views, and an appropriate physical examination. The history includes relevant psychological, social and cultural aspects.
2.1.2 Formulating and implementing a suitable management plan (including arranging investigations and providing treatment and

advice).
2.1.3 Facilitating coordination and continuity of care.
2.1.4 Referring a patient to another practitioner when this is in the patient's best interests.
2.1.5 Recognising and respecting patients' rights to make their own decisions.

2.2 Good patient care

Maintaining a high level of medical competence and professional conduct is essential for good patient care. Good medical practice involves:
2.2.1 Recognising and working within the limits of your competence and scope of practice.
2.2.2 Ensuring that you have adequate knowledge and skills to provide safe clinical care.
2.2.3 Maintaining adequate records (see Section 8.4).
2.2.4 Considering the balance of benefit and harm in all clinical-management decisions.
2.2.5 Communicating effectively with patients (see Section 3.3).
2.2.6 Providing treatment options based on the best available information.
2.2.7 Taking steps to alleviate patient symptoms and distress, whether or not a cure is possible.
2.2.8 Supporting the patient's right to seek a second opinion.
2.2.9 Consulting and taking advice from colleagues, when appropriate.
2.2.10 Making responsible and effective use of the resources available to you (see Section 5.2).
2.2.11 Encouraging patients to take interest in, and responsibility for, the management of their health, and supporting them in this.
2.2.12 Ensuring that your personal views do not adversely affect the care of your patient.

2.3 Shared decision making

Making decisions about health care is the shared responsibility of the doctor and the patient. Patients may wish to involve their family, carer or others. See Section 1.6 on substitute decision makers.

2.4 Decisions about access to medical care

Your decisions about patients' access to medical care need to be free from bias and discrimination. Good medical practice involves:
2.4.1 Treating your patients with respect at all times.
2.4.2 Not prejudicing your patient's care because you believe that a patient's behaviour has contributed to their condition.
2.4.3 Upholding your duty to your patient and not discriminating on medically irrelevant grounds, including race, religion, sex, disability or other grounds, as described in antidiscrimination legislation.[4]
2.4.4 Giving priority to investigating and treating patients on the basis of clinical need and effectiveness of the proposed investigations or treatment.
2.4.5 Keeping yourself and your staff safe when caring for patients. If a patient poses a risk to your health and safety or that of your

staff, take action to protect against that risk. Such a patient should not be denied care, if reasonable steps can be taken to keep you and your staff safe.

2.4.6 Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.

[4] See http://www.hreoc.gov.au/info_for_employers/law/index.html

2.4.7 Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.

2.5 Treatment in emergencies

Treating patients in emergencies requires doctors to consider a range of issues, in addition to the patient's best care. Good medical practice involves offering assistance in an emergency that takes account of your own safety, your skills, the availability of other options and the impact on any other patients under your care; and continuing to provide that assistance until your services are no longer required.

3 Working with patients

3.1 Introduction

Relationships based on openness, trust and good communication will enable you to work in partnership with your patients.

3.2 Doctor–patient partnership

A good doctor–patient partnership requires high standards of professional conduct. This involves:

3.2.1 Being courteous, respectful, compassionate and honest.

3.2.2 Treating each patient as an individual.

3.2.3 Protecting patients' privacy and right to confidentiality, unless release of information is required by law or by public-interest considerations.

3.2.4 Encouraging and supporting patients and, when relevant, their carer or family, in caring for themselves and managing their health.

3.2.5 Encouraging and supporting patients to be well informed about their health and to use this information wisely when they are making decisions.

3.2.6 Recognising that there is a power imbalance in the doctor–patient relationship, and not exploiting patients physically, emotionally, sexually or financially.

3.3 Effective communication

An important part of the doctor–patient relationship is effective communication. This involves:

3.3.1 Listening to patients, asking for and respecting their views about their health,

and responding to their concerns and preferences.
3.3.2 Encouraging patients to tell you about their condition and how they are currently managing it, including any alternative or complementary therapies they are using.
3.3.3 Informing patients of the nature of, and need for, all aspects of their clinical management, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment.
3.3.4 Discussing with patients their condition and the available management options, including their potential benefit and harm.
3.3.5 Endeavouring to confirm that your patient understands what you have said.
3.3.6 Ensuring that patients are informed of the material risks associated with any part of the proposed management plan.
3.3.7 Responding to patients' questions and keeping them informed about their clinical progress.
3.3.8 Making sure, wherever practical, that arrangements are made to meet patients' specific language, cultural and communication needs, and being aware of how these needs affect understanding.
3.3.9 Familiarising yourself with, and using whenever necessary, qualified language interpreters or cultural interpreters to help you to meet patients' communication needs. Information about governmentfunded interpreter services is available on the Australian Government Department of Immigration and Citizenship website.[5]

3.4 Confidentiality and privacy

Patients have a right to expect that doctors and their staff will hold information about them in confidence, unless release of information is required by law or public interest considerations. Good medical practice involves:
3.4.1 Treating information about patients as confidential.
3.4.2 Appropriately sharing information about patients for their health care, consistent with privacy law and professional guidelines about confidentiality.
3.4.3 Being aware that there are complex issues related to genetic information and seeking appropriate advice about disclosure of such information.

3.5 Informed consent

Informed consent is a person's voluntary decision about medical care that is made with knowledge and

[5] The Australian Government Department of Immigration and Citizenship's Translating and Interpreting Service (TIS) National can be contacted on 131 450, or via the website (http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/index.htm).

understanding of the benefits and risks involved. The information that doctors need to give to patients is detailed in guidelines issued by the National Health and Medical Research Council.[6] Good medical practice involves:
3.5.1 Providing information to patients in a way that they can understand before asking for

their consent.
3.5.2 Obtaining informed consent or other valid authority before you undertake any examination, investigation or provide treatment (except in an emergency), or before involving patients in teaching or research.
3.5.3 Ensuring that your patients are informed about your fees and charges.
3.5.4 When referring a patient for investigation or treatment, advising the patient that there may be additional costs, which patients may wish to clarify before proceeding.

3.6 Children and young people

Caring for children and young people brings additional responsibilities for doctors. Good medical practice involves:
3.6.1 Placing the interests and wellbeing of the child or young person first.
3.6.2 Ensuring that you consider young people's capacity for decision making and consent.
3.6.3 Ensuring that, when communicating with a child or young person, you:
• treat them with respect and listen to their views
• encourage questions and answer their questions to the best of your ability
• provide information in a way that they can understand
• recognise the role of parents and when appropriate, encourage the young person to involve their parents in decisions about their care.
3.6.4 Being alert to children and young people who may be at risk, and notifying appropriate authorities, as required by law.

3.7 Culturally safe and sensitive practice

Good medical practice involves genuine efforts to understand the cultural needs and contexts of different patients to obtain good health outcomes. This includes:
3.7.1 Having knowledge of, respect for, and sensitivity towards, the cultural needs of the community you serve, including those of Indigenous Australians.
3.7.2 Acknowledging the social, economic, cultural and behavioural factors influencing health, both at individual and population levels.
3.7.3 Understanding that your own culture and beliefs influence your interactions with patients.
3.7.4 Adapting your practice to improve patient engagement and health care outcomes.

3.8 Patients who may have additional needs

Some patients (including those with impaired decisionmaking capacity) have additional needs. Good medical practice in managing the care of these patients involves:
3.8.1 Paying particular attention to communication.
3.8.2 Being aware that increased advocacy may be necessary to ensure just access to health care.
3.8.3 Recognising that there may be a range

of people involved in their care, such as carers, family members or a guardian, and involving them when appropriate.
3.8.4 Being aware that these patients may be at greater risk.

3.9 Relatives, carers and partners

Good medical practice involves:
3.9.1 Being considerate to relatives, carers, partners and others close to the patient, and respectful of their role in the care of the patient.
3.9.2 With appropriate consent, being responsive in providing information.

[6] See the National Health and Medical Research Council's documents, *General Guidelines for Medical Practitioners on Providing Information to Patients* (2004; http://www.nhmrc.gov.au/publications/synopses/e57syn.htm) and *Communicating with Patients: Advice for Medical Practitioners* (2004; http://www.nhmrc.gov.au/publications/synopses/e58syn.htm)

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3.10 Adverse events

When adverse events occur, you have a responsibility to be open and honest in your communication with your patient, to review what has occurred and to report appropriately.[7] When something goes wrong, good medical practice involves:
3.10.1 Recognising what has happened.
3.10.2 Acting immediately to rectify the problem, if possible, including seeking any necessary help and advice.
3.10.3 Explaining to the patient as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences.
3.10.4 Acknowledging any patient distress and providing appropriate support.
3.10.5 Complying with any relevant policies, procedures and reporting requirements, subject to advice from your medical indemnity insurer.
3.10.6 Reviewing adverse events and implementing changes to reduce the risk of recurrence (see Section 6).
3.10.7 Reporting adverse events to the relevant authority, as necessary (see Section 6).
3.10.8 Ensuring patients have access to information about the processes for making a complaint (for example, through the relevant health care complaints commission or medical board).

3.11 When a complaint is made

Patients who are dissatisfied have a right to complain about their care. When a complaint is made, good medical practice involves:
3.11.1 Acknowledging the patient's right to complain.
3.11.2 Working with the patient to resolve the issue, where possible.
3.11.3 Providing a prompt, open and constructive response, including an explanation and, if appropriate, an apology.
3.11.4 Ensuring the complaint does not adversely affect the patient's care. In some cases, it may be advisable to refer the patient to another doctor.

3.11.5 Complying with relevant complaints law, policies and procedures.

3.12 End-of-life care

Doctors have a vital role in assisting the community to deal with the reality of death and its consequences. In caring for patients towards the end of their life, good medical practice involves:

3.12.1 Taking steps to manage a patient's symptoms and concerns in a manner consistent with their values and wishes.

3.12.2 Providing or arranging appropriate palliative care.

3.12.3 Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient.

3.12.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.

3.12.5 Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.

3.12.6 Respecting different cultural practices related to death and dying.

3.12.7 Striving to communicate effectively with patients and their families so they are able to understand the outcomes that can and cannot be achieved.

3.12.8 Facilitating advance care planning.

3.12.9 Taking reasonable steps to ensure that support is provided to patients and their families, even when it is not possible to deliver the outcome they desire.

3.12.10 Communicating bad news to patients and their families in the most appropriate way and providing support for them while they deal with this information.

3.12.11 When your patient dies, being willing to explain, to the best of your knowledge, the circumstances of the death to appropriate members of the patient's family and carers, unless you know the patient would have objected.

7 See http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-02

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3.13 Ending a professional relationship

In some circumstances, the relationship between a doctor and patient may become ineffective or compromised, and you may need to end it. Good medical practice involves ensuring that the patient is adequately informed of your decision and facilitating arrangements for the continuing care of the patient, including passing on relevant clinical information.

3.14 Personal relationships

Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient. In some cases, providing

care to those close to you is unavoidable. Whenever this is the case, good medical practice requires recognition and careful management of these issues.

3.15 Closing your practice

When closing or relocating your practice, good medical practice involves:

3.15.1 Giving advance notice where this is possible.

3.15.2 Facilitating arrangements for the continuing medical care of all your current patients, including the transfer or appropriate management of all patient records. You must follow the law governing health records in your jurisdiction.

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4 Working with other health care professionals

4.1 Introduction

Good relationships with medical colleagues, nurses and other health care professionals strengthen the doctor–patient relationship and enhance patient care.

4.2 Respect for medical colleagues and other health care professionals

Good patient care is enhanced when there is mutual respect and clear communication between all health care professionals involved in the care of the patient. Good medical practice involves:

4.2.1 Communicating clearly, effectively, respectfully and promptly with other doctors and health care professionals caring for the patient.

