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Messrs Robert Fitzgerald AM & Richard Spencer
Commissioners
Veterans' Compensation and Rehabilitation Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2604

Dear Messrs Robert Fitzgerald AM & Richard Spencer

Re: Inquiry into Compensation and Rehabilitation of Veterans

Introduction

I refer to previous emails, our meeting of the 18th of April, 2018 and to the invitation to provide a submission in response to the Productivity Commission's Issues Paper dated May, 2018. This submission seeks to answer the questions posed by the Issues Paper whilst addressing problems with the current scheme of the compensation and rehabilitation of veterans.

Relevant Legal Background

I am a legal practitioner admitted in 1987 and a Queensland Law Society Accredited Specialist in Personal Injury Law. I have specialised exclusively in Military Compensation claims under the three compensation schemes, including the Veterans' Entitlements Act 1986 (Cth) (VEA), the Safety, Rehabilitation and Compensation Act 1988 (Cth) (SRCA), and the Military Rehabilitation and Compensation Act 2004 (Cth) (MRCA) since 2008.

Military Compensation Matters

The Military Compensation Group at Slater and Gordon Lawyers (Slater and Gordon) is acknowledged as the largest legal practice in Australia acting on behalf of Australian Defence Force (ADF) personnel and Veterans. Slater and Gordon has assisted or represented numerous individuals and organisations in reviews of military compensation, Veterans' entitlements and Comcare schemes, and in Senate Committee and Defence inquiries. We have strongly advocated for the improvement of safety, benefits and services to injured Veterans and other defence personnel.

Our success in Federal Court and High Court appeals is a testament to our commitment to achieving the best possible outcomes for our clients. We are able to offer legal services to Registered Members in relation to Australian Military Compensation Claims.

In my official role as National Military Compensation Expert and Practice Group Leader at Slater and Gordon, I also have a variety of connections with the wider defence community and am a close associate of many RSL Advocates and members of a variety of Ex-Service Suicide by veterans and ex-service personnel Organisations. I also have close ties with other stakeholders who share an interest in the welfare of our defence personnel.

To assist the Inquiry further I would like to refer the Productivity Commission to the following, previously made, submissions:

- Transcript of Military Compensation Review Submissions (Brisbane) (9th of November 2009);
- A submission to an Inquiry into Veterans' Affairs Legislation Amendment (Military Compensation Review and Other Measures) Bill 2013 (24th of April 2013);
- A submission to the Inquiry into the Mental Health of Australian Defence Force Personnel (2nd of July 2015);
- A submission to an Inquiry into the Veterans' Affairs legislation Amendment (2015 Budget Measures) Bill 2015 (11th of September 2015);
- A submission to the Inquiry into Suicide by Veterans and Ex-Service Personnel (7th of October 2016);
- Commonwealth of Australia Senate Hansard of Foreign Affairs, Defence and Trade References Committee (2nd of February 2017);
- A submission to the Inquiry into the Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016 (24th of February 2017);
- My response to the Government's response to the recommendations made by 'The Constant Battle: Suicide by Veterans Report' (24th of October 2017); and
- Submission to the Department of Veteran Affairs Inaugural Legislation Workshop (27th of October 2017)

In making this submission to the current inquiry, I intend to draw on and refer to some of our previous work in this area, including recent submissions to the Inquiry into Suicide by Veterans and Ex-Service Personnel, the Inquiry into the Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016, the Inquiry into Mental Health of Australian Defence Force Members and Veterans (Mental Health Inquiry), the Veterans' Affairs Legislation Amendment Bill and the Review of Military Compensation Arrangements conducted in 2009. Due to our strong history of advocacy in this area, some of the following submissions may strike the Committee as familiar; the fact is that many of the concerns we have previously raised over a number of years remain issues today.

We are fortunate that the size of Slater and Gordon enables us to provide specialist expertise in this area and provide legal services for vulnerable members of the Defence community who might not have otherwise had access to justice.

1 A System to Meet the Needs of Future Veterans

What should the priority objectives for veterans' support be? Why? What principles should underpin the legislation and administration of the system? Is the current system upholding these priority objectives? Where are the key deficiencies in the system?

What should the system of veterans' support seek to achieve in the longer term? What factors should be considered when examining what is in the best interest of veterans? How have veterans' needs and preferences changed over time? How can the system better cater for the changing veteran population and the changing needs of veterans?

I would refer the Commission to the contents of the latest *Veterans' Affairs legislations Amendment (Veteran-centric Reforms No. 2) Bill 2018*.

It is widely accepted within the defence community that the Department of Veterans' Affairs (herein described as 'DVA') appears to need a major overhaul of the manner in which it is currently provides services to veterans and ex-members of the our military personnel.

I acknowledge and welcome the DVA's *Budget 2017-18: Veteran Centric Reform* as quoted in the *Veterans' Affairs legislations Amendment (Veteran-centric Reforms No. 2) Bill 2018* Report by the Foreign Affairs, Defence and Trade Legislation Committee.

I note and agree with, DVA's comments in the Report that:[1]

> DVA operations and infrastructure are no longer fit for purpose as current business systems are claims based, requiring the veteran to approach the Department, and lack the information sharing and data analysis necessary to meet veterans' expectations of a quality service. Without change, some veterans may continue to be disengaged from DVA services, which can inhibit a successful transition from the Australian Defence Force and lead to poor health and life outcomes.

1 Senate Foreign Affairs, Defence and Trade Legislation Committee. Parliament of Australia, *Veterans' Affairs, Defence and Trade Legislation Amendment (Veteran-centric Reforms No. 2) Bill 2018 [Provisions] Report* (2018) 2.

To its credit, DVA seems to have finally realised that its current service model is failing. There have been a number of budget allocations in the last two years designed to improve their services. My fear now is that there will be a lack of auditing to ascertain whether these significant budgetary increases will actually provide a positive change to veteran support services. Without an auditing process, valuable taxpayer dollars could be wasted without any accountability or redress. This is of serious concern to me as I am faced, on a day-today basis, with the consequences of what the system can do to injured veterans and their families.

No doubt the Productivity Commission will consider the contents the *Veterans' Affairs legislations Amendment (Veteran-centric Reforms No. 2) Bill 2018*, as it goes to the very heart of many of the current problems. The Parliamentary Library summarised the purpose of the legislation as follows, and I have put my initial thoughts with these objectives:[2]

- Provide additional childcare, counselling, household services and attendant care for current and former members of the Australian Defence Force (ADF) with warlike service, and their families- I consider this must be a priority for the DVA.
- Provide a new Veteran Payment to veterans with little or no financial support until their compensation claims for liability for a mental health condition are determined- This has been a long time coming and like the non-liability health care card is a significant improvement.
- Commence the Coordinated Veterans' Care Mental Health Pilot, a two year pilot in rural and regional areas targeting those with mild to moderate mental health conditions such as anxiety or depression who also have a physical condition requiring pain management- I note the current program undergoing in Townsville.
- Make it quicker to provide financial assistance with household and attendant care services to certain veterans with catastrophic injuries or diseases- The appointment of case co-ordinators and managers has been of benefit in the past year with the manner in which claims are dealt with.

2 Parliamentary Library (Cth), *Veterans' Affairs Legislation Amendment (Veteran-centric Reforms No. 1) Bill 2018 Bills Digest,* No. 91 of 2017-18, 21 March 2018, 3.

- Allow for the automated determination an individual's qualifying service under the *VEA* [*Veterans' Entitlements Act 1986*] removing the need for all veterans to manually apply for a determination of their defence service as qualifying service;
- Make a large number of changes to the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (the *DRCA*) replacing redundant references and repealing provisions unrelated to the operation of this Act- I would recommend consultation by the Department before changes are worked through, as has occurred in the past
- Makes technical amendments to the *VEA* to ensure consistent references to the Special Medical Review Council; and
- A range of minor amendments including extending Gold Card eligibility under the *Australian Participants in British Commonwealth Occupation Force (Treatment) Act 2006* to ADF members who served in Japan prior to the British Commonwealth Occupation Force and technical amendments to the *VEA*.

These objectives, I believe, are on the right path towards improving how DVA is servicing its clients. I appreciate that overhauling the current bureaucracy will be a significant challenge and is not going to occur in a matter of months. I trust that it will not be years.

However, that summary, whilst addressing specific items that requires attention, overlooks some fundamental issues which my submission will address further. The most pressing issues I see for veterans include, but are not limited to: the complexity of the various legislative schemes the lack of deemed time period and how the strict interpretation of the Statements of Principles (herein described as 'SoPs') are being used to deny claims. These issues have caused much angst for many years since the introduction of MRCA in 2004.

2 How should the Nature of Military Service be recognised?

What are the key characteristics of military service that mean veterans need different services or ways of accessing services to those available to the general population? How should these characteristics be recognised in the system of veterans' support?

What is the rationale for providing different levels of compensation to veterans to that offered for other occupations, including people in other high-risk occupations such as emergency services workers? Are there implications for better policy design?

Are differences in support and ways of accessing support based on different types of service (such as operational, peacetime and Reserve service) justified?

I note for the productivity Commission of the unique nature of the military service and how compensation, rehabilitation and other services are needed. I also refer to the numerous inquiries in the past and submissions from many interested parties that recognise military service.

From my experience as a personal injuries lawyer, other professions that experience similar issues and experiences, although not to anywhere near the same extent, would be the police, ambulance, fire brigade, emergency rescue providers and corrective services officers to name a few.

The major difference is that these professionals fall under the various work cover based schemes with their own complexities compared to the Commonwealth statutory compensation schemes and overtime the statute based schemes have also become increasingly more complicated with the plethora of various acts that are applicable. The multitude of various pieces of legislation means also means that it is not uncommon for a veteran (herein used to cover all military personnel) to cross over up to five different compensation Acts not including other legislation that is to be applied, for example dealing with the single pathway of MRCA appeal. This complexity needs to be simplified to make the road to compensation and rehabilitation more clearly and more easily understood.

I anticipate that the Commission will examine the different types of service more closely. As a general comment I do not agree with the manner in which injuries, disease or conditions are treated for purposes of assessment of entitlements depending on how they were sustained whether it be warlike, non-warlike, peacetime or reserves. This creates a divide within the Defence community and a perceived bias amongst veterans.

In saying this, I note that the different work cover legislation also treats injured persons differently depending on which state the injury may have occurred in. Perhaps it is time for a major review of the state WorkCover schemes to also be undertaken.

From my experience it is a sensitive topic when talking about veterans who sustained injuries whilst being deployed and how they should be treated by the DVA compared to those who suffer injuries during peacetime. Whilst I may have my own personal views, my role is to deal with the legislation as it stands. How veterans are treated under the various pieces of legislation and provisions relating to the type of service, is a question for the defence community as a whole. There is no doubt this will lead to much debate and I would invite the Commission to make recommendations after considering all of the evidence presented to it.

3 The Complexity of Veterans' Support

What are the sources of complexity in the system of veterans' support? What are the reasons and consequences (costs) of this complexity? What changes could be made to make the system of veterans' support less complex and easier for veterans to navigate?

Can you point to any features or examples in other workers' compensation arrangements and military compensation frameworks (in Australia or overseas), that may be relevant to improving the system of veterans' support?

Is it possible to consolidate the entitlements into one Act? If so, how would it be done? What transitional arrangements would be required? How might these be managed?

Are there approaches, other than grandfathering entitlements, that can preserve outcomes for veterans receiving benefits or who may lodge a claim in the future?

3.1 The Complexity of Compensation Mechanisms

In talking about the complexity of the compensation mechanisms for veterans, in a submission to DVA's Inaugural Legislation Workshop in 2017 I commented:[3]

The military compensation scheme is generally considered to be one of the most complex legislative compensation schemes in Australia. Veterans attempting to claim compensation may potentially have coverage 'under one, two or three Acts, depending on their date of service and date of injury'.[4]

Justice Logan in McDermid v Repatriation Commission [2016] FCA 372 (15 April 2016) commented:

> *... [The Applicant] has also had what he doubtless sees as the added misfortune of becoming enmeshed in the complexity of the provision made from time to time by Parliament in the VEA in an endeavour to prevent any duplication of benefits in respect*

3 Brian Briggs, Submission to Department of Veterans' Affairs*, Inaugural Legislation Workshop*, 27 October 2017, 12-14.

4 Submission 156, p 29-30. Of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

of like injuries or incapacity as between those payable under the SRCA or its predecessors and those otherwise payable under the VEA. In turn, that complexity is but one pathway in the labyrinth that is the VEA, an Act which has been amended no less than 127 times over the 30 years since its enactment in 1986…. Both for the members of that class and for the respondent Repatriation Commission (the Commission) and those of its delegates within the Department of Veterans' Affairs (DVA) who must administer it, that complexity, to say nothing of the wider labyrinth, presents considerable challenges of comprehension as to its application.[5]

Over the last 20 years, there have been many recommendations made to DVA and Government. Recurrent in these recommendations is the complexity and inconsistency within the legislative schemes, and the need for simplification. Coupled with this are the difficulties experienced by veterans when it comes to obtaining liability for injures and the assessment process.

As stated in Submission 451, authored by Maurice Blackburn:

The methodologies applied to reigning the costs or fiscal burdens of the scheme commonly involve a process participants describe as "being ground into submission" with repetitious medical examinations and ongoing invasive scrutiny of their life and health.[6]

The South Australian Government also commented:

This legislative framework is cumbersome, complex, confusing and difficult to navigate for advocates, DVA staff and members of the serving and ex-serving community.[7]

Commentary from the Veteran Community

The overwhelming feeling within the Defence Community is that the legislation as a whole is too complex and legalistic. I doubt the Commission will receive any views to the contrary.

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5 *McDermid v Repatriation Commission* [2016] FCA 372 (15 April 2016).

6 Submission 451 of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

7 Submission 187, p 4 of Suicide Enquiry, *The Constant Battle: Suicide by Veterans*.

For the assistance of the forum I take the opportunity to quote a few of the comments made by interested parties in the past;

- *"The MRCA if it works at all, is a tribute to those who need to interpret it! MRCA needs urgent review, simplification and that 'DVA needs to be reasonably satisfied' that the disability is services caused deleted and replaced with 'Unless DVA can prove otherwise, the claim must be accepted!'*
- *"DVA needs to emphasise in all its training there Veterans have EARNED the right to beneficial interpretation of legislation AND benefit of doubt in THEIR favour!"*
- *"While DVA have been, over the last 2 years developing legislation with only one purpose – to stifle its critics'…120 + veterans have taken their lives and DVA state that they are throwing cash at the problem which they admit they do not understand instead of fixing MRCA and DVA policy and processing, staffing, training and attitude, bureaucracy and TTP, just to mention a few."*
- *"And let's remember our esteemed Minister for Media Releases with many Titles has also failed miserably to address long standing Veteran issues like TPI Parity, DFRDB anomalies and Veteran suicides and homelessness."*

3.1.1 Single legislative scheme

Comparatively, schemes which by design foster lump sums and finality are more likely to achieve the goals of the DVA. That is, it will likely achieve veteran satisfaction and meaningful return to work. Other countries, such as the US, UK and Canada, operate a single legislative scheme for veterans compensation which greatly simplifies the compensation process and reduces the stress and confusion veterans otherwise face in Australia.

Many submissions in the Senate Inquiry recommended that legislative reform should focus on the introduction of a single piece of legislation to cover all compensation claims for veterans, rather than three overlapping Acts.

In particular, it was submitted that veterans be treated equally under the new legislative scheme. Currently, there is a high level of inconsistency between the compensation available under the existing Acts. TPI Federation illustrated this difference, nothing that:

> *...under the MRCA, a DVA client's family is currently eligible to $11,654 as a funeral allowance [but this] is markedly different with the VEA client's family where the same allowance is $2,000.*[8]

3.1.2 Recommendations

The current legislative scheme places an onerous burden on veterans when attempting to claim benefits and compensation for injuries sustained in service. Whilst it must be recognised that there are difficulties in simplifying the legislation and ensuring existing benefits are not impacted, the complexity and inconsistency within the current legislative scheme warrants reform.

Slater + Gordon recommend that the current legislative scheme urgently requires simplification, and a single legislative scheme should be investigated and implemented. Excessive complexity within the veterans compensation process places undue burden on veterans, and this should be rectified to ensure the purpose of this scheme, namely to benefit veterans, is upheld.

In regards to the introduction of DRCA into the veteran compensation scheme, there was this discussion at the Senate Foreign Affairs, Defence and Trade References Committee (2 February 2017):[9]

> *Senator LAMBIE: I will just cut straight to the chase, Mr Briggs. There is new legislation coming out called DRCA. I would imagine that you guys have pulled that apart.*
>
> *Mr Briggs: I have.*
>
> *Senator LAMBIE: What are your thoughts on that, please?*

8 Submission 307 p 5. of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

9 Commonwealth, *Parliamentary Debates*, Senate Foreign Affairs, Defence and References Committee, 2 February 2017, 29-30 (Jacqui Lambie and Brian Briggs).

Mr Briggs: I am extremely concerned about this piece of legislation. If something is not broken then why should we fix it? SRCA is, in my opinion, the best act operating at the moment. DRCA supposedly brings SRCA across into the realm of MRCC and DVA, so now they take it out of Comcare and it becomes the property of DVA MRCC. I see long-term what they intend to do, because one of the things it talks about is the power to amend, revoke, institute new guides—just do whatever they like with this piece of legislation later on down the track. I see what is going to happen is they will get rid of DRCA, it will all become MRCA and it will be all the statements of principles with all their restrictions, time periods and making it so hard to get claims accepted. Then they will pull that with the GARP M guides, the guides to the assessment, and even there the point scoring system is not as beneficial as, say, SRCA.

A classic example is the Fellowes High Court decision, which I ran. That benefited thousands of SRCA lower limb injuries. Under MRCA you can have 10 injuries for your lower limbs. One knee might go. You might have an ankle. We just bring it all in and pay substantially less money for those injuries, whereas under SRCA you are entitled to be paid for each individual injury as is the common law. We have got Commonwealth public servants who are going to have SRCA injuries who find they are all looked after, but under MRCA our veterans again will be worse off.

I have raised issues with all and sundry about this piece of legislation. The devil is in the detail in it. I know I have raised it with you, Senator. I have sent you some questions. I have sent it out to ex-service organisations. It is not just a straight, 'Oh, we're lifting SRCA and putting it in as a new piece of legislation, and it's just going to duplicate.' There is a lot more involved in this piece of legislation. Maybe I am just being cynical. Maybe there are good intentions with it. But it is not something we can look forward to if it passes, unfortunately. It needs more information. It needs to be spelled out.

DRCA has since been enacted and already it is causing concern and confusion when dealing with DVA. It has not been as straightforward as the Minister and the Department suggested. This confusion is not needed, nor should it be occurring

4 The claims and appeals process

How could the administration of the claims and appeals process be improved to deliver more effective and timely services to veterans in the future?

Are there diverging areas of the claims and appeals process under the different Acts that could be harmonised?

Are there aspects of the claims and appeals process that result in inequitable outcomes for veterans, such as limitations on legal representation?

Will the Veteran Centric Reform program address the problems with the administration of the veterans' support system?

Are advocates effective? How could their use be improved? Are there any lessons that can be drawn from advocates about how individualised support could be best provided to veterans?

Have the Statements of Principles helped to create a more equitable, efficient and consistent system of support for veterans? Are there ways to improve their use?

What is the rationale for having two different standards of proof for veterans with different types of service? Are there alternatives to recognise different groups of veterans? What would be the costs and benefits of moving to one standard of proof for all veterans (for example, would it make the claims process easier)?

4.1 Delays in Processing Claims

In relation to delays in processing claims, I observed, in a submission to DVA's Inaugural Legislation Workshop in 2017:[10]

10 Brian Briggs, Submission to Department of Veterans' Affairs*, Inaugural Legislation Workshop*, 27 October 2017, 1-5.

A key complaint in relation to DVA's administration relates to lengthy delays in the processing of claims. It has long been established that DVA fails to reach its target processing times for initial liability claims despite questionable survey results.

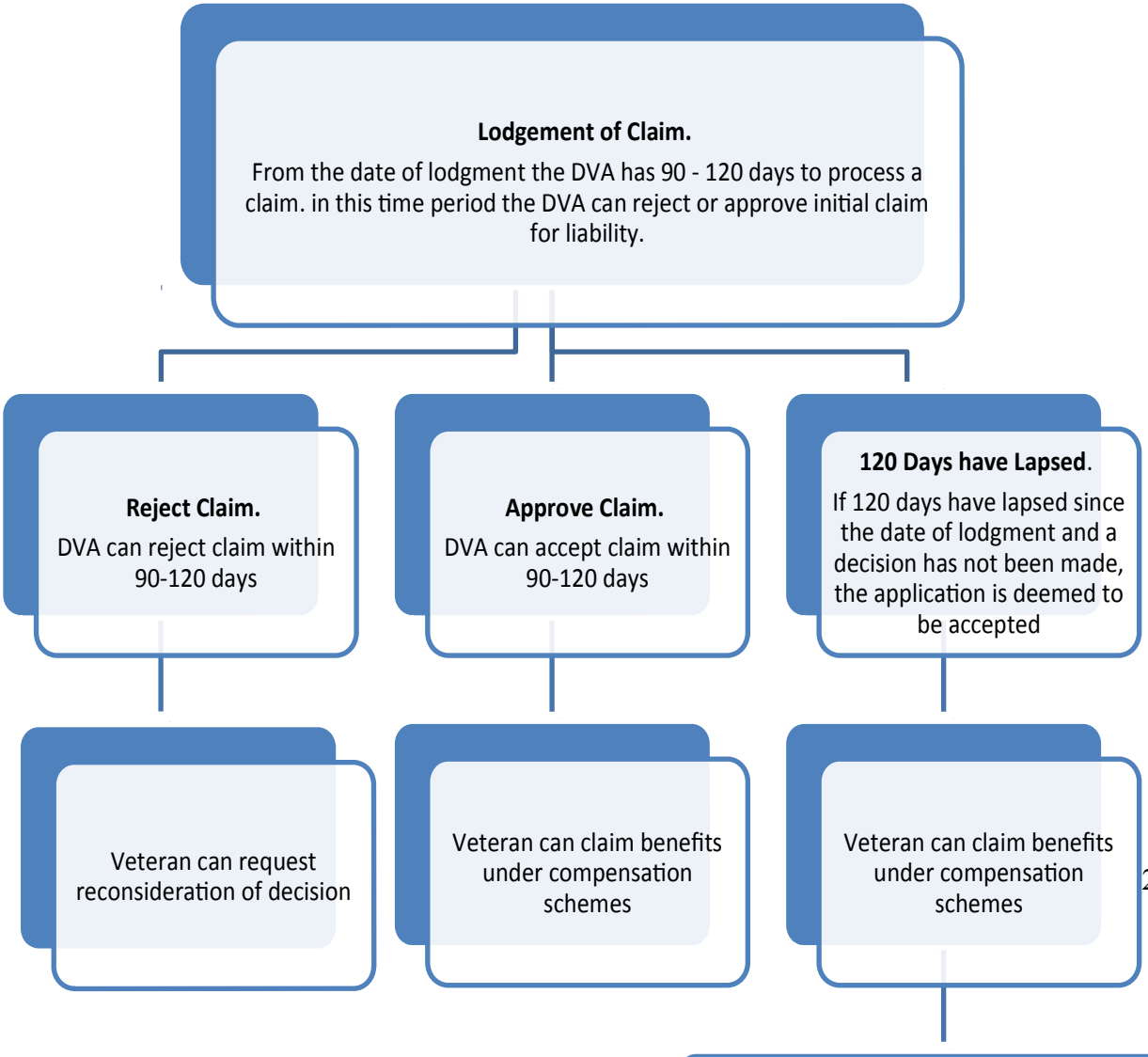
It is our experience at Slater + Gordon, and that of many advocates, that it can take years for the DVA to process client's claims. Frequently, these veterans were discharged as a result of service-related injuries and have since been unable to work. They are unable to access benefits until the DVA have accepted liability for their injuries or conditions. The financial difficulties caused by these delays are hard hitting and severe, some veteran's losing their homes as a consequence.[11] These delays also contribute to client's taking their own lives as evidenced by the tragic circumstances surrounding the recent death of Jesse Bird.

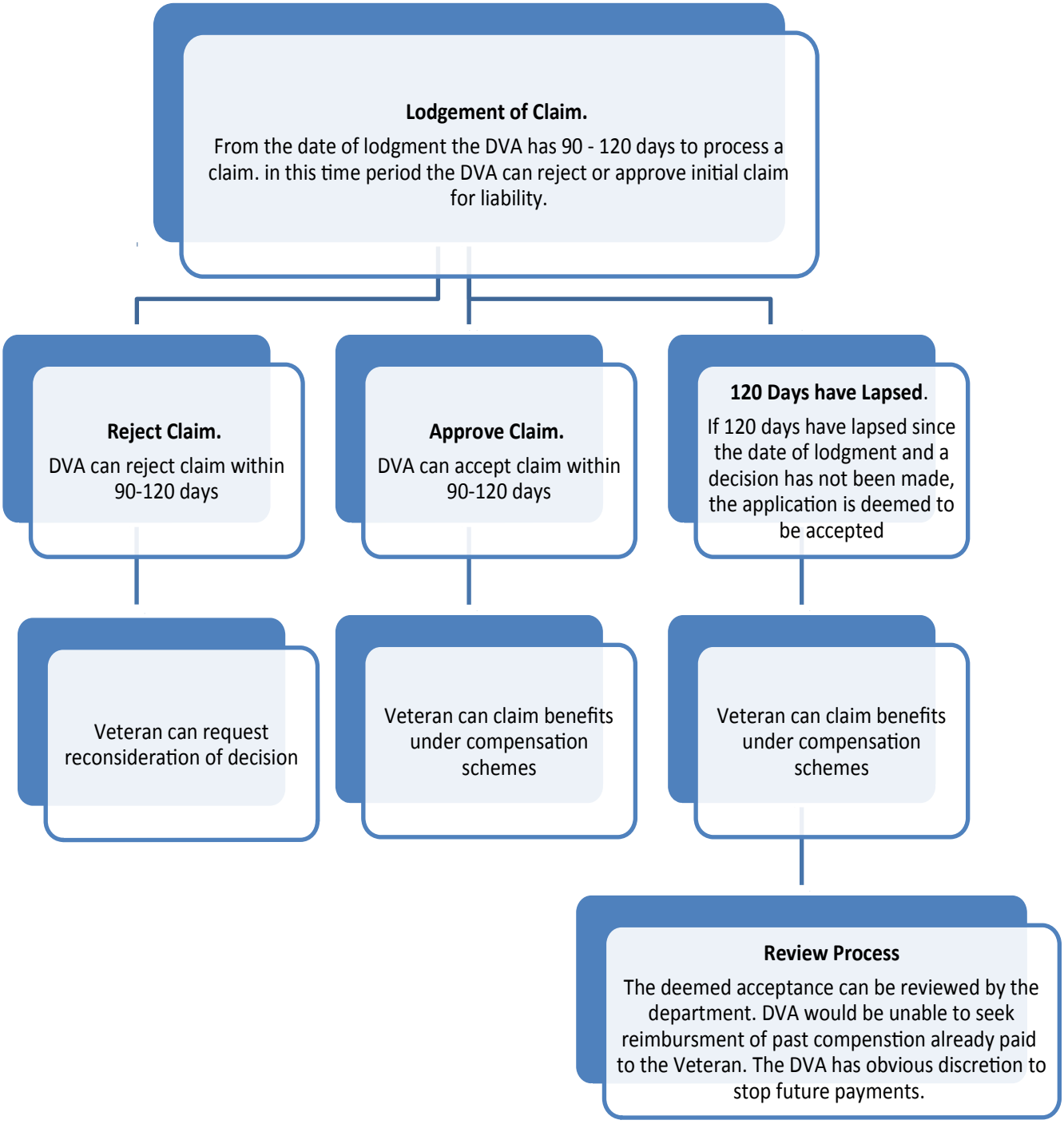
It is our opinion that the majority of these delays of the DVA are avoidable and unreasonable.

We have therefore advocated for many years for deeming time periods requiring decisions to be made or if not, the claims are taken to have been accepted.

11 Submission 451 of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

Later on in that same submission, I provided the following example of how time periods should operate:




Lodgement of Claim.
From the date of lodgment the DVA has 90 - 120 days to process a claim. in this time period the DVA can reject or approve initial claim for liability.
Reject Claim.
DVA can reject claim within 90-120 days
Approve Claim.
DVA can accept claim within 90-120 days
120 Days have Lapsed.
If 120 days have lapsed since the date of lodgment and a decision has not been made, the application is deemed to be accepted
Veteran can request reconsideration of decision
Veteran can claim benefits under compensation schemes
Veteran can claim benefits under compensation schemes
Review Process
The deemed acceptance can be reviewed by the department. DVA would be unable to seek reimbursment of past compenstion already paid to the Veteran. The DVA has obvious discretion to stop future payments.

4.1.1 Proven Success in Other Jurisdictions

Slater and Gordon note that several other overseas jurisdictions incorporated time limits into their claims processes for veterans and this had led to increased efficiency and better outcomes. To my knowledge, Australian DVA remains the only Department dealing with compensation for veterans with no requirements to proactively determine claims within set time periods.

4.1.2 Recommendation A: Deemed Time Periods

Slater + Gordon recommend that a statutory framework be introduced which includes deemed time periods. In effect, default positions so that claims for liability is accepted, taking into consideration the intent of the legislation is for the benefit of veterans. Slater + Gordon recommend the audit specifically consider what impact time periods would have on early resolution of claims.

4.1.3 Recommendation B: Groups handling all facets of claim

For the DVA to have efficient processing of DVA claims, the 'siloes of information' within the DVA processing system need to be addressed. This must be done by the quick and efficient administration of information. This will be achieved by the digitisation of its records. From this, a single coherent system is required to process and manage claims. Whilst this is more of a change in policy and practice it ties in with the simplification of the legislation.

Within this need to streamline the claims process, Slater and Gordon, in concurrence with Mr Arthur Ventham, believe that a single claim process is required for veterans to fill out even if their service cuts across multiple acts.[12]

The complexity of MRCA and the extended investigations into the range of entitlements (Permanent Impairment, Incapacity and Rehabilitation) must be simplified to become less confusing so it is more easily understood by those it is designed to assist, particularly when they are suffering from a mental health condition. This forum needs to focus on the most beneficial outcome and less on spending time rehashing over well worn ground.

12 Senate Report, *Suicide Amongst Veterans, A Constant Battle,* [5.45].

Furthermore, in regards to a lack of time frames for decision making when personnel or veterans ask for assistance, in a submission to an Inquiry into Mental Health of ADF Personnel, I said:[13]

We are witnessing Veterans being drawn into a system of combative legislation with a bureaucracy of Departments shifting responsibility.

My team can attest to the voices of other Veterans advocates and ex-service organisations that lodging claims with the DVA for compensation and treatment of physical and mental issues is "like going through a meat grinder, it grinds you up."

I have been calling for statutory timelines for many years now, requiring Veterans' Affairs to process and finalise claims. The United States, Britain, Canada and New Zealand all have these time frames. Our Department seems to be lingering in the dark ages. I do not accept the Departmental line that legislated time frames will "increase the risk of poor, incomplete and incorrect outcomes." Nor do I accept that an increase of 10 million dollars announced in the latest budget to increase the numbers of delegates, will adequately solve the problem.