4.2.2 Acknowledging and respecting the contribution of all health care professionals involved in the care of the patient.

4.3 Delegation, referral and handover

Delegation involves you asking another health care professional to provide care on your behalf while you retain overall responsibility for the patient's care. *Referral* involves you sending a patient to obtain opinion or treatment from another doctor or health care professional. Referral usually involves the transfer (in part) of responsibility for the patient's care, usually for a defined time and for a particular purpose, such as care that is outside your area of expertise. *Handover* is the process of transferring all responsibility to another health care professional. Good medical practice involves:

4.3.1 Taking reasonable steps to ensure that the person to whom you delegate, refer or handover has the qualifications, experience, knowledge and skills to provide the care required.

4.3.2 Understanding that when you delegate, although you will not be accountable for the decisions and actions of those to whom you delegate, you remain responsible for the overall management of the patient, and for your decision to delegate.

4.3.3 Always communicating sufficient information about the patient and the treatment they need to enable the continuing care of the patient.

4.4 Teamwork

Most doctors work closely with a wide range of health care professionals. The care of patients is improved when there is mutual respect and clear communication, as well as an understanding of the responsibilities, capacities, constraints and ethical codes of each other's professions. Working in a team does not alter a doctor's personal accountability for professional conduct and the care provided. When working in a team, good medical practice involves:

4.4.1 Understanding your particular role in the team and attending to the responsibilities associated with that role.

4.4.2 Advocating for a clear delineation of roles and responsibilities, including that there is a recognised team leader or coordinator.

4.4.3 Communicating effectively with other team members.

4.4.4 Informing patients about the roles of team members.

4.4.5 Acting as a positive role model for team members.

4.4.6 Understanding the nature and consequences of bullying and harassment, and seeking to eliminate such behaviour in the workplace.

4.5 Coordinating care with other doctors

Good patient care requires coordination between all treating doctors. Good medical practice involves:

4.5.1 Communicating all the relevant information in a timely way.

4.5.2 Facilitating the central coordinating role of the general practitioner.

4.5.3 Advocating the benefit of a general practitioner to a patient who does not already have one.

4.5.4 Ensuring that it is clear to the patient, the family and colleagues who has ultimate responsibility for coordinating the care of the patient.

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5 Working within the health care system

5.1 Introduction

Doctors have a responsibility to contribute to the effectiveness and efficiency of the health care system.

5.2 Wise use of health care resources

It is important to use health care resources wisely. Good medical practice involves:

5.2.1 Ensuring that the services you provide are necessary and likely to benefit the patient.

5.2.2 Upholding the patient's right to gain access to the necessary level of health care and, whenever possible, helping them to do so.

5.2.3 Supporting the transparent and equitable allocation of health care resources.

5.2.4 Understanding that your use of resources can affect the access other patients have to health care resources.

5.3 Health advocacy

There are significant disparities in the health status of different groups in the Australian community. These disparities result from social, cultural, geographic, healthrelated and other factors. In particular, the Indigenous people of Australia bear the burden of gross social, cultural and health inequity. Good medical practice involves using your expertise and influence to protect and advance the health and wellbeing of individual patients, communities and populations.

5.4 Public health

Doctors have a responsibility to promote the health of the community through disease prevention and control, education and screening. Good medical practice involves:

5.4.1 Understanding the principles of public health, including health education, health promotion, disease prevention and control and screening.

5.4.2 Participating in efforts to promote the health of the community and being aware of your obligations in disease prevention, screening and reporting notifiable diseases.

6 Minimising risk

6.1 Introduction

Risk is inherent in health care. Minimising risk to patients is an important component of medical practice. Good medical practice involves understanding and applying the key principles of risk minimisation and management in your practice.

6.2 Risk management

Good medical practice in relation to risk management involves:

6.2.1 Being aware of the importance of the principles of open disclosure and a nonpunitive approach to incident management.

6.2.2 Participating in systems of quality assurance and improvement.

6.2.3 Participating in systems for surveillance and monitoring of adverse events and 'near misses', including reporting such events.

6.2.4 If you have management responsibilities, making sure that systems are in place for raising concerns about risks to patients.

6.2.5 Working in your practice and within systems to reduce error and improve patient safety, and supporting colleagues who raise concerns about patient safety.

6.2.6 Taking all reasonable steps to address the issue if you have reason to think that patient safety may be compromised.

6.3 Doctors' performance — you and your colleagues

The welfare of patients may be put at risk if a doctor is performing poorly. If you consider there is a risk, good medical practice involves:

6.3.1 Complying with any statutory reporting requirements, including the mandatory reporting requirements under the National Law.[8]

6.3.2 Recognising and taking steps to minimise the risks of fatigue, including

complying with relevant State and Territory occupational health and safety legislation.
6.3.3 If you know or suspect that you have a health condition that could adversely affect your judgment or performance, following the guidance in Section 9.2.
6.3.4 Taking steps to protect patients from risk posed by a colleague's conduct, practice or ill health.
6.3.5 Taking appropriate steps to assist your colleague to receive help if you have concerns about a colleague's performance or fitness to practise.
6.3.6 If you are not sure what to do, seeking advice from an experienced colleague, your employer, doctors' health advisory services, professional indemnity insurers, the Medical Board of Australia or a professional organisation.

[7] Part 8 Division 2 ss140–143, *Health Practitioner Regulation National Law Act 2009* (the National Law)

7 Maintaining professional performance

7.1 Introduction

Maintaining and developing your knowledge, skills and professional behaviour are core aspects of good medical practice. This requires self-reflection and participation in relevant professional development, practice improvement and performance-appraisal processes, to continually develop your professional capabilities. These activities must continue throughout your working life, as science and technology develop and society changes.

7.2 Continuing professional development

The Medial Board of Australia has established registration standards that set out the requirements for continuing professional development and for recency of practice under the National Law.[9]

Development of your knowledge, skills and professional behaviour must continue throughout your working life. Good medical practice involves:

7.2.1 Keeping your knowledge and skills up to date.
7.2.2 Participating regularly in activities that maintain and further develop your knowledge, skills and performance.
7.2.3 Ensuring that your practice meets the standards that would be reasonably expected by the public and your peers.
7.2.4 Regularly reviewing your continuing medical education and continuing professional development activities to ensure that they meet the requirements of the Medical Board of Australia.
7.2.5 Ensuring that your personal continuing professional development program includes self-directed and practice-based learning.

[7] Section 38(1)(c) and (e) of the National Law and registration standards issued by the Medical Board of Australia.

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8 Professional behaviour

8.1 Introduction

In professional life, doctors must display a standard of behaviour that warrants the trust and respect of the community. This includes observing and practising the principles of ethical conduct.

The guidance contained in this section emphasises the core qualities and characteristics of good doctors outlined in Section 1.4.

8.2 Professional boundaries

Professional boundaries are integral to a good doctor–patient relationship. They promote good care for patients and protect both parties. Good medical practice involves:

8.2.1 Maintaining professional boundaries.

8.2.2 Never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient, such as their carer, guardian or spouse or the parent of a child patient.

8.2.3 Avoiding expressing your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress.

8.3 Reporting obligations

Doctors have statutory obligations under the National Law to report various proceedings or findings to the Medical Board of Australia.[10] They also have professional obligations to report to the medical board and their employer if they have had any limitations placed on their practice. Good medical practice involves:

8.3.1 Being aware of these reporting obligations.

8.3.2 Complying with any reporting obligations that apply to your practice.

8.3.3 Seeking advice from the medical board or your professional indemnity insurer if you are unsure about your obligations.

8.4 Medical records

Maintaining clear and accurate medical records is essential for the continuing good care of patients. Good medical practice involves:

8.4.1 Keeping accurate, up-to-date and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management.

8.4.2 Ensuring that your medical records are held securely and are not subject to unauthorised access.

8.4.3 Ensuring that your medical records show respect for your patients and do not include demeaning or derogatory remarks.

8.4.4 Ensuring that the records are sufficient to facilitate continuity of patient care.

8.4.5 Making records at the time of the events, or as soon as possible afterwards.

8.4.6 Recognising patients' right to access information contained in their medical records and facilitating that access.

8.4.7 Promptly facilitating the transfer of health information when requested by the patient.

8.5 Insurance

You have a professional obligation to ensure that your practice is appropriately covered by professional indemnity insurance. You must meet the requirements set out in the Registration Standard for Professional Indemnity Insurance established by the Medical Board of Australia under the National Law.[11]

8.6 Advertising

Advertisements for medical services can be useful in providing information for patients. All advertisements must conform to relevant consumer protection legislation, the advertising provisions in the National Law and *Advertising Guidelines* issued by the Medical Board of Australia.[12]

Good medical practice involves:

8.6.1 Making sure that any information you publish about your medical services is factual and verifiable.

8.6.2 Making only justifiable claims about the quality or outcomes of your services in any information you provide to patients.

8.6.3 Not guaranteeing cures, exploiting patients' vulnerability or fears about their future health, or raising unrealistic expectations.

[10] Sections 140–143 of the National Law

[11] Section 38 (1)(a) of the National Law and the registration standard issued by the Medical Board of Australia

[12] Section 133 of National Law and *Advertising Guidelines* issued by the Medical Board of Australia

8.6.4 Not offering inducements or using testimonials.

8.6.5 Not making unfair or inaccurate comparisons between your services and those of colleagues.

8.7 Medico-legal, insurance and other assessments

When you are contracted by a third party to provide a medico-legal, insurance or other assessment[13] of a person who is not your patient, the usual therapeutic doctor–patient relationship does not exist. In this situation, good medical practice involves:

8.7.1 Applying the standards of professional behaviour described in this code to the assessment; in particular, being courteous, alert to the concerns of the person, and ensuring that you have the person's consent.

8.7.2 Explaining to the person your area of medical practice, your role, and the purpose, nature and extent of the assessment to be conducted.

8.7.3 Anticipating and seeking to correct any misunderstandings that the person may have about the nature and purpose of your assessment and report.

8.7.4 Providing an impartial report (see Section 8.8).

8.7.5 Recognising that, if you discover an unrecognised, serious medical problem during your assessment, you have a duty of care to inform the patient or their treating doctor.

8.8 Medical reports, certificates and giving evidence

The community places a great deal of trust in doctors.

Consequently, doctors have been given the authority to sign a variety of documents, such as death certificates and sickness certificates, on the assumption that they will only sign statements that they know, or reasonably believe, to be true. Good medical practice involves:

8.8.1 Being honest and not misleading when writing reports and certificates, and only signing documents you believe to be accurate.

8.8.2 Taking reasonable steps to verify the content before you sign a report or certificate, and not omitting relevant information deliberately.

8.8.3 Preparing or signing documents and reports if you have agreed to do so, within a reasonable and justifiable timeframe.

8.8.4 Making clear the limits of your knowledge and not giving opinion beyond those limits when providing evidence.

8.9 Curriculum vitae

When providing curriculum vitae, good medical practice involves:

8.9.1 Providing accurate, truthful and verifiable information about your experience and your medical qualifications.

8.9.2 Not misrepresenting, by misstatement or omission, your experience, qualifications or position.

8.10 Investigations

Doctors have responsibilities and rights relating to any legitimate investigation of their practice or that of a colleague. In meeting these responsibilities, it is advisable to seek legal advice or advice from your professional indemnity insurer. Good medical practice involves:

8.10.1 Cooperating with any legitimate inquiry into the treatment of a patient and with any complaints procedure that applies to your work.

8.10.2 Disclosing, to anyone entitled to ask for it, information relevant to an investigation into your own or a colleague's conduct, performance or health.