It is obvious that in other countries the system of time frames is working consistently better than the system our Veterans must endure here. The position being adopted by the DVA is failing the very people they are supposed to be assisting and the constant excuses are not being accepted by my clients. I have numerous complaints on file from my clients who have documented their struggle with the DVA. The Department's incapacity and incapability is undisputed amongst the Veteran support community.

Then in explaining about how delays in DVA decision making compound disadvantages for the injured veteran, I commented:[14]

Doctors who treat ex-soldiers for mental illness report only 10% of patients have a smooth experience through the DVA compensation process. This has been a well-known phenomenon for years. I previously raised issues with under-resourcing and blow-outs and in claims being

13 Brian Briggs, Submission No 51 to Senate Foreign Affairs, Defence and Trade Committee, *Mental Health of Australian Defence Force Personnel*, 2 July 2015, 22.

14 Ibid 19.

accepted, more than 2 years ago. Things have only gotten worse, particularly in the last 9 months.

It is well-known that service personnel waiting in limbo while being discharged will often turn to drugs and alcohol to fill the void. This often becomes even worse following the discharge. Both the U.S.A and UK experience confirms the linked issue of alcohol abuse being significantly associated with service in the Armed Forces. UK studies have provided specific evidence that this issue is more common among combat veterans. This issue often exacerbates the problems faced by Veterans and ex-Veterans waiting for claims to be processed and can lead to worsening mental and physical health.

4.2 **Mismanagement of Claim Files and Payments by DVA**

Another issue is the management of claim files. In a submission to an Inquiry into Suicide by Veterans and Ex-Service Personnel, I observed:[15]

4.3 Inaccurate claim files and mismanagement of claims

Clients regularly report that their medical and psychiatric records have information missing from them. I have had one claim on hold while waiting for the DVA to find a *MRCA* file that has been missing for over 5 months. This delay is inexcusable. Some of the files provided by my clients have many documents that do not appear on the official files used and forwarded to the DVA or to the DoD. It is difficult to comprehend all of the reasons for this problem; however, nothing has changed since my earlier submissions on this point. Conspiracy theories abound that certain documents are being deliberately lost or misplaced as a means to facilitate the frustration or denial of injury or illness claims. An alternative view is simply that the filing and claims system is chaotic and mismanaged.

The Senate's previous inquiry into the mental health of ADF members and Veterans addressed this issue: The Committee received considerable evidence regarding the difficulties that many

15 Brian Briggs, Submission No 160 to to Senate Foreign Affairs, Defence and Trade Committee, Suicide by Veterans and Ex-Service Personnel, 7 October 2016, 31-32.

Veterans, especially those struggling with mental ill-health, have when seeking assistance from DVA, and the detrimental impact that the claims process can have on their mental health. The RSL told the committee that 'the DVA Compensation process complicates, aggravates and perpetuates the pre-existing psychological distress suffered by Veterans and their families'.

4.4 Examples

- An example of DVA inefficiency involved a 5 month delay in communication by a delegate in processing a reconsideration of a DVA claim. In September 2015, Slater and Gordon requested a reconsideration of a client's claim as a matter of urgency. Our client had suffered major injuries in an IED explosion in Afghanistan. On 22 December 2015, we requested an update about this claim. A further request was made on 8 February 2016, advising that our client was becoming 'increasingly upset' at the progress of his claims. The delegate responded on 11 February 2016 that 'due to some unexpected and extended leave I am taking, a number of my files have recently been forwarded to our … Brisbane Reconsideration team to be considered and finalised. Please allow time for the files to be received and reviewed.' This response came after some 5 months when the file under consideration had been transferred from Canberra DVA to Brisbane DVA. It then took a further 2 months for the reconsideration to be determined. I anticipate that with the single pathway of appeal and the lack of suitably trained advocates, these types of delays will only increase.

Another point I made in my submission to the Senate Inquiry into Suicide by Veterans and Ex-Service Personnel, was in regards to the management of payments:[16]

Incapacity payments are not well managed. The ANAO [Australian National Audit Office] provides that in 2014, the DVA reported that over 20 per cent of payments were made in error or were instances of overpayment. The DVA aims for a target rate of 5 per cent error. A client recently told us that she had been receiving an incapacity payment from the DVA and, fearing a claim against her at a later date, had purposely put money aside. However, the frequency of overpayment of claims being made against Veterans is well known in the Veteran community.

16 Ibid 38.

Accordingly, the client had been putting some of her payment away despite needing the money to survive. This is just one example of DVA's inability to manage its clients under the MRCA scheme and the fear it creates in the Defence community.

…

The review into the DVA confirms what we and our clients, have long known – it remains shambolic. Reviews have found DVA's processes are disjointed and slow, and Veterans' mental health and physical welfare is being put at risk by a department struggling under a disorganised bureaucracy. Since its inception, MRCA liabilities have grown substantially each year to $4.5 billion at 30 June 2015. This growth reflects the demand-driven nature of the scheme, which is funded through an essentially unlimited special appropriation by the government. However, a lack of performance information inhibits any understanding of the contribution that rehabilitation services make to the ongoing financial sustainability of the MRCA. Accordingly, our clients are regularly frustrated by slow, duplicated or inadequate responses and ad hoc decisions made in the absence of information and the DVA's poor processes.

4.5 **Duplication of Services**

Also in a submission to the Senate Inquiry into Suicide by Veterans and Ex-Service Personnel, I raised the issue of the duplication of services:[17]

4.5.1 Duplication of Services

I refer to my previous comments concerning the significant duplication occurring across services provided to Veterans. Advocates also perceive that the quality and consistency of services is also highly variable.

I reiterate that there should be a clear and concise mapping of the numerous organisations within the ADF support field for Veterans and their families and where necessary, consolidation of particular groups so that Veterans may be adequately supported by the services available to them and to avoid the wasting of resources. I refer to Minister Tehan's media release dated 2 September 2016. There, reference was made to 3 mental health services/pilot programs operating in the Townsville area alone in addition to the existence of a supervening government review.

It is my belief that again, the DVA has made, and continues to make far too many promises, programs and administrative reviews to protect its reputation rather than offering concrete solutions to assist Veterans and their families.

17 Ibid 29.

4.6 **Statements of Principles**

The Statements of Principles used by the DVA to assess claim, and their interpretation, has also provided a source of concern regarding the claims and appeals process. In a submission to DVA Inaugural Legislation Workshop 2017, I said:[18]

As evidenced by many submissions to various senate enquiries over the years, one of the areas which requires and is crying out for legislative reform is RMA Statements of Principles (SoP's) and the strict interpretation by DVA to deny claims based on them.

4.6.1 General Criticism of SoPs

Justice Logan in *Linwood v Repatriation Commission* [2016] FCA 90 had several criticisms of the SoP system and the language of SoPs:

> ***1.*** *Since the SoP regime was introduced, a plethora of SoP have been determined, repealed and re-determined. Within the limits of their language and application, they do achieve a consistency of sorts, but for those administering the Act or advisors, let alone an Australian Defence Force member who has rendered service covered by the Act or his or her dependents,* ***they have also in practice added an additional layer of complexity to the already elaborate provisions of the Act.***
>
> ***2.*** Justice Logan describes the language employed by the RMA in its description in the SoP of what amounts to a 'category 2 stressor' **as not terribly well adapted to the nature of military service.**
>
> ***3.*** Justice Logan also objects to the characteristic employment of ill-adapted language in the SoP. For example, the word "court" in paragraph (d) of the definition of "category 2 stressor" is apt to include an appearance before a discipline officer, subordinate summary authority, superior summary authority, Defence Force Magistrate, court martial or the Defence Force Discipline Appeal Tribunal, as well as a Chapter III or other court.

18 Brian Briggs, Submission to Department of Veterans' Affairs*, Inaugural Legislation Workshop*, 27 October 2017, 6-12.

Justice Reeves in *Forster v Repatriation Commission* [2015] FCA 198, discussed the definition of a "category 1A stressor", and said:

1. The definition "**makes no express mention of the type of feelings experienced by the veteran**."
2. He noted that while the definition refers to several types of events that the veteran may have been forced to go through, all of which "would obviously evoke feelings of severe stress", the **definition seems to deliberately eschew any such subjective factor** as a relevant consideration in determining whether the event falls within the definition.

4.7 Issues Regarding Repatriation Medical Authority (RMA)

4.7.1 Overarching Issues

1. Lack of ex-military on the board of the RMA
2. No scrutiny of SoPs and RMA decisions
   a. SoPs and RMA decisions are not subject to scrutiny in terms of the Standard of Proof legislative requirements;[19]
3. Length of time to review the SoP's
   b. In 2015-2016 the RMA reduced its backlog and wait time, with a reduction of more than 30% in the average time taken to complete a review (dropping from 939 to 642 days).[20] However, in light of the recent Australian Senate's Suicide Report, this significant time period to receive and amend a SOP to address current science and medical advancements is causing significant distress to claimants.

19 http://www.vvaa.org.au/VVAA%20Part%208.PDF pg 5

20 http://www.rma.gov.au/assets/Publications/Files/Twenty-second-Annual-Report-2015-2016.pdf pg 5

4.7.2 What Case Law has shown

Case law related to the SoPs indicates that there are a number of major issues which require legislative reform:

- The SoPs are constantly changing;[21]
- There are cases and conditions suffered by veterans where there is no applicable SoP;[22]
- The Courts and Tribunals apply the tests strictly;[23]
- Veterans on occasion are not granted access to their medical documents, and often irrelevant medical reports are considered;[24]
- There is a high evidential bar which can be difficult to meet;[25]
- There is an extreme level of record-keeping required to fulfil the SoP requirements.[26]

Illustrations from case law

***Burton and RC* [2017] AATA 606 (8 May 2017);**

Facts of the case

The claimant applied under SoP 66 for intercranial haemorrhage and SoP 64 for hypertension. There were arbitrary SoP requirements. A veteran's salt addiction, which began during service in tropics, resulted in his eventual death, but because there was not concrete proof that he was consuming 15g salt per day in Vietnam the SoPs were not made out.

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21 *Forster v Repatriation Commission* [2015] FCA 198.

22 *Iliopoulos v Repatriation Commission* [2016] FCA 756; *Scott and Repatriation Commission (Veterans' entitlements)* [2017] AATA 1 (11 January 2017).

23 *Sheridan and Repatriation Commission (Veterans' entitlements)* [2017] AATA 17 (12 January 2017); Repat*riation Commission v Watkins* [2015] FCAFC 10;

24*Blandthorn and Military Rehabilitation and Compensation Commission (Compensation)* [2017] AATA 1270 (15 August 2017)*; French and Repatriation Commission (Veterans' entitlements)* [2017] AATA 297 (8 March 2017).

25 *Burton and RC* [2017] AATA 606 (8 May 2017).

26 *Reeday and MRCC (Compensation)* [2017] AATA 1320 (18 August 2017).

What this case demonstrates

- This case highlights the recurring issue of a need to find veterans who served in the same place at the same time.
- The evidence of partners from later in life will be less persuasive.

Reeday and MRCC (Compensation) **[2017] AATA 1320 (18 August 2017)**

Facts of the case

The claimant applied under SoPs 639(i) and 65(h), which require proof of lifting loads of at least 35kg bearing weight through spine for a total of at least 168000 Kkg within a 10 year period of onset of lumbar/thoraic spondylosis. The claimant worked out for roughly a year before commencing reserve training and sought to rely on evidence of his workouts. The training had occurred roughly 6 years before he had to fill out reports detailing it, and because he had not kept a record book he was unable to provide sufficient evidence to make out the SoP.

What this case demonstrates

- This case highlights that an extreme level of record-keeping is required to fulfil the SoPs

Problems with SOPs raised in the Senate Inquiry

A range of issues have been identified in submissions to the Senate Inquiry. Professor Nick Saunders, the Chair of RMA, identified a number of problems with the SoP system:

The most common issues that have been raised seem to us to be that the statements of principles are not up to date, that they are inflexible, that they are too complex for non-expert people to use with ease, that they are designed to hinder rather than assist veterans who are seeking to make a claim and that the use of two standards of proof to write the statements of principles is inherently unfair.

Different Standards of Proof

The VEA and MRCA provide for two different standards of proof which are applied when assessing compensation claims under the SOPs depending on the type of service rendered Veterans or serving members:

- The 'reasonable hypothesis' standard is applied to Veterans and serving members who have operational service.
- The harsher 'balance of probabilities' standard is applied to Veterans and serving members with defence service, and peacetime service.[27]

This has been fairly labelled as 'inherently unfair' by Professor Nick Saunders, Chair of RMA. The divergence is exacerbated in non-operational service cases, where the legislation provides that even if the SoP is satisfied, the claim can still be denied on the basis of other contradictory evidence.[28]

Allan Anforth states that this feature, though little used, 'demonstrates a straight forward case of unfairness.'[29] The two standards of proof also complicate matters where Veterans and serving members have rendered both types of service.[30] Although the ultimate recommendation of the report was for the Productivity Commission to make its own findings, the Committee noted that there should be one standard of proof, although that this should be the higher 'balance of probabilities' standard, which puts the onus on to the claimant to prove their claim.

The chances of success in establishing compensation claims using the SOPs would be higher if a more beneficial standard is adopted. Regardless, this arbitrary discrepancy should be abolished; there can be no good basis to discriminate against Veterans and serving members who did not render operational service.

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27 Submission 32 of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

28 Submission 208 see 120B(3) VEA and section 339(3) MRCA

29 Ibid.

30 Submission 32 of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

4.7.3 Out of date

The SoPs are not regularly updated, with an average review being every 7 to 8 years. As a result, the SoPs are often out of date, and do not reflect medical advancements. This has an unfair impact on veterans, for whom evidence would be sufficient if the SoPs were up-to-date.

4.7.4 Rigid application

The government has in the past indicated its unwillingness to introduce a more flexible approach in applying the SoPs.[31] This lack of flexibility was criticised in a number of submissions to the Committee.[32] DVA also acknowledged that staff were instructed to apply the requirements strictly. This approach can have a particularly harsh effect on Veterans who attempt to make claims outside of a defined SoP by using evidence from registered specialists.[33]

Allan Anforth, a Barrister, noted that this rigid application has moved the SoPs away from their original purpose:

The SoPs were constructed to set out a list of criteria linking service to the injury/disease such that if those criteria were satisfied then the parties would be spared the cost of calling expert evidence on this point.

The original intended use of the SoP has been lost in subsequent statutory amendments to the VEA:

(a) In non-operational service cases, even if a SoP is satisfied, the claim can still be denied on the basis of other evidence that contradicts the proposition of the SoP.
(b) In all claims even if there is a large body of expert medical evidence pointing to the service cause of the injury, if the SoP is not satisfied the claim fails.[34]

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31 Government response to JSCFADT report into Care of ADF Personnel Wounded and Injured on Operations, December 2013, pp 12-13.

32 Submission 172. of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

33 Submission 171 of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

34 Submission 208.1. of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

Although the approach in (a) immediately above is not common used, its existence demonstrates a straight forward case of unfairness. If the SoP favours the veteran then the Commission can reply upon other evidence to contradict the SoP and deny the claim. The more serious unfair resides in the (b) immediately above; if the SoP does not favour the veteran then the veteran cannot rely on other evidence to support what may otherwise be a valid claim.

There have been a number of submissions indicating that in many cases the DVA delegates considering claims approach them with 'a view to avoiding liability, rather than applying the principles underpinning beneficial legislation.'[35]

RSL Tasmania has strongly criticised the application of SoPs by DVA:

> Under the principles of beneficial legislation, if there is evidence available which suggests a claim is valid, it should succeed, even if the evidence is not conclusive. If there is mixed evidence, and it is unclear whether it should succeed or fail, the principles of beneficial legislation say that the delegate should err in favour of the veteran and the claim should succeed. A claim should only fail where it is clear, on the evidence, that the claim is not valid, or where the evidence against a claim outweighs the evidence in favour. This does not always occur, and there are instances where the evidence is mixed and unclear, and the relevant principles suggest it should succeed, and instead it fails.[36]

4.7.5 Example - Delayed onset suicide SOP

A situation presents itself where a spouse or dependent may not be able to connect the person's suicide to relevant service where the suicide occurred after 2 to 5 years from their date of experiencing the category 1A or 1B stressor, and they cannot establish enough evidence to satisfy any other factor in the SOP.

It is possible that a person with relevant service has a delayed onset (more than 5 years) of a significant disorder of mental health and has not received treatment for any impairment regarding symptomology of a mental health condition.

35 Submission 169. of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

36 Submission 169 of Suicide Enquiry, *The Constant Battle: Suicide by Veterans.*

In this instance the surviving spouse or dependent claim for compensation will fail and they will be ineligible for any entitlements as the suicide occurred after the 2 and 5 year time period as stipulated in the SoPs.

It is entirely possible that a serving member may be motivated to attempt suicide in order to ensure support was provided to their families on their death. This timeframe may provide the motivation to attempt suicide.

This SOP and the relevance of this submission were discussed at the recent Younger Veterans Forum on the 21 July 2016. All representative ESO members agreed that the timeframe associated with this Factor of the SOP should be omitted.

It was recommended that the RMA remove the 2 and 5 year clause in factors 3 and 4 of the SoPs as there is evidence that psychiatric conditions can manifest and there can be a delayed onset of any impairment.

4.7.6 Recommendation

The SoPs are perceived to work against a veteran rather than in their support. Rigid, inflexible application of the SoP Risk Factors in determining a claim is inconsistent with the beneficial intent and provisions of the legislation, particularly where the veteran also suffers with PTSD. Despite improving, the time taken to undertake reviews still takes almost 2 years.

The Senate Inquiry suggested a potential system that could replace the SoP framework:

> A better system might be one closer to that envisaged by the Baume review with one standard of proof (the civil standard, with a benefit of doubt in favour of veterans with relevant operational service), initially determined by the delegates primarily guided by the SOPs prepared by the RMA. However, delegates should not be completely bound by the SOPs. Keeping in mind, the beneficial nature of entitlements for veterans, delegates

should have within their discretion the capacity to determine claims, provided there is a reasonable link to a person's service on the balance of probabilities.[37]

4.7.7 Slater + Gordon Recommendation

The current SoP structure is overly complicated and burdensome for veterans. Slater + Gordon support a number of recommendations set out in the submissions above. Namely, we urge the current SoP system be reviewed with a view to simplifying the process and reducing the unreasonable evidence requirements. Furthermore, provisions should be made for conditions recognised in the medical community that are not yet reflected in SoPs. Legislation implementing this fundamental change should be a priority for the DVA.

The fundamental issue with SoPs is that they are premised on constantly evolving medical science, yet, despite endeavours by the RMA, they are not updated soon enough to reflect these changes. By the very nature of SoPs they cannot be applied too rigorously and should only be referred to as a general guide. The strict interpretation approach needs to be removed.

Also in regards to Statements of Principles, I commented in a submission to the Senate inquiry into Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Act:[38]

This Act purports to re-enact SRCA with no changes to or impacts on veteran's entitlements. However, by excising veterans' SRCA coverage from Comcare and repackaging it as a military-specific compensation scheme, the DRCA sets a dangerous precedent.

The SRCA as it currently exists covers both defence members and all Commonwealth public servants. The tests for liability are the same for each group and the impairment provisions determining the level of compensation for injuries, diseases and conditions are more favourable to defence members.

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37 Senate Inquiry, The Constant Battle: Suicide by Veterans, p69.

38 Brian Briggs, Submission No 4 to Senate Foreign Affairs, Defence and Trade Committee, *Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016*, 24 February 2017, 11-14.

The Minister for Veterans' Affairs has confirmed that an eventual goal of the Act is to align this new defence-specific DRCA with the MRCA. The MRCA is roundly regarded as a poorly crafted piece of legislation that fails to protect the rights and entitlements of veterans. There have been widespread calls in the Defence community to repeal the MRCA. Accordingly, it is my view along with many others who represent our military that to replace the SRCA will lead to military complainants being significantly disadvantaged.

The MRCA currently provides rehabilitation and compensation coverage to defence personnel who served on or after 1 July 2004. It differs from the SRCA in that both the statutory tests for liability (*Statements of Principles* or 'SoPs') and its metric to determine payable compensation (*Guide to the Assessment of Rates of Pensions* or 'GARP M') are far more onerous for veterans.

4.7.8 Statements of Principles: Liability Tests for Lower Limbs

Under the MRCA, the SoPs determining liability for impairment are more restrictive and unnecessarily technical than the SRCA provisions. Claims can be rejected on the basis that the factors in the relevant condition's SoP are not met, even where the claimant has provided medical evidence proving that their condition is linked to their military service.

To give an example of the limitations imposed by SoPs, I refer to the recognised condition of shin splints which is common amongst my clients. In order to prove on the balance of probabilities that a typical clinical onset of shin splints is connected with their peacetime service, a veteran under the MRCA must prove one of the following factors:

> a) Running or jogging an average of at least 60 kilometres per week for the one month before the clinical onset of shin splints; or
>
> b) Undertaking weight bearing exercise involving repeated activity of the lower leg on the affected side, at a minimum intensity of five METs, for at least six hours per week for the one month before the clinical onset of shin splints; or
>
> c) Increasing the frequency, duration or intensity of weight bearing activity involving the lower leg on the affected side by at least 100 percent, to a minimum intensity of five METs for at least four hours per day, within the seven days before the clinical onset of shin splints.34

The quantification and qualification required to prove the above factors is onerous on the veteran and serves to lengthen the claims process and restrict Commonwealth liability. If a claimant cannot immediately report the onset of symptoms or if their experience does not otherwise meet these strict parameters, their claim can be denied.

In comparison, a Commonwealth public servant covered by the existing SRCA must only demonstrate that on the balance of probabilities their injury arose out of or was aggravated in the course of their employment. In my experience, this test is less restrictive and contains fewer arbitrary technicalities that seem designed to block claims by veterans.

4.7.9 Statements of Principles: Clinical Onset of Conditions

The MRCA allows delegates to deny legitimate claims from veterans on the basis of mere technicalities contained in the SoPs.

To provide an example for the Committee, one of my clients was formally diagnosed with a psychiatric condition. This condition was accepted by the DVA. Our client then claimed for the condition of bruxism (grinding of the teeth), secondary to the psychiatric condition. The relevant SoP for bruxism states that the relevant factor to be met is 'having a clinically significant disorder of mental health as specified at the time of the clinical onset of bruxism'.

The MRCC found evidence in our client's dental file that he had tooth damage recorded two months prior to his clinical diagnosis with the psychiatric condition. The MRCC therefore denied the client's claim on the basis that the client technically did not have the psychiatric condition at the time of the clinical onset of bruxism. The delegate was able to make this decision because the starting date of the psychiatric condition was formally considered to be the date of diagnosis.

The formal diagnosis clearly occurred at a point in time after the bruxism first manifested. Common sense would therefore dictate that the client's psychiatric condition and his bruxism commenced around the same time. However, the technical wording of the SoPs allowed the delegate to deny the claim. These kinds of illogical decisions often result from the restrictive and narrow tests for liability under the MRCA. The SRCA alternatively allows the delegate more flexibility and does not force them to consider the 'date of clinical onset' as a determining factor.

4.7.10 Restrictive Timeframes: Suicide and Attempted Suicide

Furthermore, the strict time limits outlined in many SoPs constitute an unnecessary and irresponsibly implemented barrier in the compensation process. To provide an example of these arbitrary timeframes, the SoP governing Suicide and Attempted Suicide requires that the claimant who attempts suicide after experiencing a category 1A or 1B stressor during their wartime service must experience this stressor within five years before the attempted suicide. If the claimant experienced the same stressor during peacetime service, the stressor must have been experienced within two years of a suicide attempt. If a veteran's suicide attempt occurs outside of this five or two year window, it cannot be relied upon as a factor and they will either have to prove some other factor or fail to establish liability altogether.

To give context, category 1A and 1B stressors include traumatic events such as experiencing a life-threatening event, being subject to a serious physical attack including rape, being an eyewitness to killings or atrocities on other persons, and viewing and handling corpses. Medical specialists acknowledge that delayed onset of symptoms can be common following trauma. Nevertheless, the SoP is formulated to prevent claims by a veteran or that veteran's estate if these narrow timeframes are not met.

These SoPs are currently being investigated by the Repatriation Medical Authority but have nonetheless been in place for years and are representative of the kind of limitations imposed under the MRCA. Again, a Commonwealth public servant covered by the SRCA can more easily prove liability for the same condition using the more lenient tests under the SRCA.

In light of these strict liability tests required by the MRCA, I query why the future alignment of this proposed defence-specific SRCA with the MRCA is considered a desirable goal by the Minister for Veterans' Affairs.

4.8 *Military Rehabilitation and Compensation Act 2004* (Cth)

In a submission to an Inquiry into Suicide by Veterans and Ex-Service Personnel, I also discussed the *Military Rehabilitation and Compensation Act 2004 (MRCA)* and the issues that it raised:[39]

4.8.1 Background

In May 2016, the Australian National Audit Office (ANAO) produced an independent performance audit of the DoD and the DVA entitled 'Administration of Rehabilitation Services under the *Military Rehabilitation and Compensation Act 2004* (*MRCA*)' (the Audit). The *MRCA* was introduced to bring together rehabilitation and compensation provisions for all serving and former members of the ADF regardless of the type of service performed for injuries and illnesses suffered from service rendered on or after 1 July 2004.

The Audit concluded that providing compensation and rehabilitation services to Veterans is the core business of the DVA. The DVA's operations are intended to be geared towards transitioning clients to civilian work and maximising quality of life for Veterans after an injury or illness related to ADF service.

The Australian Government Actuary estimated that liability under the *MRCA* (including accepted claims and future liabilities) was $4.56 billion, up from $3.84 billion in the 2014-15 financial year – constituting a rise of almost 15 per cent in one year. It is suggested the accrued liabilities of the DVA are significant and growing.

39 Brian Briggs, Submission No 160 to to Senate Foreign Affairs, Defence and Trade Committee, Suicide by Veterans and Ex-Service Personnel, 7 October 2016, 37-39.

4.8.2 Performance Measurement Frameworks

Neither the DoD nor the DVA reliably measure or report on outcomes in managing rehabilitation programs for Veterans. Satisfactory performance information has not been sufficiently developed or utilised by the DVA to manage the *MRCA* scheme in terms of assessing the risks of injury and illness in Defence through to considering the impact of rehabilitation on the overall performance and financial sustainability of the scheme as a whole.

The ANAO audit found that the return to work rate is significantly lower than the national benchmark—54 per cent for DVA and 55 per cent for the ADF, compared with the Australian average of 77 per cent in 2013–14. There has also been a significant decline in the rate of transition to civilian work for Veterans' Affairs rehabilitation clients from 66 per cent to 48 per cent over the same period. The performance measurement framework for the ADF Rehabilitation Program is poorly developed and does not measure performance against all key indicators.

Performance data within DoD is not sufficiently reliable or consistent across years to determine whether preventable injuries and illnesses. According to the ANAO, failure to produce satisfactory data has a 'downstream impact' on DVA re-deployment capabilities and the accrual of liabilities under the *MRCA*. Further, DoD acknowledges that not all serious incidents are reported as not all parts of the ADF have access to reporting systems, namely Navy vessels at sea and Cadets. The ANAO was also informed during numerous audit interviews by a range of ADF staff of their reluctance to report incidents due to the perceived potential negative career impacts that may result from reporting.

Despite rehabilitation services being core business for the DVA, there is no comprehensive performance data available to indicate whether rehabilitation services are effectively meeting the needs of Veterans. Available data shows a substantial decline in successful rehabilitation outcomes for Veterans with a return to work goal over the five years to 2015, suggesting that rehabilitation services by Veterans' Affairs may be becoming less effective.

4.8.3 Cost

Defence does not effectively manage the costs of ADF rehabilitation services as it does not record the full cost of the ADF Rehabilitation Program. The total value of rehabilitation related expenditure in Defence is unknown as rehabilitation services are reported as part of the total ADF health costs.

I note that part of the report in suggesting that the Department does not have a basis to demonstrate that its rehabilitation services represent value for money. The DVA has not completed market testing or established service level agreements with rehabilitation service providers to monitor and manage performance, and there is no documented rationale for selecting one provider over another when clients are referred to rehabilitation providers.

4.8.4 Administration/Management of Payments

Incapacity payments are not well managed. The ANAO provides that in 2014, the DVA reported that over 20 per cent of payments were made in error or were instances of overpayment. The DVA aims for a target rate of 5 per cent error. A client recently told us that she had been receiving an incapacity payment from the DVA and, fearing a claim against her at a later date, had purposely put money aside. However, the frequency of overpayment of claims being made against Veterans is well known in the Veteran community. Accordingly, the client had been putting some of her payment away despite needing the money to survive. This is just one example of DVA's inability to manage its clients under the *MRCA* scheme and the fear it creates in the Defence community.

4.8.5 The state of the DVA's operations

The review into the DVA confirms what we and our clients have long known – it remains shambolic. Reviews have found DVA's processes are disjointed and slow, and Veterans' mental health and physical welfare is being put at risk by a department struggling under a disorganised bureaucracy. Since its inception, *MRCA* liabilities have grown substantially each year to $4.5 billion at 30 June 2015. This growth reflects the demand-driven nature of the scheme, which is funded through an essentially unlimited special appropriation by the government.

However, a lack of performance information inhibits any understanding of the contribution that rehabilitation services make to the ongoing financial sustainability of the *MRCA*. Accordingly, our clients are regularly frustrated by slow, duplicated or inadequate responses and ad hoc decisions made in the absence of information and the DVA's poor processes.

4.8.6 Common Law claims under *MRCA*

Currently, a Veteran's right to recover common law damages from the Commonwealth is restrictive and unfair. Section 389 of the *MRCA* provides that 'a person may choose to institute an action or proceeding against the Commonwealth' over damages for noneconomic loss provided that they meet the criteria set out under the Act.

In *Hetherington v Department of Defence*, the Victorian Supreme Court rejected the claim of a plaintiff Veteran who failed to meet the restrictive conditions listed under section 389(1)(a).

The cap on non-economic loss is unfair and disadvantageous to Veterans. Where permitted, the largest amount a Veteran can elect to sue for is $110,000. This amount was set at the time of enactment (2004). Despite compensation under the *MRCA* being indexed, the amount available for a claim in damages at common law is not index linked. The Reserve Bank of Australia's Inflation Calculator provides that the $110,000 maximum available would be equivalent to $144,409.03 today. Veterans who elect to sue for common law damages are only able to recover 70 per cent of damages potentially available to them under the Act. Veterans are subject to the *Defence Discipline Act* 24 hours, 7 days a week while at service. They should be fully covered for any injuries sustained. The beneficial intention of this legislation should license a more generous interpretation of its provision in order to serve its purpose of assisting incapacitated ex-service personnel.

In a submission to the DVA's Inaugural Legislation Workshop 2017, I also said the following in regards to the DVA removing rights to commence common law action under MRCA:[40]

40 Brian Briggs, Submission to Department of Veterans' Affairs*, Inaugural Legislation Workshop*, 27 October 2017, 19.

Of equal concern is the unilateral decision of DVA to automatically strip away Common Law rights when it comes to making MRCA elections. DVA are advising claimants that if they do not advise the Department within one month that they wish to commence Common Law action by returning the election form, the permanent impairment periodic payments will be automatically paid and this will remove the right to take any Common Law action for accepted conditions.