8.10.3 Assisting the coroner when an inquest or inquiry is held into a patient's death by responding to their enquiries and by offering all relevant information.

8.11 Conflicts of interest

Patients rely on the independence and trustworthiness of doctors for any advice or treatment offered. A conflict of interest in medical practice arises when a doctor, entrusted with acting in the interests of a patient, also has financial, professional or personal interests, or relationships with third parties, which may affect their care of the patient. Multiple interests are common. They require identification, careful consideration, appropriate disclosure and accountability. When these interests compromise, or might

[10] See *Independent Medical Assessments on Behalf of Parties Other Than the Patient* — 1998 (revised 2002) (http://www.ama.com.au/node/510)

reasonably be perceived by an independent observer to compromise, the doctor's primary duty to the patient, doctors must recognise and resolve this conflict in the best interests of the patient.

Good medical practice involves:

8.11.1 Recognising potential conflicts of interest that may arise in relation to initiating or continuing a professional relationship with a patient.
8.11.2 Acting in your patients' best interests when making referrals and when providing or arranging treatment or care.
8.11.3 Informing patients when you have an interest that could affect, or could be perceived to affect, patient care.
8.11.4 Recognising that pharmaceutical and other medical marketing influences doctors, and being aware of ways in which your practice may be being influenced.
8.11.5 Recognising potential conflicts of interest in relation to medical devices and appropriately managing any conflict that arises in your practice.
8.11.6 Not asking for or accepting any inducement, gift or hospitality of more than trivial value, from companies that sell or market drugs or appliances that may affect, or be seen to affect, the way you prescribe for, treat or refer patients.
8.11.7 Not asking for or accepting fees for meeting sales representatives.
8.11.8 Not offering inducements to colleagues, or entering into arrangements that could be perceived to provide inducements.
8.11.9 Not allowing any financial or commercial interest in a hospital, other health care organisation, or company providing health care services or products to adversely affect the way in which you treat patients. When you or your immediate family have such an interest and that interest could be perceived to influence the care you provide, you must inform your patient.

8.12 Financial and commercial dealings

Doctors must be honest and transparent in financial arrangements with patients. Good medical practice involves:
8.12.1 Not exploiting patients' vulnerability or lack of medical knowledge when providing or recommending treatment or services.
8.12.2 Not encouraging patients to give, lend or bequeath money or gifts that will benefit you directly or indirectly.
8.12.3 Avoiding financial involvement, such as loans and investment schemes, with patients.
8.12.4 Not pressuring patients or their families to make donations to other people or organisations.
8.12.5 Being transparent in financial and commercial matters relating to your work, including in your dealings with employers, insurers and other organisations or individuals. In particular:
• declaring any relevant and material financial or commercial interest that you or your family might have in any aspect of the patient's care
• declaring to your patients your professional and financial interest in any product you might endorse or sell from your practice, and not making

an unjustifiable profit from the sale or endorsement.

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9 Ensuring doctors' health

9.1 Introduction

As a doctor, it is important for you to maintain your own health and wellbeing. This includes seeking an appropriate work–life balance.

9.2 Your health

Good medical practice involves:

9.2.1 Having a general practitioner.

9.2.2 Seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and self-treatment.

9.2.3 Making sure that you are immunised against relevant communicable diseases.

9.2.4 Conforming to the legislation in your State or Territory in relation to self-prescribing.

9.2.5 Recognising the impact of fatigue on your health and your ability to care for patients, and endeavouring to work safe hours wherever possible.

9.2.6 Being aware of the doctors' health program in your State or Territory if you need advice on where to seek help.

9.2.7 If you know or suspect that you have a health condition or impairment that could adversely affect your judgment, performance or your patient's health:

• not relying on your own assessment of the risk you pose to patients

• consulting your doctor about whether, and in what ways, you may need to modify your practice, and following the doctor's advice.

9.3 Other doctors' health

Doctors have a responsibility to assist medical colleagues to maintain good health. All health professionals have responsibilities in certain circumstances for mandatory notification under the National Law.[14] Good medical practice involves:

9.3.1 Providing doctors who are your patients with the same quality of care you would provide to other patients.

9.3.2 Notifying the Medical Board of Australia if you are treating a doctor whose ability to practise may be impaired and may thereby be placing patients at risk. This is always a professional, and in some jurisdictions, a statutory, responsibility.

9.3.3 Encouraging a colleague (whom you are not treating) to seek appropriate help if you believe they may be ill and impaired. If you believe this impairment is putting patients at risk, notify the Medical Board of Australia. It may also be wise to report your concerns to the doctor's employer and to a doctors' health program.

9.3.4 Recognising the impact of fatigue on the health of colleagues, including those under your supervision, and facilitating safe

working hours wherever possible.

[14] Sections 140–143 of the National Law and *Mandatory Reporting Guidelines* issued by the Medical Board of Australia.

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10 Teaching, supervising and assessing

10.1 Introduction

Teaching, supervising and mentoring doctors and medical students is important for their development and for the care of patients. It is part of good medical practice to contribute to these activities and provide support, assessment, feedback and supervision for colleagues, doctors in training and students.

10.2 Teaching and supervising

Good medical practice involves:

10.2.1 Seeking to develop the skills, attitudes and practices of an effective teacher, whenever you are involved in teaching.

10.2.2 Making sure that any doctor or medical student for whose supervision you are responsible receives adequate oversight and feedback.

10.3 Assessing colleagues

Assessing colleagues is an important part of making sure that the highest standards of medical practice are achieved. Good medical practice involves:

10.3.1 Being honest, objective and constructive when assessing the performance of colleagues, including students. Patients will be put at risk if you describe as competent someone who is not.

10.3.2 Providing accurate and justifiable information when giving references or writing reports about colleagues. Do so promptly and include all relevant information.

10.4 Medical students

Medical students are learning how best to care for patients. Creating opportunities for learning improves their clinical practice and nurtures the future workforce. Good medical practice involves:

10.4.1 Treating your students with respect and patience.

10.4.2 Making the scope of the student's role in patient care clear to the student, to patients and to other members of the health care team.

10.4.3 Informing your patients about the involvement of medical students, and encouraging their consent for student participation while respecting their right to choose not to consent.

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11 Undertaking research

11.1 Introduction

Research involving humans, their tissue samples or their health information, is vital in improving the quality of health care and reducing uncertainty for patients now and in the future, and in improving the health of the population as a

whole. Research in Australia is governed by guidelines[15] issued in accordance with the *National Health and Medical Research Council Act 1992*. If you undertake research, you should familiarise yourself with, and follow, these guidelines.

Research involving animals is governed by legislation in States and Territories and by guidelines issued by the National Health and Medical Research Council (NHMRC).[16]

11.2 Research ethics

Being involved in the design, organisation, conduct or reporting of health research involving humans brings particular responsibilities for doctors. These responsibilities, drawn from the NHMRC guidelines, include:

11.2.1 According to participants the respect and protection that is due to them.

11.2.2 Acting with honesty and integrity.

11.2.3 Ensuring that any protocol for human research has been approved by a human research ethics committee, in accordance with the *National Statement on Ethical Conduct in Human Research.*

11.2.4 Disclosing the sources and amounts of funding for research to the human research ethics committee.

11.2.5 Disclosing any potential or actual conflicts of interest to the human research ethics committee.

11.2.6 Ensuring that human participation is voluntary and based on an adequate understanding of sufficient information about the purpose, methods, demands, risks and potential benefits of the research.

11.2.7 Ensuring that any dependent relationship between doctors and their patients is taken into account in the recruitment of patients as research participants.

11.2.8 Seeking advice when research involves children or adults who are not able to give informed consent, to ensure that there are appropriate safeguards in place. This includes ensuring that a person empowered to make decisions on the patient's behalf has given informed consent, or that there is other lawful authority to proceed.

11.2.9 Adhering to the approved research protocol.

11.2.10 Monitoring the progress of the research and promptly reporting adverse events or unexpected outcomes.

11.2.11 Respecting the entitlement of research participants to withdraw from any research at any time and without giving reasons.

11.2.12 Adhering to the guidelines regarding publication of findings, authorship and peer review.

11.2.13 Reporting possible fraud or misconduct in research as required under the *Australian Code for the Responsible Conduct of Research*.

11.3 Treating doctors and research

When you are involved in research that involves your patients, good medical practice includes:

11.3.1 Respecting the patients' right to withdraw from a study without prejudice to their treatment.

11.3.2 Ensuring that a patient's decision not to participate does not compromise the doctor–patient relationship or their care.

[15] See the *National Statement on Ethical Conduct in Human Research* (NHMRC 2007; http://www.nhmrc.gov.au/publications/synopses/e72syn.htm) and the *Australian Code for the Responsible Conduct of Research* (NHMRC 2007; http://www.nhmrc.gov.au/PUBLICATIONS/synopses/r39syn.htm)

[16] See the *Australian Code of Practice for the Care and Use of Animals for Scientific Purposes*, 7th edition (NHMRC 2004; http://www.nhmrc.gov.au/publications/synopses/ea16syn.htm)

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In developing this code, the AMC considered and drew on both general and specific information about standards from codes of good medical practice issued by Australian State and Territory medical boards and the Australian Medical Association *Code of Ethics*. The process was also informed by similar documents issued by the General Medical Council of the United Kingdom, the Medical Council of New Zealand, the National Alliance for Physician Competence in the United States and the Royal College of Physicians and Surgeons in Canada. In addition, sections of the code were informed by relevant guidelines issued by the National Health and Medical Research Council and by guidelines developed by specialist medical colleges in Australia and New Zealand.

ANNEX 1.2

EXPERT WITNESS CODE OF CONDUCT

Supreme Court of NSW

(Schedule K, Part 36 Rule 13C(1) and Part 39 Rule 2(1))

Application of code

1. This code of conduct applies to any expert engaged to:
    (a) provide a report as to his or her opinion for use as evidence in proceedings or proposed proceedings, or
    (b) give opinion evidence in proceedings or proposed proceedings, or

General duty to the Court

2. An expert witness has an overriding duty to assist the Court impartially on matters relevant to the expert's area of expertise.
3. An expert witness's paramount duty is to the Court and not to the person retaining the expert.
4. An expert witness is not an advocate for a party.

The form of expert reports

5. A report by an expert witness must (in the body of the report or in an annexure) specify:
    (a) the person's qualifications as an expert, and
    (b) the facts, matters and assumptions on which the opinions in the report are based (a letter of instructions may be annexed), and
    (c) reasons for each opinion expressed, and
    (d) if applicable—that a particular question or issue falls outside his or her field of expertise, and
    (e) any literature or other materials utilised in support of the opinions, and
    (f) any examinations, tests or other investigations on which he or she has relied and identify, and give details of the qualifications of, the person who carried them out.
6. If an expert witness who prepares a report believes that it may be incomplete or inaccurate without some qualification, that qualification must be stated in the report.
7. If an expert witness considers that his or her opinion is not a concluded opinion because of insufficient research or insufficient data or for any other reason, this must be stated when the opinion is expressed.
8. An expert witness who, after communicating an opinion to the party engaging him or her (or that party's legal representative), changes his or her opinion on a material matter must forthwith provide the engaging party (or that party's legal representative) with a supplementary report to that effect which must contain such of the information referred to in paragraph 5 (b), (c), (d), (e) and (f) as is appropriate.
9. Where an expert witness is appointed by the Court, the preceding paragraph applies as if the Court were the engaging party.

Experts' conference

10. An expert witness must abide by any direction of the Court to:
    (a) confer with any other expert witness, and
    (b) endeavour to reach agreement on material matters for expert opinion, and
    (c) provide the Court with a joint report specifying matters agreed and matters not agreed and the reasons for any non agreement.