In my opinion, this is an unbelievable abuse of power by DVA. How can the Department justify removing Common Law rights on the basis that an election form is not returned within 30 days? I am confident that any Court would not enforce such an attempt by the Department to uphold any such action. I believe that this policy which seems to suggest amendment to regulations without notice, constitutes a fundamental breach of natural justice. I have not seen any amendment of legislation giving the Department unfettered power to do this. The practice should cease immediately.

In regards to issues with military rehabilitation and compensation (payment into bank or foreign corporation account) (s430(3C)) of MRCA), in a submission to DVA's Inaugural Legislation Workshop, I observed:[41]

We note that in 2015, without consultation, Parliament overturned the Queensland Supreme Court decision of *Hansen v Military Rehabilitation and Compensation Commission.* This had a direct impact on the way few law firms who were able to represent Veterans in the area of the claim process and ensuring that our military could obtain access to independent legal advice. At the time there were less than 5 firms actively involved in this area.

In making the amendments to section 430(3A)-430(3C), Parliament observed that:

> Section 430 of the Act, in the form it existed at the time, did not require DVA, on behalf of the Military Rehabilitation and Compensation Commission, to pay a beneficiary's lump sum compensation to the credit of an account maintained by the beneficiary at the bank and that DVA, on behalf of the Military Rehabilitation and Compensation

41 Ibid 17-19.

Commission, could, at the direction of the beneficiary, pay the lump sum compensation to the credit of a bank account maintained by a solicitor.

The amendments were deliberately designed to overturn the Hansen decision. There was no consultation for the amendment on the basis that the instrument was beneficial to safeguarding the interests of beneficiaries. By making such amendments, the result was that other lawyers previously acting on behalf of clients on a 'no win no fee' basis withdrew from acting on behalf veterans. In one swoop the government and DVA overnight diluted the pool of legal representation available to veterans.

It is noted that there has been no such dilution in the DVA panel lawyers, as evidenced by annual reporting the Government and DVA have increased their spending year on year in briefing external law firms to oppose claims. This represents a gross inequity for our military as compared to the rights and benefits available to Commonwealth Public servants who still have the ability to direct compensation to be paid into lawyers trust accounts.

It has also placed onerous pressure on claimants in having to meet the costs of their legal representatives by having to transfer monies, draw cheques, or direct transfer monies after their claims were finalised.

The government, in justifying the amendments, suggested that this would prevent deductions for fees and disbursements from solicitors that would be unreasonable or cause unreasonable delay in monies reaching the beneficiary. No examples were provided as to this ever occurring. In truth, there were very few solicitors acting on behalf of beneficiaries and the client already had recourse and the ability to request itemised bills and referring matters to the Law Societies if there was an issue with the fees and disbursements.

As a solicitor, one could easily form the impression that the amendments were made purely to remove solicitors from representing the Defence Community. Any search or enquiry will find how few lawyers practice in this space on behalf of injured military personnel. It is our respectful

submission that those amendments need to be repealed and the law as existed following the *Hansen* Decision reinstated.

DVA continues to have problems with how compensation monies or incapacity payments and other benefits are paid. I have experienced in the recent times delegates depositing monies directly into clients' bank accounts when it should have been paid to either to trust account, depositing monies to us when it should be incapacity payments, depositing the money with Centrelink, making double payments, to name only a few examples. The Department should not have these problems, and whilst there has been a definite improvement in how fast the compensation is paid, there remain some difficulties which need fixing.

4.8.7 Recommendations for Appeal Process

- Slater + Gordon recommend that the prohibitions preventing lawyers appearing before the Veterans Review Board be repealed. Further, the VRB should become a full costs jurisdiction for the Applicant. That is, it will enable legal and other representatives to assess the merits of cases and pursue them on a 'no win, no fee' basis. Additionally, the AAT should become a full costs jurisdiction for the Applicant in the event of successful outcome against the DVA.
- In response to the amendments of S430(3A)- 430(3C), Slater + Gordon recommend a claimant be able to nominate the bank account that they would like to have the lump sum compensation be paid to, including a solicitor's trust account should they so wish.

4.9 Appeal Processes

Further observations I made in a submission to DVA's inaugural legislation workshop in 2017 regarding the appeal processes were these:[42]

4.9.1 Appeals Process

It is obvious that the appeals process promotes unfairness and injustice. This position, I would suggest, is now worse due to the implementation of the single pathway for MRCA/VEA appeals. As of 1 January 2017, any veterans who disagree with decisions made by DVA in relation to

42 Ibid 15-16.

claims under MRCA must be appealed to the Veterans' Review Board (VRB). SRCA/DRCA matters can still be appealed by internal reconsideration before proceeding to the AAT.

There are a number of issues with the appeal process that create an additional burden on veterans:

- Veterans can be legally represented if they can afford it. Even if they are successful at the AAT, there are few instances where costs and disbursements are awarded to them. As a result, unrepresented veterans cannot afford to pay lawyers and their prospects of success are greatly diminished. It becomes a David and Goliath battle.
- The matter is heard de novo before the AAT. Veterans are expected to adduce medical and other evidence in support of their case. To obtain a report from an independent medical specialist requires that the veteran identify the relevant specialist, travel to the specialist office for examination, frame the relevant questions for the specialist to answer and then call specialist to give evidence at the hearing. In comparison DVA have the resources to spend on medical specialists who, in many instances, have a reputation for producing consistently non-favourable reports.

4.9.2 SRCA Review and Appeal Routes

Under SRCA claims the administering authority is the Military Rehabilitation and Compensation Commission (MRCC) and not the Repatriation Commission. The veteran will proceed direct from a denial by MRCC to the Administrative Appeals Tribunal. If successful in the AAT appeal the veteran is entitled to recover a large portion of their costs for their lawyers and medical witnesses including the cost of independent medical reports.

4.9.3 MRCA Review and Appeal Routes

As things presently stand a veteran injured after 1 July 2004 comes under the MRCA. If the MRCC denied a claim the veteran could seek review either through the VRB or an internal reconsideration before proceeding to the AAT. From the 1st January 2017 a Veteran is subject to the unattractive constraints referred to above relating to appeals from the VRB/AAT. With the prospect of non-recovery of costs and the restrictions of the single pathway, Veterans will be worse off in the future. We are waiting on how this will affect appeal numbers in the process as I am of the view that there will be a marked decline which will be to the detriment of Veterans who have been incorrectly denied claims which should have been accepted at the primary level.

4.9.4 Federal Court Review

Putting aside the problems with appeal, even if a veteran is successful before the AAT, the Commonwealth may appeal this to the Federal Court on a point of law. Not only is this an onerous and stressful experience for veterans, the veteran must pay the Commonwealth's Federal Court costs if the appeal succeeds. A conservative estimate of these costs is around $30,000 to $40,000 – well beyond what most veterans can afford.[43]

Even if the veteran survives in the Federal Court, the matter could be referred to the Full Federal Court. Again, were the Commonwealth to succeed, the veteran is liable to pay the court costs, which at the Full Federal Court, can exceed $100,000.[44]

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43 Submission 208, Supplementary submission 1, p. 1.

44 Ibid.

There are legislative instruments that support financial support to claimants in managing costs where the Commonwealth appeals a decision favourable to the claimant. However, as noted by Allan Anforth in his submission the Veteran Suicide Report, these grants have not be indexed for inflation since their creation in 1981. Currently a claimant can receive $6,000 for the costs of the Commonwealth's appeal to the Federal Court, and $8,000 for Federal Court fees itself.[45] This is completely inadequate to ease veterans' costs and improve access to justice.

Slater + Gordon support the recommendation put forward by Mr Anforth that the Federal Proceedings (Costs) Act 1891 be amended to prove:

(a) That if the Commonwealth successfully appeals a decision from the AAT, no costs are to be ordered against the veteran or if the costs are awarded then the Commonwealth will pay itself;

(b) No costs should be awarded to the Commonwealth on test cases.

4.10 Single Pathway of Appeals

In a submission to a Senate inquiry into Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill, I said in regards to issues with the single pathway of appeals:[46]

The enactment of the DRCA further raises concerns for the ability of veterans or defence force personnel to appeal determinations made by the DVA where they are unsatisfied as to the outcome. These concerns arise as the system of review through the MRCA have recently been altered through the *Budget Savings (Omnibus) Act 2016* ('*Omnibus Act'*), and the present Act is anticipated to modify the SRCA's review system to match that of the MRCA.

45 Ibid.

46 Brian Briggs, Submission No 4 to Senate Foreign Affairs, Defence and Trade Committee, *Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016*, 24 February 2017, 20-25.

4.10.1 Background

By way of explanation, the amendments made by the recent *Omnibus Act*, which were highly contested in the defence community in the months prior to the change, effectively eliminated a vital pathway for compensation claimants to seek appeals of their respective determinations.

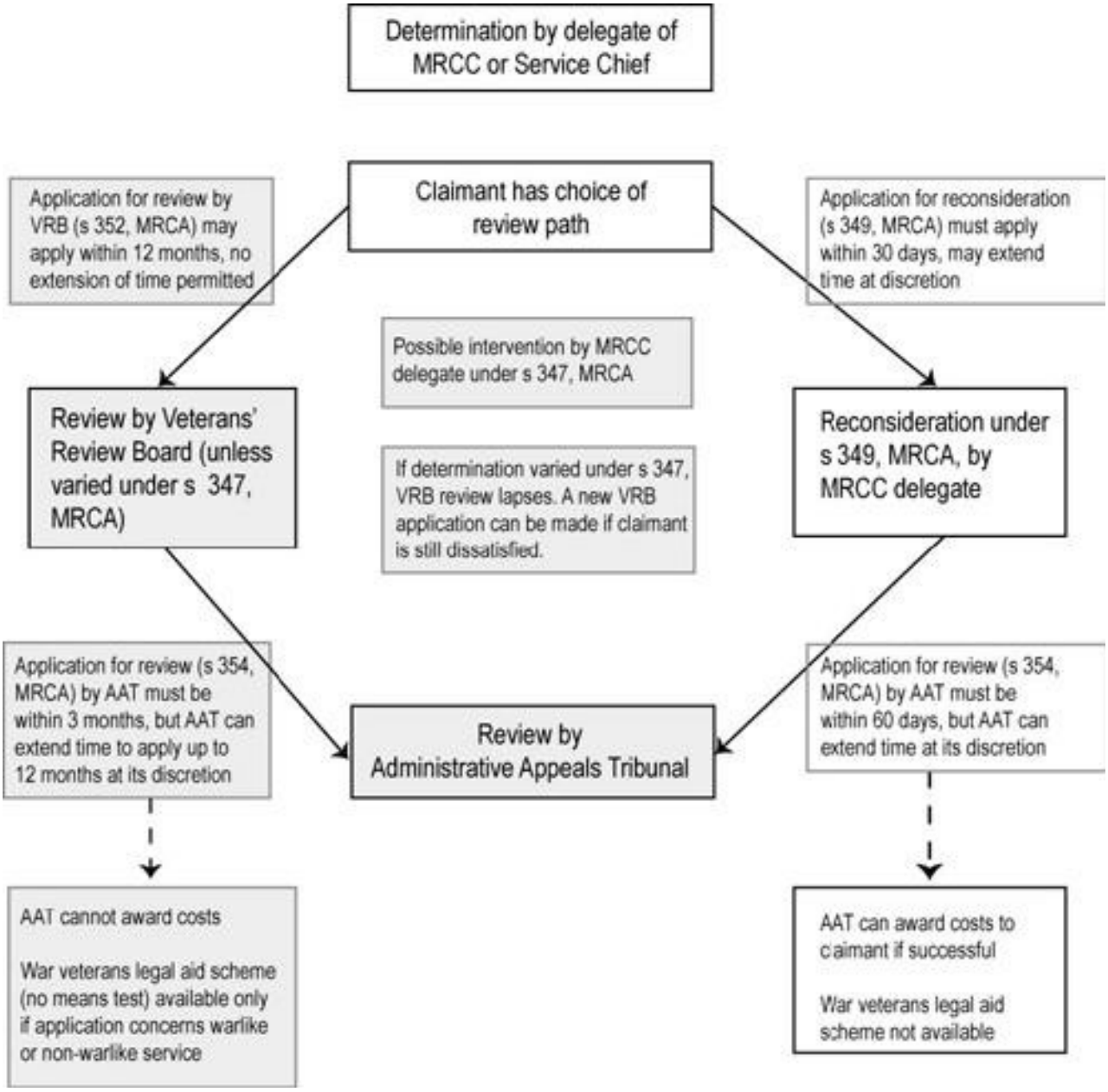


Figure 4.7.1. Former Dual Pathways to Appeals for DVA Applicants

In order to grasp the detrimental effect of these changes on military compensation claimants, it is necessary to [illegible] applicants prior to the amendments. The Figure 4.7.1., illustrates this former system.

As shown in Figure 4.7.1., the two pathways of appeal available to DVA applicants were either an application of review to the Veterans Review Board ('VRB') or an application for internal reconsideration by a MRCC delegate. If a claimant remained unsatisfied after the review or reconsideration, they could then approach the Administrative Appeals Tribunal ('AAT') for a final review of their case. However, there are notable differences between the two methods, which led to the internal reconsideration method being given preference by applicants and professionals alike.

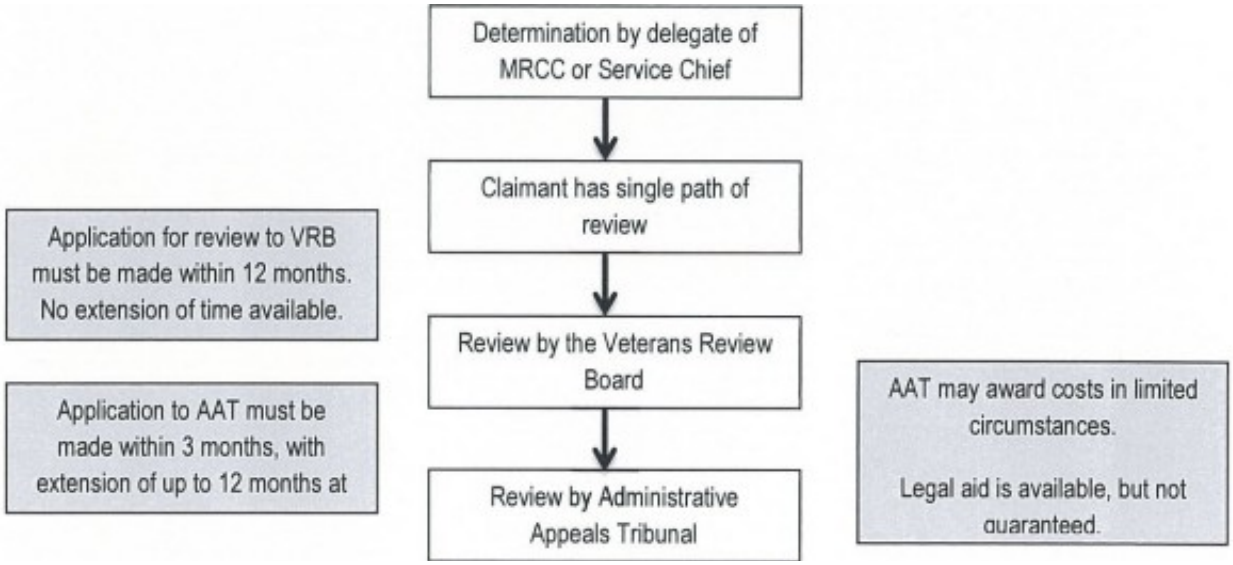
4.10.2 Differences between the Two Appeal Methods

Perhaps the most crucial difference between the two methods is the applicant's entitlement to legal representation and the subsequent legal costs. As mentioned in Slater and Gordon's previous submissions, where a claimant applies for a review process under the VRB, they are not only disallowed legal representation at the VRB review hearing but further denied legal costs and disbursements should they choose to appeal the decision by the VRB to the AAT with legal representation. In comparison, the DVA is allowed to procure as many in-house or external lawyers as they deem necessary, and indeed they do, as demonstrated by the $10.62 million spent on legal services in the past year. This creates an imbalance in resources which is counterintuitive to the very mission of the DVA – "to support those who serve or have served in the defence of our nation and commemorate their service and sacrifice."