11. An expert witness must exercise his or her independent, professional judgment in relation to such a conference and joint report, and must not act on any instruction or request to withhold or avoid agreement.

Supreme Court rules for expert witnesses – Part 36 rule 13C

(1) For the purposes of this rule and rule 13CA:

"expert witness" means an expert engaged for the purpose of:

(a) providing a report as to his or her opinion for use as evidence in proceedings or proposed proceedings; or

(b) giving opinion evidence in proceedings or proposed proceedings;

"the code" means the expert witness code of conduct in Schedule K.

(2) Unless the Court otherwise orders:

(a) at or as soon as practicable after the engagement of an expert as a witness, whether to give oral evidence or to provide a report for use as evidence, the person engaging the expert shall provide the expert with a copy of the code;

(b) unless an expert witness's report contains an acknowledgment by the expert witness that he or she has read the code and agrees to be bound by it:

(i) service of the report by the party who engaged the expert witness shall not be valid service for the purposes of the rules or of any order or practice note; and

(ii) the report shall not be admitted into evidence;

(c) oral evidence shall not be received from an expert witness unless:

(i) he or she has acknowledged in writing, whether in a report relating to the proposed evidence or otherwise in relation to the proceedings, that he or she has read the code and agrees to be bound by it; and

(ii) a copy of the acknowledgment has been served on all parties affected by the evidence.

(3) If an expert witness furnishes to the engaging party a supplementary report, including any report indicating that the expert witness has changed his or her opinion on a material matter expressed in an earlier report by the expert witness:

(a) the engaging party must forthwith serve the supplementary report on all parties on whom the engaging party has served the earlier report; and

(b) the earlier report must not be used in the proceedings by the engaging party, or by any party in the same interest as the engaging party on the question to which the earlier report relates, unless paragraph (a) is complied with.

(4) This rule shall not apply to an expert engaged before this rule commences.

Australian Government
Department of Veterans' Affairs

ACT OFFICE

Mr Rod Thompson

Dear Rod

I refer to your e-mail of 28 May 2012 to [redacted] in which you provided a discussion paper in relation to medico-legal reports.

I appreciate the considerable effort you have put into the discussion paper and apologise for the delay in responding. Unfortunately, your paper was initially overlooked. When this was realised, due to the significant and extensive issues it raised, I asked a number of areas across the Department to consider them so that I would be in a position to provide you with a comprehensive and considered response.

You would appreciate that it is important that those claiming compensation for a condition or disability on the basis of its relationship to their Australian Defence Force service must be prepared for their claim to be carefully investigated. This is not because of any doubt with regard to the veracity of any individual claim. Rather, it is to ensure that decisions made about a claim are made in accordance with the specific legislative requirements of each Act and that the integrity of the Repatriation system is maintained.

The use of medico-legal firms is just one of a number of options for obtaining medical reports used by DVA in the investigative process and generally the medico-legal reports are comprehensive and received in a timely manner.

I have noted your observations and while no system is perfect, the evidence available to the Department does not support your concerns. However, I will take this opportunity to clarify DVA's claims investigative practices relating to medical reports and more broadly, the determination process.

Beneficial Legislation

Section 119 of the *Veterans' Entitlements Act 1986* (VEA) stipulates, amongst other things, that the Repatriation Commission is not bound by any rules of evidence when making decisions about a claim or application under the VEA. There are similar provisions in the *Military Rehabilitation and Compensation Act 2004* (MRCA), closely modeled on those in the VEA.

These beneficial provisions do not provide delegates with the authority to simply resolve in an applicant's favour where there is a mere assertion of a fact or where there is a conflict in evidence without attempting to seek further evidence to establish the truth. Nor do these provisions allow a delegate to disregard matters such as the requirements of factors within Statements of Principles. Rather, they are intended to assist delegates in making determinations in certain circumstances such as:

- where there is ambiguity in the legislation;
- where the legislation leaves the result open to the delegate's discretion; or
- where there is evidence that would normally be inadmissible in a court of law (such as hearsay).

The beneficial provisions are also intended to ensure that, when establishing the facts of an individual case, delegates take into account such factors as the effects of the passage of time or deficiencies in official records (e.g. service records) on the availability of evidence.

Use of Medico-Legal Firms

The frequency of using medico-legal firms varies between DVA locations and amongst delegates and is also influenced by the Act under which the claim is being determined. However, there is no evidence to suggest that such firms are used to the extent that you suggest.

It is true that medico-legal firms are generally used in cases involving assessment of permanent impairment. This is due to the nature of the medical evidence required to satisfy the legislative requirements for a permanent impairment payment under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) and the MRCA.

A medico-legal firm will be approached when an individual who has lodged a claim for benefits has no treating specialist, or if the treating specialist declines to provide a report. In many instances, the expertise of an occupational physician is required to assess impairment, disability and the fitness of the individual for specific work tasks or return to work programs. Generally, individuals do not have a treating occupational physician so consultations with this specialty are usually arranged through a medico-legal firm.

Additional factors that influence the decision to use a medico-legal firm include that such firms:

- offer a single point of contact for a range of specialists;
- a clear understanding of DVA's requirements;
- the prompt return of reports; and
- access for rural and remote clients.

Notwithstanding these benefits, it remains DVA's preference to use treating specialists in the majority of cases. Where a claimant, who does not have a treating specialist, or his or her representative, asks to be assessed by a particular specialist, DVA would have no objection. In determining the claim, the conclusion of any specialist is considered together with all other evidence obtained in the investigative process.

Referrals to Non-treating Specialists
When referring a claimant to a medical specialist, delegates are assisted by DVA's Contracted Medical Advisers to prepare a referral.

Referrals to a psychiatrist are made in accordance with DVA's comprehensive *Guidelines for Psychiatric Compensation Claims*, a copy of which is enclosed.

Specialists, other than psychiatrists, are simply asked to diagnose all conditions within their area of expertise, commenting on the aetiology of each condition, the physical signs and symptoms, clinical onset, and the extent of any incapacity as well as reasonable rehabilitative treatment options. If relevant service medical documents, previous reports or other information is held by DVA, this is attached to the referral.

With regard to DVA's letters to claimants advising of medical appointments that have been made, while there is a standard format, individual delegates determine what additional information to include to assist the claimant on a case by case basis. The claimant is asked to take copies of relevant previous investigations, such as x-ray films, to the appointment, and the specialist is authorised to arrange any additional outpatient investigations considered necessary. In the course of the examination, it is expected that the existence of any other relevant information will become evident.

It should be noted that even a treating specialist may not always have seen, or been made aware of, all relevant information. This is particularly the case with service medical records and information of an historical nature. In all cases, DVA delegates must ensure that a medical specialist is in a position to provide an informed opinion based on the medical facts of each case.

Use of American Medical Association Guides
You mention that the use of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA Guides) is a point of conjecture amongst some medical professionals involved in the medico-legal field. The AMA Guides provide a standard framework and method of analysis through which medical practitioners can evaluate, report on and communicate information about impairment to any human organ system. The AMA Guides are widely accepted and are used around the world.

Within DVA, the AMA Guides are used on a restricted basis for SRCA cases. Comcare has responsibility for SRCA policy and, in certain circumstances, the Comcare *Guide to the Assessment of the Degree of Permanent Impairment* (Comcare Guide) recommends the use of the AMA Guides. The AMA Guides may also be used by medical practitioners when there is no table in the Comcare Guide which provides for an adequate assessment to be made.

The AMA Guides, like the Comcare Guide, the VEA *Guide to Assessment of Rates of Veterans' Pensions* (GARP) and the MRCA *Guide to Determining Impairment and Compensation* (GARP M), are evidence-based guides to assessment. Ratings given under all of these guides are based on observable or measureable signs and symptoms. The decision to give one rating rather than another is a matter for the clinical judgment of the medical practitioner concerned.

If a medical practitioner gives ratings with reference to the AMA Guides, the opinion of a DVA Contracted Medical Adviser will be sought concerning the corresponding rating in the Comcare Guide or in GARP or in GARP M. Any rating unsupported by the evidence will generally be questioned.

Examinations by Non-Treating Specialists

Lack of rapport

It is acknowledged that claimants may not be able to establish a rapport with medical practitioners to whom they are referred by DVA. It is for this reason that a treating specialist is preferred. When there is no treating specialist, however, or when a treating specialist is unwilling to assist DVA, there is no alternative to such a referral. Even when a good rapport is not established, it is nevertheless expected that the medical practitioner, as a professional, will report his or her conclusions on the basis of the evidence considered.

Impact of medication on assessment

I have noted your concern about the impact of medications on the medical practitioner's assessment of the severity of disablement. However, it is usual for a medical specialist to obtain a medication history from each patient at the examination and to comment on the effects of that medication. Any clinical findings that are unusual will invariably be noted. In addition, a specialist will generally establish whether or not signs or symptoms of a condition vary in intensity from day to day.

Under the GARP and GARP M, the type of medication or treatment is in certain circumstances used as an indicator of the severity of disablement. Persistent and permanent side effects of treatment are also taken into account under GARP and GARP M. There are similar provisions in the Comcare Guide. There is no need for medication to be discontinued, even temporarily, in order for the specialist to undertake accurate assessment.

Attendance of family member

Where a claimant would like a family member to be present during an examination, the claimant should discuss this with the medical practitioner prior to the examination as most medical practitioners allow a family member to be present during an examination. Indeed, in many cases the corroborative history that a family member, particularly a spouse, can provide is often of great assistance.

Length and Frequency of Appointments

DVA appreciates that, for some claimants, medical examinations can be very stressful. However, DVA has a responsibility to thoroughly investigate all matters to which the claim relates so that a determination can be made. Consequently, where a medical report is required, DVA leaves it to the particular medical practitioner to decide the length of an appointment or appointments that will enable the practitioner to provide an opinion. For psychiatric conditions, for example, a psychiatrist may require two or more appointments before a conclusion can be reached.

Inaccuracies in Medico-Legal Reports

If a particular medical practitioner proves uncooperative or unreliable in any way, DVA will, if possible, avoid referring patients to that practitioner. DVA's Contracted Medical

Advisers consider most reports obtained from external medical practitioners and will advise the Repatriation Commission and the Military Rehabilitation and Compensation Commission delegates if there is a consistent pattern of unsatisfactory reporting.

I should mention, however, that applicants have the right to be referred to a medical practitioners of their choosing. Even when DVA considers the medical practitioner requested might not provide the best quality report, DVA complies with the wishes of the applicant or their representative.

Having said that, if a delegate becomes aware of any conflict in evidence in a particular case, the delegate has a responsibility to resolve this conflict to his or her reasonable satisfaction. This may involve obtaining further information, clarification or a supplementary report. In the event of an incomplete or inaccurate report being received, a delegate may decline payment for that report until the deficiency is addressed to his or her satisfaction.

Determination Process

You have suggested that medical practitioners should be made aware of legislative requirements and of precedent cases. However, the role of a medical practitioner is limited wholly to matters of a medical nature. It is delegates, not medical practitioners, who make decisions about the relationship of conditions to service and eligibility for compensation in accordance with the legislative requirements of each Act.

It is important to understand that the claims process is inquisitorial rather than adversarial. That is, it is the role of delegates to consider all the relevant material before making a decision on the outcome of a claim. A delegate must nevertheless make findings of fact on the basis of the material considered and in accordance with the legislative requirements of the relevant Act/s. At times, findings of fact are such that a claim for benefits cannot succeed.

Complaints Process

With regard to your suggestion that claimants be required to complete a satisfaction survey after each medical examination, the significant resources that would be required to collate and analyse the information from the many hundreds of medical examinations organised each year cannot be justified on the basis of the very small number of complaints DVA receives.