Further, the VRB hearing is tape-recorded and thus may lead to evidence gathered against an applicant and later used in a subsequent appeal to the AAT. The MRCC reconsideration method on the other hand has proven itself to being a faster appeal method without the requirement for an applicant's case to be restated due to its internal nature. This result in the latter method being unquestionably be more cost efficient, less time consuming and less stressful for an applicant.

4.10.3 Changes to the MRCA Review Pathway

As mentioned above, the amendments of the *Omnibus Act* resulted in the abolishing of the internal reconsideration pathway, leading to the current review system illustrated in Figure 4.7.2. below. At first glance, this new 'single pathway' seems to be simpler, easier to understand, and perhaps more efficiently structured. However, the reality of this system in practice is, as referred



to above, the elimination of a fairer, quicker and more efficient system in favour of a review system that is both prejudicial and biased against veterans.

Figure 4.7.2. Current Single Pathway to Appeals for DVA Applicants

Granted, the new single pathway through the VRB and AAT now allows for costs to be paid, as opposed to the prior situation where costs were not available at all. However, the AAT is precluded from making such costs where:

> a) The claimant has provided to the Tribunal a document relevant to the review, and the VRB did not have the document prior to the review and the claimant could have provided the document to the VRB without unreasonable expense or inconvenience and the VRB would have made a determination more favourable to the claimant than the reviewable determination;

b) The claimant was previously granted legal aid;

c) The claimant failed, without reasonable excuse, to appear at the hearing of the review by the Board;

d) The Tribunal remits a decision for the Commission to make a new decision.

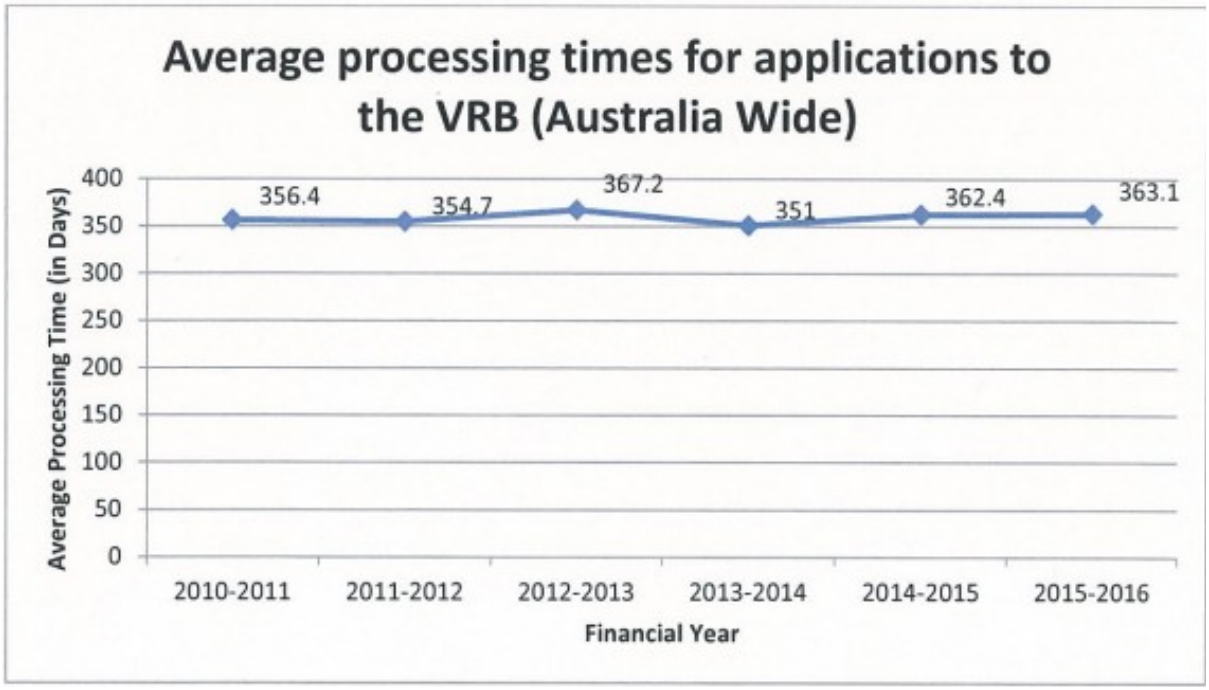
These exclusions in effect result in a total restriction on the AAT to award costs save for the most limited of circumstances. This disparity and bias in favour of the DVA is especially prominent when considering the effect of restriction (a), which discourages the claimant from obtaining or submitting any updated or recent documents such as updated medical reports. In contrast, no such restriction applies on the DVA in presenting its case to the AAT. This restriction, while seemingly innocuous, is disastrous for any claimant appealing their case. In practical terms, this limitation allows the DVA to bring in any number of updated medical reports and documentation with near unlimited resources to prove their case, while the claimant would be punished or completely disallowed from countering those documents depending on their financial situation. As many veteran claimants are by their nature unable to work, their financial situation alongside this restriction effectively disables them from defending themselves appropriately. In comparison, Commonwealth public servants under the SRCA have no such restrictions. This represents an abrogation of the Commonwealth's obligations as a model litigant – to not take advantage of a claimant who lacks the resources to litigate a legitimate claim. This doctrine of unfairness and inequality, while already abhorrent and in place for the MRCA, cannot be allowed to prevail through the DRCA.

One redeeming factor in favour of the single pathway being proposed by DVA is the suggestion that Legal Aid that would purportedly be available through the new pathway. However, the reality of Legal Aid, as others have pointed out, is very different from the all-encompassing coverage that the DVA usually ascribes to it. The first caveat of Legal Aid is that it is only available where a veteran has been injured under operational service – essentially overseas service. The second is that the DVA cannot guarantee Legal Aid for anyone. Legal Aid is a wholly separate system that encompasses more than just the compensation of veterans, and is basically a creature of each respective State and Territory. In effect, this means that a veteran's right or even ability to receive Legal Aid is not enshrined, as illustrated by the brief withdrawal

of NSW Legal Aid from the funding of veterans even with operational service in 2014. Further, it is well known that Legal Aid is extremely difficult to obtain and most States have reduced the amounts available, causing Legal Aid to be an unreliable source of funds and thus relief for claimants.

Admittedly, the amendments to the MRCA do not totally remove the MRCC reconsideration process. The process may still be enlivened through a request by the Chief of the Defence Force to the MRCC, which is not available to a veteran claimant.59 However, it is argued that this internal review does not provide for a proper reconsideration and is fundamentally dissimilar to the path previously available to claimants, being obscured by the layers of governance and creating a system with less apparent accountability and oversight.

As a final practical matter on this change, the move to the single pathway appeal is understandably anticipated to substantially increase the workload of the VRB. I question the VRB's capacity to handle this greater workload. There is insufficient data to adequately answer this concern at the present time, the reforms having only taken place recently. However, it is noted that the average application times from lodgement to finalisation at the VRB in the past three financial years have been 363.1, 362.4 and 376.6 days respectively (See Figures 4.7.3. and 4.7.4. below) – an entire year for a claimant to appeal their case. Figure 4.7.3. and 4.7.4. below also shows no apparent improvement in the efficiency of the VRB in recent years, and I would argue that these numbers do not bode well for the high influx of cases that are currently directed



to the VRB through the MRCA amendments. To further shift the veterans under the SRCA to this same single pathway system would only cause undue delays and distress.

Figure 4.7.3. Graph of Average Processing Times for Applications to VRB

Financial Year	Average Processing Times in Days (Australia-Wide)
2010-2011	356.4
2011-2012	354.7
2012-2013	367.2
2013-2014	351
2014-2015	362.4
2015-2016	363.1

Figure 4.7.4. Table of Average Processing Times for Applications to VRB

I foreshadow that if these reforms were to happen, there will be problems in practice and confusion within the AAT as to how appeals will proceed or be directed back to the MRCC. I question the need for such reforms when the existing method of reconsideration has been in place for many years, and has proven itself to be more advantageous in terms of costs and efficiency. It is my opinion that to move the SRCA to this single pathway system is not only an unwise decision in terms of practicability, but also runs utterly contrary to the aforementioned mission of the DVA.

4.11 **Use of Medico-Legal Firms**

In a response I made to Recommendation 10 made by the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, in regards to the DVA's use of medico-legal firms in relation to the assessment of conditions of veteran, I said:[47]

47 Slater & Gordon Lawyers Response to Recommendation 10 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans.*

4.11.1 Issues with Current System

In some instances, the current DVA process requires veterans to attend multiple medical appointments at medico-legal firms. This is inefficient and often detrimental to the health of the veteran as they are required to rehash experiences that are inappropriate and difficult. A single appointment, which may take a matter of minutes, with a doctor who is a total stranger, is grossly inadequate in assessing the medical needs of veterans when compared to a report from a veterans' long-term treating specialist.

Slater + Gordon agree that veteran dissatisfaction with the current system is well founded, and believes that medico-legal firm's protocols should be reviewed. Evidence presented to the Inquiry supports our stance that the use of medico-legal firms is inappropriate when addressing the conditions of veterans, particularly in the case of mental health conditions.[48]

To address the issues outlined above, the Committee confirmed that it supports 'the efforts by DVA, Defence and CSC to implement a Single Medical Assessment Process to minimise situations where veterans are required to attend multiple medical appointments.'

However the committee has recommended that DVA reassess its use of medico-legal firms to ensure the assessments are appropriate for the conditions of veterans, particularly mental health conditions.[49]

Strong concern was raised regarding the 'quality, appropriateness and fairness of medical assessments required by DVA in the claims processes.[50] That is,

> 'DVA outlined that its departmental guidelines state that a report from a treating specialist is preferred, however it noted that it may use external, non-treating medical practitioners (often a medico-legal firm) to seek an independent report in some cases. These medico-legal companies are selected on a case by case basis and there is no schedule of fees or contract and payment is on a case by case basis.'[51]

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48 Foreign Affairs, Defence and Trade References Committee, *The Constant Battle: Suicide Amongst Veterans* [5.104].

49 Ibid.

50 Ibid [5.61].

51 Ibid.

Of particular concern is the practice of DVA to refer veterans to medico-legal firms when the delegate is dissatisfied with the treating doctor's response.[52] This should ring alarm bells when considering the treating specialist has had more time with the veteran and therefore is likely able to reach a more appropriate diagnosis. To the veteran community such action portrays a Department who is prepared to 'doctor shop' to seek the best outcome for DVA, and not for the very people they are supposed to be assisting. This practice flies in the face of the spirit of beneficial legislation, and that delegate should be identifying ways for claims to be accepted, not denied.

As reported by RSL Tasmania,

> '… its advocates were finding DVA's policies were 'often not adhered to'. It stated that '[i]n many cases, a claimant has a treating specialist, and these details have been provided to the delegate, but the treating specialist is not used and, instead, an MLCOA specialist is used'.[53]

This preference also goes against the essential requirement of trust between patient and specialist to reach an accurate diagnosis. Our experience is that often the doctors are poorly briefed by DVA, and questions can be framed to illicit negative answers. To the injured veteran it then appears that the goal is to deny the claim. Often doctors require multiple consultations to be able to respond to the complicated and strict nature of the statement of principle (SOPs) and then to assess under the guides and tables. The whole process can take many months, and all of these steps only compound the anxiety and distress being experienced by the veteran.

4.11.2 Costs of Current System

DVA provides payment for rehabilitation, medical and other related services under a number of legislative instruments, including the *Military Rehabilitation and Compensation Act 2004* (Cth) (MRCA). When a veteran makes a claim for compensation under the MRCA, the Military Rehabilitation and Compensation Commission (MRCC) may require them to undergo a medical examination by a medico-legal firm or practitioner. The MRCA states that the Commonwealth is

52 Ibid.

53 Submission 169, p. 8.

liable to pay the cost of conducting the examination, and is also liable to pay the claimant for any reasonably incurred costs when making the journey to the examination.[54]

These medico-legal costs are in addition to the costs of compensating veterans for any medical reports they may obtain from their treating specialist when lodging a claim.[55] According to the Report, medico-legal companies are payed on a case by case basis, as there is no schedule of fees or contract. One company that is relied upon by to provide Independent Medical Examiners ('IMEs') is MLCOA, which in 2015 earned almost $70 million in revenue.[56] MLCOA is owned by the MedHealth group, the parent company of which was sold by American IME provider ExamWorks to US-based private equity firm Leonard Green & Partners LP for the equivalent of $2.8 billion.[57] MLCOA has come under some scrutiny regarding its record-keeping practices, such publicity no doubt raises concerns for independent observers.[58] In the context of providing IMEs to insurance providers, there have been some claims that IMEs have been payed as much as $4000 for a single consultation, and that one IME processing claims for WorkSafe Victoria earned $1.25 million doing so. Will Barsby of Shine Lawyers states that insurers ordinarily pay IMEs between $3000 and $4000 to assess a claimant.[59] He argues that because this represents lucrative supplementary income for medical practitioners that IMEs are incentivised to make findings which are agreeable to the interests of the insurance company.[60]

WorkSafe Victoria, which has received negative press due to the release of a critical report by the Victorian Obudsman Deborah Glass in 2015,[61] provides schedule of fees to be paid to IMEs when assessing claims.[62] For GPs the first examination and report costs a maximum of $437.67

54 MRCA s 328.

55 https://www.dva.gov.au/consultation-and-grants/reviews/review-military-compensation-arrangements/implementation-activiti-14

56 http://www.smh.com.au/business/banking-and-finance/life-insurers-accused-of-cherrypicking-medical-advice-to-deny-and-delay-claims-20170406-gvfhex.html

57 Ibid.

58 Ibid.

59 Ibid.

60 Ibid.

61 Ibid.

62 https://www.worksafe.vic.gov.au/health-professionals/fees-and-policies

(GST inclusive), for specialist dentists the cost is a maximum of $661.85 (GST inclusive), for psychiatrists the cost is a maximum of $959.41 (GST inclusive), and for pain management specialists the cost is a maximum of $1510.26 (GST inclusive). As stated earlier, it is unclear exactly how much IMEs are being paid to assess Veteran claimants, but given that some claimants report being passed between multiple IMEs it is clear that the costs being incurred by DVA are substantial. If the use of medico-legal assessments by DVA were minimised and greater trust was placed in the reliability of medical reports from treating specialists, then the costs incurred by DVA in assessing claims from veterans would be greatly reduced.

Whilst there may be a need in some circumstances for an independent medico-legal assessment, in the vast majority of cases DVA should focus on the needs of veterans, and minimise situations where veterans are required to attend multiple medical appointments.

4.11.3 Slater + Gordon Comments

Slater + Gordon agree with the Committee's recommendation that medico-legal firms should undertake training on treating veterans. We further recommend that medico-legal firms should be excluded from the DVA claims process if they cannot demonstrate that they are adequately trained in the complexities of the veteran's statutory compensation schemes.

Slater + Gordon agrees that DVA should favour obtaining reports from the treating specialist as opposed to medico-legal firm reports where possible. The treating specialist has an established relationship of trust with their clients, and in most circumstances can provide a more holistic and accurate view of a veteran's health condition than medico-legal firms. Unfortunately many treating specialists are not prepared to complete the medico-legal reports required by DVA, leaving no alternative but for the department to use the medico-legal firms.

The veteran's own doctor or treating specialist should be worked with when assessing veteran compensation claims. Treating specialists have a clearer picture of a claimant's mental health, and their expertise and experience should be utilised in preference over medico-legal reports when available.

Rather than leaving the review in the hands of DVA, an alternative would be for either the Productivity Commission or the Australian National Audit Office (ANAO) to undertake the task.

This would at least mean that any review would be transparent and open, thereby allaying many of the current concerns within the veteran community.

4.12 **Obtaining Medical Reports**

In regards to obtaining medical reports for clients, there was this discussion at the Senate Foreign Affairs, Defence and Trade References Committee (2 February 2017):[63]

> *Senator KAKOSCHKE-MOORE: I believe you were sitting in on the previous witnesses who were from the Defence Force Welfare Association. They commented that it has taken FOI requests to obtain medical reports for their clients, even just to find out what is happening with a case. Is that news to you or have you heard about FOI requests being used?*
>
> *Mr Briggs: We have to do that as well.*
>
> *Senator KAKOSCHKE-MOORE: You do it as well?*
>
> *Mr Briggs: All the time. One of the first things we do is FOI entire DVA files, pension files and medical records. One of the problems we find is that DVA are issuing decisions referring to medical reports and they do not give you the medical reports. So then we have to FOI DVA, and if you do not get in fast enough they shunt the file off. It is like, 'Oh, we have done our bit, so we will close that file down.' We are told we have to FOI to get a copy of a medical report that has a direct bearing on the decision. You can imagine there is a further delay. It will take a month or two months to get those medical reports so that we can actually look at them and say, 'Well, why have you denied this claim?' And I am not talking just about psychological injuries or PTSD; I am talking about physical injuries as well. There is a delay. That is why I am calling for time periods where they have to do things. Where, in any piece of legislation, can you make a decision about someone's claim and what they are entitled to and refer to medical reports, but not give you the medical report—you have got to go and find that later and then you get into the recon process and drag it out for another six months.*

63 Commonwealth, *Parliamentary Debates*, Senate Foreign Affairs, Defence and References Committee, 2 February 2017, 27-28 (Skye Kakoschke-Moore and Brian Briggs).

Senator KAKOSCHKE-MOORE: DVA, themselves, are advising that you need to FOI that report: 'We're not going to give that to you'?

Mr Briggs: Yes. It is a bit of a lottery, because you will get some delegates—I am not here to totally attack every delegate in DVA, because there are some really good people out there, and we do not have dramas with them. When we get their decision, their medical report is there and we can analyse, advise the client and give them correct advice or say, 'Your claim is good'—or bad or whatever. But then you can get another lottery—it might be another permanent impairment group somewhere else around the country—and they say: 'Oh no, we don't have to give you the medical reports. You'll have to FOI them.' It is a lottery of which DVA department in which city you get to deal with as to how your claim gets dealt with. For example, Brisbane has some of the best delegates in the entire country. I do not want to criticise others, but others are just atrocious, just poor.

Senator KAKOSCHKE-MOORE: So an individual, even though the medical report is about them—they are the one who was interviewed and they told the psychiatrist things they have never told anyone else before—is not entitled, as a matter of course, to get a copy of that report?

Mr Briggs: Psychiatric reports are a very sensitive issue. My practice is not to give a psych client a copy of those reports, because I have seen what happens if they get hold of them. If there is damning information in there, where their credibility is attacked or something like that, they will go and top themselves. We give the report to either the treating GP or the treating psychologist or treating psychiatrist. We advise the client that they have the report and let them sit down with their treating specialist—those medical practitioners— to discuss the contents, because if you give someone a report that has stuff like, 'Oh, it is all due to your upbringing and your mother was depressive; therefore we're going to deny your claim,' there can be tragic results. It is just not done. But reports for physical injuries: we do not get them either, from certain delegates. They will be saying, 'We denied it because it says this in the report'. But you do not get the whole report; they will just put a little paragraph in. And when you actually read the entire

report, it normally ends up on appeal or reconsideration—'Let's drag out the process a bit longer.'

In a submission to an Inquiry into the Mental Health of ADF personnel, I also talked about the issues surrounding the withholding of mental health records from the families of ADF personnel under the Privacy Act:[64]

I would further support the submission made to this enquiry by the Inspector General of the Australian Defence Force regarding the need to address issues surrounding the operation of the *Privacy Act 1988* (Cth).

Protecting the sensitive health records of service personnel must always be of paramount concern to those within the Defence Community. However, I would urge the Committee to investigate the possibility of relaxing the operation of the Act in situations where a serving or ex-service member presents symptoms of mental illness that pose an immediate risk to personal safety.

In such situations, the ADF must have the authority to release certain details of a serviceman or woman's mental health record to their families in order for them to assist in providing support. In this regard, I submit that the Committee must do everything in its power to ensure that families do not have to endure the heartbreak of losing a loved one from a potentially treatable mental illness. I would refer the Committee to the recent tragic case of 27 year-old Navy sailor Stuart Addison, to illustrate the need for change in this area. The story is available at http://m.heraldsun.com.au/news/national/families-of-adf-military-suicides-powerless-against-privacy-act/story-fni0xqrb-1227410023710

4.13 **Siloes of Information**

In response to Recommendation 13 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I also commented the following in regards to siloes of information:[65]

64 Brian Briggs, Submission No 51 to Senate Foreign Affairs, Defence and Trade Committee, *Mental Health of Australian Defence Force Personnel*, 2 July 2015, 21.

4.13.1 Recommendation B: Groups handling all facets of claim

For the DVA to have efficient processing of DVA claims, the 'siloes of information' within the DVA processing system need to be addressed. This must be done by the quick and efficient administration of information. This will be achieved by the digitisation of its records. From this, a single coherent system is required to process and manage claims.

Within this need to streamline the claims process, Slater and Gordon, in concurrence with Mr Arthur Ventham, believe that a single claim process is required for veterans to fill out even if their service cuts across multiple acts.[66]

The complexity of MRCA and the extended investigations into the range of entitlements (Permanent Impairment, Incapacity and Rehabilitation) must be simplified to become less confusing so it is more easily understood by those it is designed to assist, particularly when they are suffering from a mental health condition.

65 Slater & Gordon Lawyers Response to Recommendation 13 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans.*

66 Senate Report, *Suicide Amongst Veterans, A Constant Battle,* [5.45].

5 System governance

Do the governance arrangements for the veterans' support system encourage good decision making — from initial policy development to its administration and review? If not, what changes could be made?

Are incentives sufficiently aligned between agencies, or are there areas of conflict that could be better managed? If there are any incentive problems how can they be resolved?

Is the veterans' support system sufficiently transparent and accountable for both veterans and the community?

What role should ESOs play? Are there systemic areas for improvement in the ESO sector that would enhance veterans' wellbeing?

5.1 The Need for Institutional and Legislative Reform

In my speech to the Senate Foreign Affairs, Defence and Trade References Committee (2 February 2017), I highlighted how the DVA must undergo institutional and legislative reform:[67]

> Second is institutional reform. Institutional reform solutions, including the adoption of previous recommendations to the processes within the relevant government departments, as well as increased accountability as per earlier reviews, must be prioritised. The specific solutions I propose are: that the Department of Defence and DVA publish periodic written assessments of the implementation of review recommendations, the progress of mental health reform and any additional enhancements to current programs; and that the DVA be properly funded to undertake much-needed organisational restructure and reform in the areas of information and communication technology and the claim administration process. We welcome measures outlined on page 4 of the 2015-16 DVA annual report that will see nearly $24 million directed towards improvements to DVA's outdated information technology systems for compensation claims processing, including improvements that will ensure that existing claims processing systems remain

67 Commonwealth, *Parliamentary Debates*, Senate Foreign Affairs, Defence and References Committee, 2 February 2017, 24-25 (Brian Briggs).

> viable and that it becomes easier to submit, track and process claims online, and the veteran-centric reform program and the associated Project Lighthouse, which are aimed at streamlining claims processes through use of an electronic wizard. I welcome these measures and reiterate the importance of adequate funding for this. However, I would point out that the recent trial for automated population of data and an inability to override the same is a complete failure. As a trial, this does not bode well for the IT programs in the future.
>
> Third is legislative reform. To address the deficiencies and difficulties of the system, I propose the following legislative solutions. Parliament must show a willingness for change. As a person at the coalface every day, I believe the current system is failing our veterans. I strongly support the following: amendment of the Repatriation Medical Authority statements of principles to extend or remove the strict time frames and to explicitly provide that they are used as guidelines only. The introduction of time limits for the administration of claims by the DVA to bring the system in line with international and state-based compensation schemes; and the removal of the barriers to access to justice imposed by the restrictions on legal representation and cost recovery for veteran claimants under the new single appeal pathway. I foresee the new single pathway will lead to possible suicides and it will be some time before the true impact of this becomes obvious. I reiterate that our veterans will now be worse off than Commonwealth public servants. Many of the above recommendations require financial support. The public expects government to adequately fund the DVA and associated entities to provide the quality support that veterans deserve. I anticipate the committee will fully endorse this aspect in its review.

In response to Recommendation 12 made by the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I also observed this in relation to the governance arrangements and administrative processes of the DVA:[68]

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68 Slater & Gordon Lawyers Response to Recommendation 12 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

5.1.1 Staffing issues

The Senate Report highlighted that reduced staffing for DVA diminished its ability to fulfil its administrative functions. Further, a lack of continuity in staff when processing claims led to much difficulty for veterans attempting to claim compensation. The quality and training of DVA staff was also identified as a major issue, with many members of staff lacking in an appropriate understanding of military service, and the difficulties suffered by veterans.

5.1.2 Communication

A range of submissions further identified that a lack of clear communication, and a lack of availability of information, was a major administrative issue within the DVA. Many claimants were not given the correct or appropriate information about the support available to them, or how this support could be obtained.[69] Correspondence with DVA was also described by TPI Federation as 'confusing, ambiguous and too legalistic'.

5.1.3 Adversarial approach

The veteran's compensation scheme was created with a beneficial and veteran centric purpose, however many submissions have highlighted that DVA takes an adversarial approach to claims. Claims are often seen as being assessed by DVA 'with a view to avoiding liability, rather than applying the principles underpinning beneficial legislation'.[70]

5.2 The Need for Improved Staff Training

In response to Recommendation 9 made by the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I made the following observations about the training programs of DVA staff and how needs to be addressed:[71]

5.2.1 Current Recommendation

The committee recommends that the Department of Veterans Affairs conduct a review of its training program to ensure relevant staff:

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69 Senate Report, *The Constant Battle: Suicide by Veterans* [5.76].

70 Submission 169, Senate Report, *The Constant Battle: Suicide by Veterans.*

71 Slater & Gordon Lawyers Response to Recommendation 9 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

- Have an understanding of the realities of military service
- Have an understanding of health issues of veterans
- Have appropriate communication skills to engage with clients with mental health conditions; and
- Have sufficient training to interpret medical assessment and reports

5.2.2 Issues with Current System

The overreaching issue with the DVA is the system is confusing and badly administered.[72] This problem with the Department has been of serious concern for many years. Reform has been at a snail's pace. Alongside this reality is a view that many of its employees are unable to effectively communicate with Veterans. We at Slater + Gordon, in our day-to-day dealings with our clients and the Defence community as a whole recognise veterans' frustration with the staff and are often the single point of contact available to them.

The report notes that a predominant concern addressed by Recommendation 9 is the requirement for veterans to attend appointments with a medical practitioner that is not their own treating specialist.[73] Often medico-legal firms have been held to be inappropriate and incapable of adequately dealing with mental health conditions amongst Veterans. On occasion examinations have been terminated when the patient loses control and has an outburst at the appointment. It is clear from many submissions to the Enquiry that there needs to be a change to the assessment methods used by the DVA to ensure the Veterans are able to receive the appropriate care for a variety of health conditions, in particular, mental health conditions.

Of concern is the delay when specialist reports are obtained and pressed onto Department Medical Officials for further review. This review can take months. Further staff will frequently seek supplementary reports and then not accept the findings of treating doctors. This flies in the face of the beneficial nature and underlying theme of the statutory scheme. Staff should be able to interpret medical reports.

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72 Burrows, John, *Suicide by veterans and ex-service personnel - Submission 189.* Available at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Foreign_Affairs_Defence_and_Trade/VeteranSuicide/Submissions

73 *The Constant Battle: Suicide Amongst Veterans* [5.104].

The report states that,

> *Maintaining high client service standards is a constant issue in any department where there is a turnover of staff or where non-ongoing staff are employed. DVA also faces this challenge. Given the concerns raised regarding the conduct and expertise of DVA staff in submissions to the inquiry, the committee considers DVA should re-examine its training programs directed to delegates and those other staff dealing with veterans making claims for compensation and rehabilitation.*[74]

We agree from our experience that many delegates are inadequately trained. We support that a review is necessary but question how the DVA should conduct the review in the light of the significant criticism levelled at the Department and the calls for a Royal Commission into its operation. Many veterans suffering from mental health conditions will be highly suspicious of any findings unless independent parties are involved. Clients will fear that issues with DVA will simply be pushed under the carpet.

5.2.3 Slater + Gordon Comments

- Slater + Gordon emphasise the frustration veterans feel when dealing with the DVA and the inability of the staff to demonstrate an understanding of the realities of service. That is, Slater + Gordon are often relegated with instances of Veterans being unable to communicate with the DVA.
- Slater + Gordon endorse the training program 'goals' set out on Recommendation 9.
- Slater + Gordon commend the recognition of the shortcomings of DVA staff with dealing with clients who often have complex and difficult mental health conditions
- Slater + Gordon recommend these training programs commence as soon as practicable.
- Slater + Gordon support that the National Audit examine the procedures and programs of the DVA as opposed to the DVA examining its own methods.

74 *The Constant Battle: Suicide Amongst Veterans* [5.102].

5.3 **Legislative Constraints inherent in *Budget Savings (Omnibus) Act 2016* (Cth)**

Furthermore, in the submission to the Senate Inquiry into Suicide by Veterans and Ex-Service Personnel, I commented on the constraints imposed by the *Budget Savings (Omnibus) Act 2016* (Cth):[75]

On 15 September the Senate passed the *Budget Savings (Omnibus) Act 2016* (*Omnibus Bill*). Tacked on the end of this raft of cost-cutting measures was the introduction of a single appeal path under the *MRCA*. This was in a form substantially similar to changes rejected following the Inquiry into the Veterans' Affairs Legislation Amendment (2015 Budget Measures) Bill 2015. Despite amendments, many of the issues I raised in my submission to that inquiry still apply and the difficulties now placed on Veterans in the appeals process pose significant constraints for their effective rehabilitation and compensation.

The statement in the Explanatory Memorandum that the amendments have the broad support of the Veteran community is a distortion of the position. While the move to a single appeal path was indeed a recommendation of the 2011 Review into Military Rehabilitation and Compensation Arrangements, the changes made fail to take account of other recommendations made by that Review. The Review recommended that the Veterans' Review Board become a full costs jurisdiction. However, the recent changes maintain the stark imbalance between the DVA and claimants.

DVA uses private sector and in-house lawyers to defeat Veterans' claims, and while there is no limit on their use of lawyers, the Veterans' Review Board (VRB) process expressly disallows legal representation for Veterans. The barriers imposed against the award of costs for a successful Veteran in the Administrative Appeal Tribunal (AAT), means that while Veterans are strictly entitled to legal representation at this stage, this will in practice see many denied that opportunity due to resource constraints.