I would mention, however, it does happen from time to time that a claimant will express concern to DVA about the conduct or attitude of a medical practitioner. In such cases, claimants are advised of the formal complaints process to the relevant professional association in each state and territory. In addition, the report itself is carefully considered to ensure that all conclusions are supported by evidence. If dissatisfaction with a medical practitioner is of such a degree as to leave no alternative, an appointment with another medical practitioner will be arranged.

Compensation for financial loss

I note your comment that an act of grace payment could be considered in the event that a claimant suffers a serious financial loss because of a delay in a determination due to a flawed medico-legal report. It is possible for excessive delays in processing a claim, or the making of a decision that clearly cannot be sustained on the facts, to give rise to

consideration of compensation for defective administration but only if it can be shown that an economic loss is directly attributable to departmental actions or inactions. It is unlikely that an act of grace payment would be considered in these circumstances.

Code of Conduct

You mention that at the end of each medico-legal report the doctor acknowledges that "he/she has read the Expert Witness Code of Conduct and agrees to be bound by it", but this is not a requirement of medico-legal reports provided to DVA.

I should mention, however, that the *Good Medical Practice: A Code of Conduct for Doctors in Australia* (the Code) sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of all doctors in Australia by the professional peers and the community. Section 8.7 of the Code sets out the principles to be met by medical practitioners providing medico-legal, insurance and other assessments and Section 8.8 details the principles relating to the provision of medical reports, certificates and giving evidence.

The Code and other codes and guidelines developed by the Medical Board of Australia are available online at http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

Medical practitioners have a professional responsibility to be familiar with the Code and to apply the guidance it contains. Serious or repeated failure to meet the standards of the Code may result in a medical practitioner being de-registered and therefore unable to practice medicine in Australia.

Flexibility of current system

DVA takes a flexible approach to sourcing medical opinions by making use of the services of treating doctors as well as medico-legal firms and other suitable available specialists. DVA also accepts recommendations concerning specialists from claimants, their representatives, and their local medical officers. There are no plans to change this by entering into a less flexible system of external contracts.

The complex matters raised have been carefully considered and, while some are not within DVA's jurisdiction, overall DVA is satisfied with the current arrangements. Having said that, you can be assured that this Department will continue to review and revise its policies and procedures with a view to ensuring that veterans and their families receive the assistance and support that they require.

Yours sincerely

Neil Bayles
A/g First Assistant Secretary
Rehabilitation and Support Division

22 April 2013

Australian Government
Department of Veterans' Affairs

Department of Veterans' Affairs (DVA): Unreasonable Complainant Conduct (UCC) Policy

1. INTRODUCTION

1.1 Statement of support

It is the mission of the Department of Veterans' Affairs (DVA) to support those who serve or have served in the defence of our nation and commemorate their service and sacrifice. DVA plays a crucial role in ensuring that both current and former serving members and their families receive the highest level of support and services and consistently strives to do the utmost to meet the needs of all we serve.

DVA's strategic plan, DVA Towards 2020, is shaped by three clear strategic themes: to be client-focused, responsive and connected. The plan outlines a series of strategies that will make it easier for clients to work with the Department, by ensuring that we are responsive to all groups of clients, across all areas of our business and ensure a coordinated and consistent approach to delivering services into the future. DVA has consulted and continues to consult with a range of clients about their experiences with DVA, to gather feedback that will help shape changes to our service delivery approach.

Within this context, DVA is committed to being accessible and responsive to all complainants who approach the Department for assistance and/or with a complaint. At the same time, the success of the Department in meeting its mission depends on:

- our ability to do our work and perform our functions in the most effective and efficient ways possible;
- the health, safety and security of our staff; and
- our ability to allocate our resources fairly across all the complaints we receive.

When complainants behave unreasonably in their dealings with us, their conduct can significantly affect our service. As a result, DVA will take proactive and decisive action to manage any complainant conduct that negatively and unreasonably affects us and will support staff to do the same in accordance with this policy.

I authorise and expect all DVA staff to implement the strategies provided in this policy while continuing to acknowledge, commemorate and provide support to veterans and their families.

Secretary APPROVAL

[Signature]

2. OBJECTIVES

2.1 Policy aims

This policy has been developed to assist all DVA staff members to better manage unreasonable complainant conduct ('UCC'). Its aim is to ensure that all staff:

- Feel confident and supported in taking action to manage UCC.
- Act fairly, consistently, honestly and appropriately when responding to UCC.
- Are aware of their roles and responsibilities in relation to the management of UCC and how this policy will be used.
- Understand the types of circumstances when it may be appropriate to manage UCC using one or more of the following mechanisms:
  - The strategies provided in the Managing Unreasonable Complainant Conduct Practice Manual (2nd edition) ('practice manual') including the strategies to change or restrict a complainant's access to our services.
  - Alternative dispute resolution strategies to deal with conflicts involving complainants and members of our organisation.
  - Legal mechanisms, such as trespass laws/legislation, to prevent a complainant from coming onto DVA premises and orders to protect specific staff members from any actual or apprehended personal violence, intimidation or stalking.
- Have a clear understanding of the criteria that will be considered before we decide to change or restrict a complainant's access to our services.
- Are aware of the processes that will be followed to record and report UCC incidents as well as the procedures for consulting and notifying complainants about any proposed actions or decisions to change or restrict their access to our services.
- Are familiar with the procedures for reviewing decisions made under this policy, including specific timeframes for review.

3. DEFINING UNREASONABLE COMPLAINANT CONDUCT

3.1 Unreasonable complainant conduct

Most complainants who approach DVA act reasonably and responsibly in their interactions with the Department, even when they are experiencing high levels of distress, frustration and anger about their complaint. However in a very small number of cases some complainants behave in ways that are inappropriate and unacceptable – despite DVA's best efforts to help them. They are aggressive and

verbally abusive towards our staff. They threaten harm and violence, bombard DVA offices with unnecessary and excessive phone calls and emails, make inappropriate demands on our time and our resources and refuse to accept DVA decisions and recommendations in relation to their complaints. When complainants behave in these ways we consider their conduct to be 'unreasonable'.

Definition of UCC: Unreasonable complainant conduct ('UCC') is any behaviour by a current or former complainant which, because of its nature or frequency raises substantial health, safety, resource or equity issues for DVA, its staff, other service users and complainants or the complainant himself/herself.

UCC can be divided into five categories of conduct:

- Unreasonable persistence;
- Unreasonable demands;
- Unreasonable lack of cooperation;
- Unreasonable arguments; or
- Unreasonable behaviours.

3.2 Unreasonable persistence

Unreasonable persistence is continued, incessant and unrelenting conduct by a complainant that has a disproportionate and unreasonable impact on DVA, staff, services, time and/or resources. Some examples of unreasonably persistent behaviour include:

- An unwillingness or inability to accept reasonable and logical explanations including final decisions that have been comprehensively considered and dealt with.
- Persistently demanding a review simply because it is available and without arguing or presenting a case for one.
- Pursuing and exhausting all available review options when it is not warranted and refusing to accept further action cannot or will not be taken on complaints.
- Reframing a complaint in an effort to get it taken up again.
- Bombarding our staff/organisation with phone calls, visits, letters, emails (including cc'd correspondence) after repeatedly being asked not to do so.
- Contacting different people within DVA and/or externally to get a different outcome or more sympathetic response to their complaint – internal and external forum shopping.

3.3 Unreasonable demands

Unreasonable demands are any demands (express or implied) that are made by a complainant that have a disproportionate and unreasonable impact on DVA, staff, services, time and/or resources. Some examples of unreasonable demands include:

- Issuing instructions and making demands about how we have/should handle their complaint, the priority it was/should be given, or the outcome that was/should be achieved.
- Insisting on talking to a senior manager or the Secretary or other senior DVA Executive personally when it is not appropriate or warranted.
- Emotional blackmail and manipulation with the intention to guilt trip, intimidate, harass, shame, seduce or portray themselves as being victimised – when this is not the case.
- Insisting on outcomes that are not possible or appropriate in the circumstances – e.g. for someone to be sacked or prosecuted, an apology and/or compensation when no reasonable basis for expecting this.
- Demanding services that are of a nature or scale that we cannot provide when this has been explained to them repeatedly.

3.4 Unreasonable lack of cooperation

Unreasonable lack of cooperation is an unwillingness and/or inability by a complainant to cooperate with DVA, staff, or complaints system and processes that results in a disproportionate and unreasonable use of our services, time and/or resources. Some examples of unreasonable lack of cooperation include:

- Sending a constant stream of comprehensive and/or disorganised information without clearly defining any issues of complaint or explaining how they relate to the core issues being complained about – only where the complainant is clearly capable of doing this.
- Providing little or no detail with a complaint or presenting information in 'dribs and drabs'.
- Refusing to follow or accept our instructions, suggestions, or advice without a clear or justifiable reason for doing so.
- Arguing frequently and/or with extreme intensity that a particular solution is the correct one in the face of valid contrary arguments and explanations.
- Displaying unhelpful behaviour – such as withholding information, acting dishonestly, misquoting others, and so forth.

3.5 Unreasonable arguments

Unreasonable arguments include any arguments that are not based in reason or logic, that are incomprehensible, false or inflammatory, trivial or delirious and that disproportionately and unreasonably impact upon DVA, staff, services, time, and/or resources. Arguments are unreasonable when they:

- fail to follow a logical sequence.
- are not supported by any evidence and/or are based on conspiracy theories.
- lead a complainant to reject all other valid and contrary arguments.

- are trivial when compared to the amount of time, resources and attention that the complainant demands.
- are false, inflammatory or defamatory.

3.6 Unreasonable behaviour

Unreasonable behaviour is conduct that is unreasonable in all circumstances – regardless of how stressed, angry or frustrated that a complainant is – because it unreasonably compromises the health, safety and security of our staff, other service users or the complainant himself/herself. Some examples of unreasonable behaviours include:

- Acts of aggression, verbal abuse, derogatory, racist, or grossly defamatory remarks.
- Harassment, intimidation or physical violence.
- Rude, confronting and threatening correspondence.
- Threats of harm to self or third parties, threats with a weapon or threats to damage property including bomb threats.
- Stalking (in person or online).
- Emotional manipulation.

All staff should note that DVA has a zero tolerance policy towards any harm, abuse or threats directed towards them. Any conduct of this kind will be dealt with under this policy, *[insert relevant security policy/procedure]* and in accordance with our duty of care and work health and safety responsibilities.

4. ROLES AND RESPONSIBILITIES

4.1 All staff

All staff are responsible for familiarising themselves with this policy as well as the *Individual Rights and Mutual Responsibilities of the Parties to a Complaint* in Appendix A. Staff are also encouraged to explain the contents of this document to complainants particularly those who engage in UCC or exhibit the early warning signs for UCC.

Staff are also encouraged and authorised to use the strategies and scripts provided in Part 5 of the practice manual to manage UCC, in particular:

- Strategies and script ideas for managing unreasonable persistence: pages 39 – 48.
- Strategies and script ideas for managing unreasonable demands: pages 50 – 63.
- Strategies and script ideas for managing unreasonable lack of cooperation: pages 64 – 68.
- Strategies and script ideas for managing unreasonable arguments: 69 – 76.
- Strategies and script ideas for managing unreasonable behaviours: pages 77 – 88.

However, it must be emphasised that any strategies that effectively change or restrict a complainant's access to DVA services must be considered at the Chief Operating Officer/Deputy President level or higher as provided in this policy.

Staff are also responsible for recording and reporting all UCC incidents they experience or witness (as appropriate) to the relevant Assistant Secretary or Deputy Commissioner within 24 hours of the incident occurring. A file note of the incident should also be retained.

4.2 The Chief Operating Officer/Deputy President

The Chief Operating Officer/Deputy President, in consultation with relevant staff, have the responsibility and authority to change or restrict a complainant's access to DVA services in the circumstances identified in this policy. When doing so they will take into account the criteria in Part 7.2 below and will aim to impose any service changes/restrictions in the least restrictive ways possible. Their aim, when taking such actions will not be to punish the complainant, but rather to manage the impacts of their conduct.

When applying this policy the Chief Operating Officer/Deputy President will also aim to keep at least one open line of communication with a complainant. However, we do recognise that in extreme situations all forms of contact may need to be restricted for some time to ensure the health and safety and security of our staff and/or third parties.

The Chief Operating Officer/Deputy President are also responsible for recording, monitoring and reviewing all cases where this policy is applied to ensure consistency, transparency and accountability for the application of this policy. They will also manage and keep a file record of all cases where this policy is applied.

4.3 Senior managers

All senior managers are responsible for supporting staff to apply the strategies in this policy. Senior managers are also responsible for ensuring compliance with the procedures identified in this policy and ensuring that all staff members are trained to deal with UCC – including on induction.

Following a UCC and/or stressful interaction with a complainant senior managers are responsible for providing affected staff members with the opportunity to debrief and vent their concerns either formally or informally. Senior managers will also ensure that staff are provided with proper support and assistance including medical and/or police assistance and support through programs such as Employee Assistance Program (EAPS), if necessary.

Depending on the circumstances senior managers may also be responsible for arranging other forms of support for staff which are detailed in Part 12 of this policy.

5. RESPONDING TO AND MANAGING UCC

5.1 Changing or restricting a complainant's access to our services

UCC incidents will generally be managed by limiting or adapting the ways that we interact with and/or deliver services to complainants by restricting:

- **Who they have contact with** – e.g. limiting a complainant to a sole contact person/staff member in DVA.
- **What they can raise with us** – e.g. restricting the subject matter of communications that we will consider and respond to.
- **When they can have contact** – e.g. limiting a complainant's contact with DVA to a particular time, day, or length of time, or curbing the frequency of their contact with us.
- **Where they can make contact** – e.g. limiting the locations where we will conduct face-to-face interviews to secured facilities or areas of the office.
- **How they can make contact –** e.g. limiting or modifying the forms of contact that the complainant can have with us. This can include modifying or limiting face-to-face interviews, telephone and written communications, prohibiting access to our premises, contact through a representative only or taking no further action.

When using the restrictions provided in this section we recognise that discretion will need to be used to adapt them to suit a complainant's personal circumstances, level of competency, literacy skills, etc. In this regard, we also recognise that more than one strategy may need to be used in individual cases to ensure their appropriateness and efficacy.

5.2 Who – limiting the complainant to a sole contact point

Where a complainant tries to forum shop internally within DVA, changes their issues of complaint repeatedly, reframes their complaint, or raises an excessive number of complaints it may be appropriate to restrict their access to a single staff member (a sole contact point) who will exclusively manage their complaint(s) and interactions with DVA. This may ensure they are dealt with consistently and may minimise the chances for misunderstandings, contradictions and manipulation.

To avoid staff 'burn out' the sole contact officer's supervisor will provide them with regular support and guidance – as needed. Also, the Chief Operating Officer/Deputy President will review the arrangement every six months to ensure that the officer is managing/coping with the arrangement.

Complainants who are restricted to a sole contact person will however be given the contact details of one additional staff member who they can contact if their primary contact is unavailable – e.g. they go on leave or are otherwise unavailable for an extended period of time.

5.3 What – restricting the subject matter of communications that we will consider

Where complainants repeatedly send written communications, letters, emails, or online forms that raise trivial or insignificant issues, contain inappropriate or abusive content or relate to a complaint/issue that has already been comprehensively considered and/or reviewed (at least once) by DVA, we may restrict the issues/subject matter the complainant can raise with DVA/we will respond to. For example, we may:

- Refuse to respond to correspondence that raises an issue that has already been dealt with comprehensively, that raises a trivial issue, or is not supported by clear/any evidence. The complainant will be advised that future correspondence of this kind will be read and filed without acknowledgement unless we decide that we need to pursue it further in which case, we may do so on our 'own motion'.
- Restrict the complainant to one complaint/issue per month. Any attempts to circumvent this restriction, for example by raising multiple complaints/issues in the one complaint letter may result in modifications or further restrictions being placed on their access.
- Return correspondence to the complainant and require them to remove any inappropriate content before we will agree to consider its contents. A copy of the inappropriate correspondence will also be made and kept for our records to identify repeat/further UCC incidents.

5.4 When – limiting when and how a complainant can contact us

If a complainant's telephone, written or face-to-face contact with DVA places an unreasonable demand on our time or resources because it is overly lengthy (e.g. disorganised and voluminous correspondence) or affects the health safety and security of DVA staff because it involves behaviour that is persistently rude, threatening, abusive or aggressive, we may limit when and/or how the complainant can interact with the Department. This may include:

- Limiting their telephone calls or face-to-face interviews to a particular time of the day or days of the week.
- Limiting the length or duration of telephone calls, written correspondence or face-to-face interviews. For example:
  - Telephone calls may be limited to *[10]* minutes at a time and will be politely terminated at the end of that time period.
  - Lengthy written communications may be restricted to a maximum of *[5]* typed or written pages, single sided, font size 12 or it will be sent back to the complainant to be organised and summarised – This option is only appropriate in cases where the complainant is capable of summarising the information and refuses to do so.

- Limiting face-to-face interviews to a maximum of *[45]* minutes.

- Limiting the frequency of telephone calls, written correspondence or face-to-face interviews. Depending on the nature of the service(s) provided we may limit:
  - Telephone calls to a set time every two weeks/ month.
  - Written communications to once every two weeks/month.
  - Face-to-face interviews to once every two weeks/month.

For irrelevant, overly lengthy, disorganised or frequent written correspondence we may also:

- Require the complainant to clearly identify how the information or supporting materials they have sent to DVA relate to the central issues that we have identified in their complaint.
- Restrict the frequency with which complainants can send emails or other written communications to DVA offices.
- Restrict a complainant to sending emails to a particular email account (e.g. DVA's General Enquiries email account) or block their email access altogether and require that any further correspondence be sent through Australia Post only.

Writing only restrictions

When a complainant is restricted to 'writing only' they may be restricted to written communications through:

- Australia Post only
- Email only to a specific staff/section email or the DVA General Enquiries email account
- Fax only to a specific fax number
- Some other relevant form of written contact, where applicable.

If a complainant's contact is restricted to 'writing only', the Chief Operating Officer/Deputy President will clearly identify the specific means that the complainant can use to contact our office (e.g. Australia Post only). Also if it is not suitable for a complainant to enter DVA premises to hand deliver their written communication, this must be communicated to them as well.

Any communisations that are received by our office in a manner that contravenes a 'write only' restriction will either be returned to the complainant or read and filed without acknowledgement.

5.5 Where – limiting face-to-face interviews to secure areas

If a complainant is violent or overtly aggressive, unreasonably disruptive, threatening or demanding or makes frequent unannounced visits to our premises, we may consider restricting our face-to-face contact with them.

These restrictions may include:

- Restricting access to particular secured premises or areas of the office – such as the reception area or secured room/facility.
- Restricting their ability to attend DVA premises to specified times of the day and/or days of the week only – for example, when additional security is available or to times/days that are less busy.
- Allowing them to attend DVA premises on an 'appointment only' basis and only with specified staff. Note – during these meetings staff should always seek support and assistance of a colleague for added safety and security.
- Banning the complainant from attending DVA premises altogether and allowing some other form of contact – e.g. 'writing only' or 'telephone only' contact.

Contact through a representative only

In cases where DVA cannot completely restrict contact with a complainant and their conduct is particularly difficult to manage, we may also restrict their contact to contact through a support person or representative only. The support person may be nominated by the complainant but must be approved by a relevant DVA manager.

When assessing a representative/support person's suitability, the nominated manager should consider factors like: the nominated representative/support person's competency and literacy skills, demeanour/behaviour and relationship with the complainant. If the manager determines that the representative/support person may exacerbate the situation with the complainant the complainant will be asked to nominate another person or we may assist them in this regard.

5.6 Maximum contact restriction

In rare cases, and as a last resort, the Secretary may decide that it is necessary for the Department to refuse to correspond further with a complainant if they persist in their complaint after the Department's complaint process has been exhausted.

While a client will not be prevented from accessing their lawful DVA entitlements, a decision to have no further contact with a complainant may be made if it appears that the complainant is unlikely to modify their conduct and/or their conduct poses a significant risk for our staff or other parties. Maximum contact restriction may be applied where the complainant concerned:

- is consistently abusive, or makes threats to staff or other members of the public;
- causes damage to the property of the agency, or intimidates or threatens physical harm to staff or third parties;
- is physically violent; or
- produces a weapon.

In these cases the complainant will be sent a letter notifying them that their access has been restricted as outlined in Part 7.4 below.

A complainant's access to DVA services and premises may also be restricted (directly or indirectly) using the legal mechanisms such as trespass laws/legislation or legal orders to protect members of our staff from personal violence, intimidation or stalking by a complainant.

5.7 Vexatious complainant declaration

In addition, the Secretary reserves a discretion to decide that the Department will not undertake or continue to process a complaint on the basis that the complaint is frivolous or vexatious, or not made in good faith. This discretion may apply to a series of complaints about the same matter or matters.

In extreme cases, the Secretary may declare a person to be a vexatious complainant in respect of their complaints to DVA. This action may be appropriate where the Secretary is satisfied that:

- the complainant had repeatedly engaged in complaint activity that involves an abuse of process;
- the complainant made a particular complaint that would involve an abuse of process; or
- the processing of a particular complaint or series of complaints by the person would be manifestly unreasonable.

'Abuse of process' includes harassing or intimidating a departmental employee or employees; or unreasonably interfering with the Department's operations.

A series of complaints of a repetitive nature apparently made with the intention of annoying or harassing staff or disrupting the Department's operations could be classified as vexatious.

An individual's previous complaint activity may be relevant, particularly if a fresh complaint or series of complaints relates to the same issues as past complaints that are considered resolved or otherwise closed.

6. ALTERNATIVE DISPUTE RESOLUTION

6.1 Using alternative dispute resolution strategies to manage conflicts with complainants

If the Chief Operating Officer/Deputy President determine that DVA cannot terminate services to a complainant in a particular case or that DVA/staff bear some responsibility for causing or exacerbating their conduct, they may consider using alternative dispute resolution strategies ('ADR') such as mediation and conciliation to resolve the conflict with the complainant and attempt to rebuild DVA's relationship with them. If ADR is considered to be an appropriate option in a particular case, the ADR will be conducted by an independent third party to ensure transparency and impartiality.

However, we recognise that in UCC situations, ADR may not be an appropriate or effective strategy particularly if the complainant is uncooperative or resistant to

compromise. Therefore, each case will be assessed on its own facts to determine the appropriateness of this approach.

7. PROCEDURE TO BE FOLLOWED WHEN CHANGING OR RESTRICTING A COMPLAINANT'S ACCESS TO OUR SERVICES

7.1 Consulting with relevant staff

When a manager (e.g. relevant Assistant Secretary/Deputy Commissioner) receives a UCC incident report from a staff member they will contact the staff member to discuss the incident. They will discuss:

- The circumstances that gave rise to the UCC/incident.
- The impact of the complainant's conduct on DVA, relevant staff, time, resources, etc.
- The complainant's responsiveness to the staff member's warnings/requests to stop the behaviour.
- The actions the staff member has taken to manage the complainant's conduct, if any.
- The suggestions made by relevant staff on ways that the situation could be managed.

7.2 Criteria to be considered

Following a consultation with relevant staff (this may include Case-coordination staff, DVA Social Workers or Security staff) the relevant Assistant Secretary/Deputy Commissioner will gather information about the complainant's prior conduct and history with DVA to brief the Chief Operating Officer/Deputy President. They will also consider the following criteria:

- Whether the conduct in question involved overt anger, aggression, violence or assault (which is unacceptable in all circumstances).
- Whether the complainant's case has merit.
- The likelihood that the complainant will modify their unreasonable conduct if they are given a formal warning about their conduct.
- Whether changing or restricting access to our services will be effective in managing the complainant's behaviour.
- Whether changing or restricting access to DVA services will affect the complainant's ability to meet their obligations, such as reporting obligations.
- Whether changing or restricting access to our services will have an undue impact on the complainant's welfare, livelihood or dependants etc.
- Whether the complainant's personal circumstances have contributed to the behaviour. For example, the complainant is a vulnerable person who is under significant stress as a result of one or more of the following:
  - homelessness

  - physical disability
  - illiteracy or other language or communication barrier
  - mental or other illness
  - chronic pain
  - personal crises
  - substance or alcohol abuse.
- Whether the complainant's response/ conduct in the circumstances was moderately disproportionate, grossly disproportionate or not at all disproportionate.
- Whether there any statutory provisions that would limit the types of limitations that can be put on the complainant's contact/access to our services.

It is acknowledged that in some cases, a complainant's mental health and/or psychosocial factors may indicate a need for early intervention strategies other than the standardised warning and contact restrictions. Where such factors are apparent, consultation with a DVA Social Work Advisor and Mental Health Advisor should occur. Case-coordination and/or Security staff may also be consulted depending on the nature of UCC and personal circumstances. Where considered appropriate, the Social Work Advisor may contact the complainant and consider alternative management strategies.

The mental health needs of our clients is a priority. If people are worried about how they are feeling or coping, then we encourage them to seek help. People can contact the Veterans and Veterans Families Counselling Service or VVCS on 1800 011 046 or www.vvcs.gov.au, talk to their doctor, or go-on-line to DVA's mental health web portal *At Ease.*

Once the Chief Operating Officer/Deputy President has been briefed and considered the above factors they will decide on the appropriate course of action. They may suggest formal or informal options for dealing with the complainant's conduct which may include one or more of the strategies provided in the practice manual and this policy.

7.3 Providing a warning letter

Unless a complainant's conduct poses a substantial risk to the health and safety of staff or other third parties, the Chief Operating Officer/Deputy President will provide them with a written warning about their conduct in the first instance.

The warning letter will:

- Specify the date, time and location of the UCC incident.
- Explain why the complainant's conduct/ UCC incident is problematic.

- List the types of access changes and/or restrictions that may be imposed if the behaviour continues. (Note: not every possible restriction should be listed only those that are most relevant).
- Provide clear and full reasons for the warning being given
- Include an attachment of the organisation's ground rules and / or briefly state the standard of behaviour that is expected of the complainant. See Appendix A.
- Provide the name and contact details of the staff member who they can contact about the letter.
- Be signed by the Chief Operating Officer/Deputy President.

7.4 Providing a notification letter

If a complainant's conduct continues after they have been given a written warning or in extreme cases of overt aggression, violence, assault or other unlawful/unacceptable conduct the Chief Operating Officer/Deputy President has the discretion to send a notification letter immediately restricting the complainant's access to our services (without prior written warning).

This notification letter will:

- Specify the date, time and location of the UCC incident(s).
- Explain why the complainant's conduct/UCC incident(s) is problematic.
- Identify the change and/or restriction that will be imposed and what it means for the complainant.
- Provide clear and full reasons for this restriction.
- Specify the duration of the change or restriction imposed, which will not exceed 12 months.
- Indicate a time period for review.
- Provide the name and contact details of the senior officer who they can contact about the letter and/or request a review of the decision.
- Be signed by the Chief Operating Officer/Deputy President.

7.5 Notifying relevant staff about access changes/restrictions

The Chief Operating Officer/Deputy President will notify relevant staff about any decisions to change or restrict a complainant's access to our services, in particular reception and security staff in cases where a complainant is prohibited from entering our premises.

The Chief Operating Officer/Deputy President will also make a record outlining the nature of the restrictions imposed and their duration.

7.6 Continued monitoring/oversight responsibilities

Once a complainant has been issued with a warning letter or notification letter the Chief Operating Officer/Deputy President will review the complainant's record/restriction every *[3, 6 or 12 months]*, on request by a staff member, or

following any further incidents of UCC that involve the particular complainant to ensure that they are complying with the restrictions/the arrangement is working.

If the Chief Operating Officer/Deputy President determines that the restrictions have been ineffective in managing the complainant's conduct or are otherwise inappropriate they may decide to either modify the restrictions, impose further restrictions.

8. APPEALING A DECISION TO CHANGE OR RESTRICT ACCESS TO OUR SERVICES

8.1 Right of appeal

Complainants are entitled to one appeal of a decision to change/restrict their access to DVA services. This review will be undertaken by a senior staff member who was not involved in the original decision to change or restrict the complainant's access. This staff member will consider the complainant's arguments along with all relevant records regarding the complainant's past conduct. They will advise the complainant of the outcome of their appeal by letter which must be signed off by the Chief Operating Officer/Deputy President. The staff member will retain any materials/records relating to the appeal in an appropriate file.

If a complainant continues to be dissatisfied after the appeal process, they may seek an external review from an oversight agency such as the Ombudsman. The Ombudsman may accept the review (in accordance with its administrative jurisdiction) to ensure that we have acted fairly, reasonably and consistently and have observed the principles of good administrative practice including, procedural fairness.

9. NON-COMPLIANCE WITH A CHANGE OR RESTRICTION ON ACCESS TO OUR SERVICES

9.1 Recording and reporting incidents of non-compliance

All staff members are responsible for recording and reporting incidents of non-compliance by complainants. This should be recorded in a file note and a copy forwarded to the Chief Operating Officer/Deputy President who will decide whether any action needs to be taken to modify or further restrict the complainant's access to DVA services.

10. PERIODIC REVIEWS OF ALL CASES WHERE THIS POLICY IS APPLIED

10.1 Period for review

All UCC cases where this policy is applied will be reviewed every 3, 6 or 12 months (depending on the nature of the UCC and the service provided) and not more than 12 months after the service change or restriction was initially imposed or continued/upheld.

10.2 Notifying the complainant of an upcoming review

The Chief Operating Officer/Deputy President will invite all complainants to participate in the review process unless they determine that this invitation will provoke a negative response from the complainant (ie further UCC). The invitation will be given and the review will be conducted in accordance with the complainant's access restrictions (eg if contact has been restricted to writing only then the invitation to participate will be done in writing).

10.3 Criteria to be considered during a review

When conducting a review the Chief Operating Officer/Deputy President will consider:

- Whether the complainant has had any contact with DVA during the restriction period.
- The complainant's conduct during the restriction period.
- Any information/arguments put forward by the complainant for review.
- Any other information that may be relevant in the circumstances.

The Chief Operating Officer/Deputy President may also consult any staff members who have had contact with the complainant during the restriction period.

Note – Sometimes a complainant may not have a reason to contact DVA during their restriction period. As a result, a review decision that is based primarily on the fact that the complainant has not contacted DVA during their restriction period (apparent compliance with our restriction) may not be an accurate representation of their level of compliance/reformed behaviour. This should be taken into consideration, in relevant situations.

10.4 Notifying a complainant of the outcome of a review

The Chief Operating Officer/Deputy President will notify the complainant of the outcome of their review using the appropriate/relevant method of communication as well as a written letter explaining the outcome, as applicable. The review letter will:

- Briefly explain the review process.
- Identify the factors that have been taken into account during the review.
- Explain the decision/outcome of the review and the reasons for it.

If the outcome of the review is to maintain or modify the restriction the review letter will **also**:

- Indicate the nature of the new or continued restriction.
- State the duration of the new restriction period.
- Provide the name and contact details of a designated contact officer who the complainant can contact to discuss the letter.
- Be signed by the Chief Operating Officer/Deputy President.

10.5 Recording the outcome of a review and notifying relevant staff

Like all other decisions made under this policy, the Chief Operating Officer/Deputy President is responsible for keeping a record of the outcome of the review, updating file records and notifying all relevant staff of the outcome of the review including if the restriction has been withdrawn.

11 MANAGING STAFF STRESS

11.1 Staff reactions to stressful situations

Dealing with complainants who are demanding, abusive, aggressive or violent can be extremely stressful and at times distressing or even frightening for all our staff – both experienced and inexperienced. It is perfectly normal to get upset or experience stress when dealing with difficult situations.

As an organisation, DVA has a responsibility to support staff members who experience stress as a result of situations arising at work and we will do our best to provide staff with debriefing and counselling opportunities, when needed. However, to do this we also need help of all DVA staff to identify stressful incidents and situations. As a result, all staff have a responsibility to notify relevant supervisors/senior managers of UCC incidents and any stressful incidents that they believe require management involvement.

11.2 Debriefing

Debriefing means talking things through following a difficult or stressful incident. It is an important way of 'off-loading' or dealing with stress. Many staff members naturally do this with colleagues after a difficult telephone call, but debriefing can also be done with a supervisor or senior manager or as a team following a significant incident. We encourage all staff to engage in an appropriate level of debriefing, when necessary.

Staff may also access an external professional service on a needs basis. All staff can access the Employee Assistance Program – a free, confidential counselling service. To make an appointment call: 1300 366 789. For traumatic incident or crisis counselling, call 1800 451 138. Information about this service is available on the DVA Intranet.

12 OTHER REMEDIES

12.1 Compensation for injury

Any staff member who suffers injury as a result of aggressive behaviour from complainants is entitled to make a workers' compensation claim. DVA People Services will assist wherever possible in processing claims.

12.2 Legal assistance

If a staff member is physically attacked, or is a victim of employment generated harassment and the police do not lay charges, the Department will consider the potential for providing legal assistance in accordance with the *Legal Services Directions 2005*. If a DVA staff member considers they have been defamed by a complainant, the Department's defamation guidelines should be considered.

12.3 Threats outside the office or outside working hours

Where threats are directed at a particular staff member and it appears those threats may be carried out outside normal working hours or outside the office, the staff member will receive the support of the office. Requests for such assistance should be made to the Chief Operating Officer/Deputy President via a relevant Assistant Secretary/Deputy Commissioner.

12.5 Escorts home

When a staff member fears for their safety following a threat from a complainant, another staff member may accompany them home or the office can meet the cost of the staff member going home in a taxi. Ask the relevant Assistant Secretary/Deputy Commissioner for more information.

12.6 Telephone threats on home numbers

If a staff member or their family have been harassed by telephone at their home and they believe it is connected with their employment they may apply to have the office meet the cost of having their telephone number changed and/or made silent. The staff member should also contact their telephone carrier, as they may provide an interception/monitoring service.

If assistance is approved, the office will meet the cost incurred for a period up to 12 months. Once approval is given, the staff member is responsible for making the necessary arrangements and will be reimbursed after producing a paid account.

Applications for reimbursement must be approved via a relevant Assistant Secretary/Deputy Commissioner.

12.7 Other security measures

If other security measures are necessary, the office will give consideration to providing all reasonable support to ensure the safety and welfare of the staff member.

13. TRAINING AND AWARENESS

DVA is committed to ensuring that all staff are aware of and know how to use this policy. All staff who deal with complainants in the course of their work will also

receive appropriate training and information on using this policy and on managing UCC on a regular basis in particular, on induction.

14. OMBUDSMAN MAY REQUEST COPIES OF OUR RECORDS

DVA will keep records of all cases where this policy is applied, including a record of the total number of cases where it is used every year. This data may be requested by the Commonwealth Ombudsman to conduct an overall audit and review in accordance with its administrative functions and/or to inform its work on UCC.

15. POLICY REVIEW

All staff are responsible for forwarding any suggestions they have in relation to this policy to the *[nominated senior manager]*, who along with relevant senior managers will review it biennially (every 2 years).

16. SUPPORTING DOCUMENTS AND POLICIES

16.1 Statement of compliance

This policy is compliant with and supported by the following documents:

- DVA Feedback Management Policy
- Managing unreasonable complainant conduct practice manual (2nd edition)
- Unauthorised entry onto agency premises – applying the provisions of the *Commonwealth Crimes Act 1914*
- Court Orders and legislation to address violence, threats, intimidation and / or stalking by complainants.

Appendix A

Australian Government

Department of Veterans' Affairs

Complaints Management in the Department of Veterans' Affairs (DVA): Individual Rights and Mutual Responsibilities of the Parties to a Complaint

In order for the Department of Veterans' Affairs (DVA) to ensure that all complaints are dealt with fairly, efficiently and effectively and that occupational health and safety standards and duty of care obligations are adhered to, the following rights and responsibilities must be observed and respected by all of the parties to the complaint process.

Individual rights[i]

Complainants have the right:

- to make a complaint and to express their opinions in ways that are reasonable, lawful and appropriate[ii].
- to a reasonable explanation of the organisation's complaints procedure, including details of the confidentiality, secrecy and/or privacy rights or obligations that may apply.
- to a fair and impartial assessment and, where appropriate, investigation of their complaint based on the merits of the case[iii].
- to a fair hearing[iv].
- to a timely response.
- to be informed in at least general terms about the actions taken and outcome of their complaint[v].
- to be given reasons that explain decisions affecting them.
- to at least one right of review of the decision on the complaint[vi].
- to be treated with courtesy and respect.
- to communicate valid concerns and views without fear of reprisal or other unreasonable response.[vii]

DVA staff have the right:

- to determine whether, and if so how, a complaint will be dealt with.
- to finalise matters on the basis of outcomes they consider to be satisfactory in the circumstances[viii].
- to expect honesty, cooperation and reasonable assistance from complainants.
- to expect honesty, cooperation and reasonable assistance from organisations and people within jurisdiction who are the subject of a complaint.
- to be treated with courtesy and respect.
- to a safe and healthy working environment[ix].

- to modify, curtail or decline service (if appropriate) in response to unacceptable behaviour by a complainant.[x]

Subjects of a complaint have the right:

- to a fair and impartial assessment and, where appropriate, investigation of the allegations made against them.
- to be treated with courtesy and respect by staff of DVA.
- to be informed (at an appropriate time) about the substance of the allegations made against them that are being investigated[xi].
- to be informed about the substance of any proposed adverse comment or decision.
- to be given a reasonable opportunity to put their case during the course of any investigation and before any final decision is made[xii].
- to be told the outcome of any investigation into allegations about their conduct, including the reasons for any decision or recommendation that may be detrimental to them.
- to be protected from harassment by disgruntled complainants acting unreasonably.

Mutual responsibilities

Complainants are responsible for:

- treating staff of DVA with courtesy and respect.
- clearly identifying to the best of their ability the issues of complaint, or asking for help from the staff of DVA to assist them in doing so.
- providing to DVA to the best of their ability all the relevant information available to them at the time of making the complaint.
- being honest in all communications with DVA.
- informing DVA of any other action they have taken in relation to their complaint[xiii].
- cooperating with the staff who are assigned to assess/ investigate/resolve/determine or otherwise deal with their complaint.

If complainants do not meet their responsibilities, DVA may consider placing limitations or conditions on their ability to communicate with staff or access certain services.

DVA has a zero tolerance policy in relation to any harm, abuse or threats directed towards its staff. Any conduct of this kind may result in a refusal to take any further action on a complaint or to have further dealings with the complainant.[xiv] Any such conduct of a criminal nature will be reported to police and in certain cases legal action may also be considered.

DVA staff are responsible for:

- providing reasonable assistance to complainants who need help to make a complaint and, where appropriate, during the complaint process.
- dealing with all complaints, complainants and people or organisations the subject of complaint professionally, fairly and impartially.
- giving complainants or their advocates a reasonable opportunity to explain their complaint, subject to the circumstances of the case and the conduct of the complainant.
- giving people or organisations the subject of complaint a reasonable opportunity to put their case during the course of any investigation and before any final decision is made[xv].
- informing people or organisations the subject of investigation, at an appropriate time, about the substance of the allegations made against them[xvi] and the substance of any proposed adverse comment or decision that they may need to answer or address[xvii].
- keeping complainants informed of the actions taken and the outcome of their complaints[xviii].

- giving complainants reasons that are clear and appropriate to their circumstances and adequately explaining the basis of any decisions that affect them.
- treating complainants and any people the subject of complaint with courtesy and respect at all times and in all circumstances.
- taking all reasonable and practical steps to ensure that complainants[xix] are not subjected to any detrimental action in reprisal for making their complaint[xx].
- giving adequate warning of the consequences of unacceptable behaviour.

If DVA or its staff fail to comply with these responsibilities, complainants may complain to:

- In writing to: The Manager, Feedback Management Team, GPO Box 9998, SYDNEY NSW 2001
- Emailing: feedback@dva.gov.au
- Telephoning: DVA Feedback Management Team on 1300 555 785

Subjects of a complaint are responsible for:

- cooperating with the staff of DVA who are assigned to handle the complaint, particularly where they are exercising a lawful power in relation to a person or body within their jurisdiction[xxi].
- providing all relevant information in their possession to DVA or its authorised staff when required to do so by a properly authorised direction or notice.
- being honest in all communications with DVA and its staff.
- treating the staff of DVA with courtesy and respect at all times and in all circumstances.
- refraining from taking any detrimental action against the complainant[xxii] in reprisal for them making the complaint.[xxiii]

If subjects of a complaint fail to comply with these responsibilities, action may be taken under relevant laws and/or codes of conduct.

DVA is responsible for:

- having an appropriate and effective complaint handling system in place for receiving, assessing, handling, recording and reviewing complaints.
- decisions about how all complaints will be dealt with.
- ensuring that all complaints are dealt with professionally, fairly and impartially[xxiv].
- ensuring that staff treat all parties to a complaint with courtesy and respect.
- ensuring that the assessment and any inquiry into the investigation of a complaint is based on sound reasoning and logically probative information and evidence.
- finalising complaints on the basis of outcomes that the organisation, or its responsible staff, consider to be satisfactory in the circumstances[xxv].
- implementing reasonable and appropriate policies/procedures/practices to ensure that complainants[xxvi] are not subjected to any detrimental action in reprisal for making a complaint[xxvii], including maintaining separate complaint files and other operational files relating to the issues raised by individuals who make complaints.
- giving adequate consideration to any confidentiality, secrecy and/or privacy obligations or responsibilities that may arise in the handling of complaints and the conduct of investigations.

If DVA fails to comply with these responsibilities, complainants may complain to the:

- Commonwealth Ombudsman (regarding general DVA complaints processes or Freedom of Information [FOI] complaints): contact by telephone on 1300 362 072 or via the internet at http://www.ombudsman.gov.au/
- Office of the Australian Information Commissioner (OAIC) for privacy complaints: contact by telephone on 1300 363 992 or via the internet at http://www.oaic.gov.au/

Links to other DVA documents

This document should be read in conjunction with the following documents that also detail the rights and responsibilities of both DVA and its clients regarding service provision and complaints about DVA staff and services:

- **The DVA Service Charter**: outlines what you can expect from DVA. It also tells our clients what they can do to help DVA give them the best service possible. You can read the DVA Service Charter at http://www.dva.gov.au/about-dva/overview/dva-service-charter.
- **The DVA Feedback Policy**: DVA aims to achieve excellence in service delivery. To accomplish this, DVA is an organisation that welcomes complaints, compliments and suggestions (feedback) which are the most immediate and effective forms that will assist efforts to improve our service. You can read the DVA Feedback Policy at http://www.dva.gov.au/contact/feedback#policy.

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[i] The word 'rights' is not used here in the sense of legally enforceable rights (although some are), but in the sense of guarantees of certain standards of service and behaviour that a complaint handling system should be designed to provide to each of the parties to a complaint.

[ii] Differences of opinion are normal: people perceive things differently, feel things differently and want different things. People have a right to their own opinions, provided those opinions are expressed in acceptable terms and in appropriate forums.

[iii] While degrees of independence will vary between complaint handlers, all should assess complaints fairly and as impartially as possible, based on a documented process and the merits of the case.

[iv] The 'right to be heard' refers to the opportunity to put a case to the complaint handler/decision-maker. This right can be modified, curtailed or lost due to unacceptable behaviour, and is subject to the complaint handler's right to determine how a complaint will be dealt with.

[v] Provided this will not prejudice on-going or reasonably anticipated investigations or disciplinary/criminal proceedings.

[vi] Such a right of review can be provided internally to the organisation, for example by a person not connected to the original decision.

[vii] Provided the concerns are communicated in the ways set out in relevant legislation, policies and/or procedures established for the making of such complaints/allegations/disclosures/etc.

[viii] Some complaints cannot be resolved to the complainant's satisfaction, whether due to unreasonable expectations or the particular facts and circumstances of the complaint [see also Endnote 25].

[ix] See for example WH&S laws and the common law duty of care on employers.

[x] Unacceptable behaviour includes verbal and physical abuse, intimidation, threats, etc.

[xi] Other than where there is an overriding public interest in curtailing the right, for example where to do so could reasonable create a serious risk to personal safety, to significant public funds, or to the integrity of an investigation into a serious issue. Any such notifications or opportunities should be given as required by law or may be timed so as not to prejudice that or any related investigation.

[xii] Depending on the circumstances of the case and the seriousness of the possible outcomes for the person concerned, a reasonable opportunity to put their case, or to show cause, might involve a face to face discussion, a written submission, a hearing before the investigator or decision maker, or any combination of the above.

[xiii] For example whether they have made a similar complaint to another relevant person or body or have relevant legal proceedings at foot.

[xiv] Other than in circumstances where the organisation is obliged to have an ongoing relationship with the complainant.

[xv] See Endnote 11.

[xvi] Other than where an allegation is so lacking in merit that it can be dismissed at the outset.

[xvii] See Endnote 11.

[xviii] See Endnote 5.

[xix] 'Complainants' include whistleblowers/people who make internal disclosures.

[xx] 'Complaints' includes disclosures made by whistleblowers/people who make internal disclosures.

[xxi] This does not include any obligation to incriminate themselves in relation to criminal or disciplinary proceedings, unless otherwise provided by statute.

[xxii] See Endnote 19.

[xxiii] See Endnote 20.

[xxiv] See Endnote 3.

[xxv] Once made, complaints are effectively 'owned' by the complaint handler who is entitled to decide (subject to any statutory provisions that may apply) whether, and if so how, each complaint will be dealt with, who will be the case officer/investigator/decision-maker/etc, the resources and priority given to actioning the matter, the powers that will be exercised, the methodology used, the outcome of the matter, etc. Outcomes arising out of a complaint may be considered by the complaint handler to be satisfactory whether or not the complainants, any subjects of complaint or the organisation concerned agrees with or is satisfied with that outcome.

[xxvi] See Endnote 19.

[xxvii] See Endnote 20.