The procedure provided for internal Military Rehabilitation Compensation Commission (MRCC) initiated review under s 347 is unclear and likely to lead to further delays. This process has no

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75 Brian Briggs, Submission No 160 to to Senate Foreign Affairs, Defence and Trade Committee, Suicide by Veterans and Ex-Service Personnel, 7 October 2016, 34-36.

mechanism by which an applicant can put forward his or her reasons for considering the decision under review to be incorrect. Indeed, in the absence of submissions from the applicant the benefit of such a review is questionable. Unless there is some glaring inaccuracy, the decision is highly unlikely to be revoked or varied.

The amendments, including the ability for the AAT to remit a matter back to the MRCC, leads to an absurd situation in which a single matter could be reviewed on six occasions – initially by the MRCC, by the MRCC again under s 347, by the VRB, by the AAT, by the MRCC on remittance and finally by the AAT again. The suggestion that these amendments simplify and streamline the appeals process is simply wrong. In addition to the matters outlined above, the amendments will see a large increase in the workload of the VRB. The Review of Military Compensation and Rehabilitation Arrangements in 2011 indicated that VRB matters were taking 418 days to resolve.

I refer to Minister Tehan's press release on 22 September 2016.

With the greatest respect, I find the attempt to justify the amendment which was slipped into the tail end of the *Omnibus Bill* by referring to Veterans not needing the assistance of lawyers to be offensive.

The Minister seems to be more focused on attacking lawyers than the significant impact the single pathway and the restrictions on recovery of costs in the AAT will have on those people who will be fighting to overturn liability and permanent impairment decisions. My estimate would be that are between 5 and 10 law firms that practice in this area.

It appears that the Minister and DVA are intent on demonising lawyers and suggesting that the Veterans pay for our services on reconsideration and appeals before the AAT. However, in reality the majority of the legal costs are recovered from DVA if the outcome is successful.
The single pathway will now result in the Veteran paying their legal costs and the costs of medical reports out of their own pockets.

The Minister fails to address the concerns of many who have raised the issue of recovery of legal costs. It will be extremely difficult for a Veteran to recover any costs if the following occurs:

- The claimant supplies additional documentation for consideration to the AAT;
- The claimant does not appear at the VRB review hearing; or
- The Tribunal elects to remit the matter under review to the Commission, under proposed subsection 354(1C).

I note that it is the lawyers who practise in this jurisdiction who have been to AAT, Federal Court and High Court appeals that have set precedents in increasing the compensation and benefits for Veterans and not the DVA. I ran the case of *Fellowes* in the High Court which resulted in a Veteran receiving the right to two separate lump sum payments for two separate knee injuries. Without Slater and Gordon Lawyers being willing to conduct this case on a 'no win no fee' basis, this case would have never have been litigated in the High Court. It would appear that the Department does not wish to have such scrutiny of their failures and poor decisions.

DVA should be held accountable for their errors and that is why access to lawyers should not be denied to Veterans. No doubt the Minister and the Department will argue that a Veteran's right to a lawyer remains. The Veteran's right does remain where they are able to meet the legal expenses incurred however any reference made to a Veteran obtaining legal aid is a furphy. Instead of attacking lawyers, the DVA needs to address the failures of their organisation and the system as a whole and not just the injustice of the decisions that are made on a daily basis. I note the Minister in his press release failed to state how much the Department spends on external lawyers fighting Veterans' claims. I refer to the submissions of Mr Greg Isolani (KCI Lawyers) previously made concerning this amendment and the 2014-2015 Annual Report of the DVA.

Costs incurred for external legal services (ELS) in 2014-2015 totaled $7.225m; an increase from $6.244m in 2013-2014 and $5.6m in 2012-2013 whereas costs incurred for internal legal services (ILS) totaled $2.82m in 2014-2015; decreasing from $3.18m in 2013-2014 and $3.4m in 2012-2013. Despite the decrease in ILS, the DVA reported total legal services expenditure (Total LSE) of $10.044m in 2014-2015; an increase from $9.429m in 2013-2014 and $9.01m in 2012-2013.

We note that this amount exceeds the applicable inflation rate from 2012-2013 to 2014-2015 even if this is taken into account. See Figure 5.3.1.

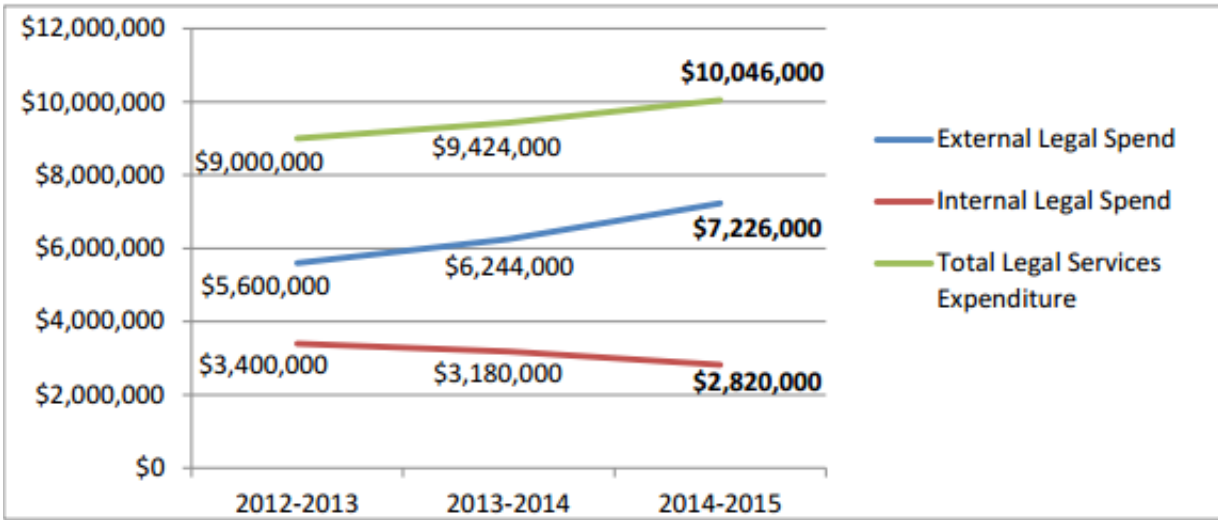

Figure 5.3.1. Graph of Legal Expenditure by DVA

The *Omnibus Bill* w ıre. Veterans should not have been caught up in this process. It is clear to see that the DVA is reducing their fleet of in-house lawyers (Internal Legal Expenditure) and farming out their legal services expenditure (External Legal Services Expenditure) through the use of expensive private law firms in order to defend against the claims of Veterans.

The Minister's reference to 85 per cent of applications being finalised in two months by alternative dispute resolution is misleading and deceptive. I would invite the Minister to particularise these figures and detail exactly which claims constitute this figure. My suspicion is that many of these claims, if not the majority, will be for minor issues in dispute. I note that the Alternative Dispute Resolution model has only been trialed in NSW on a limited rollout and has

not been finalised. From my experience and from the Department's own figures the delays and backlogs in the VRB are years long. Frankly, I question how the Minister could come up with a figure such as this.

The Minister refers to a Veteran using an ex-service organisation for representation in the VRB. However, I note that there are fewer and fewer advocates available to assist as more are retiring and fewer are becoming involved in this area (See previous submissions to the Mental Health Inquiry on this).

5.4 The MRCC having Self-Regulating Power

In a submission to the Inquiry into the Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016, I raised the issue of the MRCC having self-regulating power:[76]

The absolute power that the MRCC have in military compensation will only be more entrenched with the passing of this Bill. With no safeguards in place there will be nothing to stop the MRCC from preparing, amending, varying or revoking the Guide to the Assessment of the Degree of Permanent Impairment ('the Comcare Guide') and thereafter riding roughshod over entitlements. Simply, this will mean a worse deal for ex-service members and veterans.

5.4.1 The Henry VIII Clause and the Problems of Executive Legislative Power

The unfettered power that the Act confers is encapsulated in the Henry VIII clause mentioned in the Explanatory Memorandum (s121B). A Henry VIII clause delegates legislative power to a person who makes regulations, effectively permitting them to modify the application of a primary statute. As long as Parliament is to retain the right to repeal or amend the primary statute, this will not be held to be unconstitutional. Section 121B will be unconstitutional if the new regulation making power abrogates Parliament's ability to amend the DRCA itself. If the DRCA is meant to be a simple duplication of the SRCA it begs the question as to why this specific clause, which is not present in the SRCA, was inserted into this Act. This clause does not make the Act a duplication, rather it is a substantive alteration to existing law. The granting of legislative power to the Minister to modify the operation of the Act is an unacceptable instance of unrestrained power being placed in the hands of a single department or individual.

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76 Brian Briggs, Submission No 4 to Senate Foreign Affairs, Defence and Trade Committee, *Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016*, 24 February 2017, 9.

5.5 Australian Public Service Commission (APSC) Review 2013

In a submission to the Senate Inquiry into Suicide by Veterans and Ex-Service Personnel, I said this in regards to the APSC capability review of the DVA:[77]

5.5.1 DVA Capability Review

The results of the 2013 APSC review uncovered concerning practices within the DVA chiefly relating to its operating structure, governance arrangements, ICT systems, and its approach to clients and DVA culture.

A range of recommendations were made by the APSC to remedy the identified issues. DVA Secretary Simon Lewis at the time accepted the findings of the review, recognising that the Department 'faced numerous challenges'. Mr Lewis noted that the DVA needed to take a fresh look at the foundations of its business and its operating and delivery models.

In October 2015, the then Minister for Veterans' Affairs, Mr Stuart Robert declared his intention to transform the services available to Veterans and their families under the DVA from being 'claims focused' to 'people focused'. He announced that the Department's priorities would be to:

- streamline the claims process;
- upgrade and integrate IT systems;
- improve the transition processes for personnel leaving military service;
- provide vocational rehabilitation options to assist those who are unable to return to the workforce; and
- ensure the ongoing availability of mental health resources and treatment available to Veterans.

It is worrying to see the Minister similarly pledging reform two years after the Secretary of the DVA. The only implication to be drawn is that despite the Secretary's announcement in 2013, and the Minister's pledge in 2015, minimal progress has been made by the Department. The constant talk of reform within the DVA coupled with the lack of action taken by those

77 Brian Briggs, Submission No 160 to to Senate Foreign Affairs, Defence and Trade Committee, Suicide by Veterans and Ex-Service Personnel, 7 October 2016, 28-29.

responsible leaves little hope that both the Secretary and the Minister's claims were anything more than another hollow promise proffered by the DVA.

DVA's deficiencies are well-known and well-accepted. However, this has not led to any progress of reform within the DVA. Indeed, the Mental Health Committee made several recommendations to the Government following the Mental Health Inquiry; the bulk of which were not fully accepted.

Concerning the much lamented archaic Information Communication Technology (ICT) systems of the DVA, the Committee recommended that DVA "be adequately funded to achieve a full digitisation of its records and modernisation of its ICT systems by 2020, including the introduction of a single coherent system to process and manage claims."

Although the Government agreed in principle with the Committee's recommendations, no commitment has been forthcoming. The Government noted that funds had been designated in the 2016/17 Federal Budget to design a transformation program to facilitate Veteran centric reform. The program was conceived to improve customer service for Veterans underpinned by better processes and technology. However, no accompanying timeframe has been provided for implementation of that program.

The Veteran and Defence Force community continues to wait for any meaningful reform to occur within the DVA.

To quote an extract from the APSC Capability Review:

> "In the absence of a single client number or reference point, it is impossible for staff to see the full range of services that may be given to, or purchased for an individual at any one point in time. This somewhat ironic given the commitment of individual staff to their clients … A siloed and rules-bound culture means that opportunities for improvement are lost, agility is forsaken, risks are exaggerated in the absence of a broader perspective and motivation to support Veterans and their families is hard to sustain."

5.6 **DVA Client Survey**

Also in the submission to the Senate Inquiry into Suicide by Veterans and Ex-Service Personnel, I drew attention to the 2014 DVA Client Survey:[78]

5.6.1 DVA Client Survey 2014

In 2014, the DVA conducted a survey of 3,073 DVA clients across Australia. The purpose of this survey was to seek feedback from their clients to improve the quality of service available to Veterans and their families. From this survey, the DVA identified areas for improvement including:

- the usability of its website;
- use of email in responding to clients;
- response to feedback from DVA clients; and
- the DVA's timeliness in processing requests for services and benefits for their clients

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The survey suggests that 89 per cent of clients surveyed were 'satisfied' or 'very satisfied' with the level of service that DVA provides and that 90 per cent of respondents agreed that DVA is committed to providing high-quality service to its clients. From my experience dealing with clients, I am of the view that the DVA's survey is defective in scope. The survey does not document the quality or quantity of the range of services provided to DVA clients. It is important to note that these services may range from simple claims for reimbursement of medical or travel expenses to which DVA respond quickly, to more complex total impairment claims likely to be defended by DVA and which can take many years to be resolved.

Veteran Angus Sim conducted surveys in 2015 and 2016 to test the veracity of the DVA's 2014 survey. Mr Sim said that his 2015 survey found a 95 per cent dissatisfaction rate amongst DVA clients despite the DVA's supposed 90 per cent satisfaction rate with DVA clients. The veracity of the DVA's claim to a 90 per cent satisfaction rate is hard to comprehend in light of the survey results produced by Mr Sim. Further, in light of the overwhelming anecdotal evidence, the DVA's results do not seem to reflect the reality that Veterans and their families are facing. Mr

78 Ibid 29-30.

Sim said that the DVA's administration of the compensation scheme 'needs to be overhauled, stripped back and rebooted' and that it is 'a joke that is killing Veterans.'

The results of the 2016 satisfaction survey reinforced that things have only gotten worse for the Departments despite the attempt to paint things over, wearing rose coloured glasses. My biggest concern is how these veterans under 45 perceived DVA. The executive summary records that there has been a 6% drop in satisfaction since 2015. And only 49% of veterans under 45 are satisfied with the Department.[79]

5.7 Issues with ESOs

In a submission by the RSL Queensland Branch to DVA's Inaugural Legislative Workshop 2017, RSL Queensland raised issues regarding DVA and ESOs. To assist the Commission, I have extracted the relevant points that should be considered. I acknowledge and credit the RSL QLD branch for their contributions:[80]

5.7.1 ISSUE- ESO Training

DVA has worked for many years in partnership with ESOs. I t has long been recognised by DVA that ESOs provide a valuable link into the community and are able to provide excellent assistance to members and former members of the ADF when lodging claims with DVA. The TIP training which was funded by DVA was found wanting via various reviews in relation to the quality of the training provided and hence the quality of the advice being provided by ESOs. The new ATDP initiative is excellent as a concept but it is failing due to lack of appropriate funding and a serious lack of direction. ATDP is placing a huge burden on volunteers to manage a very complex process and it is running the risk of losing the support of all ESOs. DVA does not have the resources to meet the needs of regional clients (in fact it is in the process of closing VAN offices). On-line claiming does not fill the gap. There is still a need for injured and ill members

79 Department of Veterans' Affairs & Orima Research, Department of Veterans' Affairs 2016 Client Survey Satisfaction Survey Results Summary (May 2017). https://www.dva.gov.au/sites/default/files/files/consultation%20and%20grants/2016%20Results%20Summary.PDF

80 Queensland Branch of Returned and Services League of Australia, Submission to Department of Veterans' Affairs, *Inaugural Legislation Workshop*, 27 October 2017.

and former members to get expert personalised assistance to work through the claims process and to understand where it is appropriate to request the review of a decision.

5.7.2 SUGGESTION

There is a desperate need for ATDP to be managed by full time paid professionals (which can only be done by DVA). DVA also needs to make a commitment to an adequate IT system to facilitate the training process. They also need to explain the training process to the volunteers.

5.7.3 ISSUE- Failure by DVA to inform ESOs of Policy and Procedural Changes

When there is a change of policy or procedure within the DVA a Businessline is issued which identifies the change. The relevant updates are then made in CLIK to reflect those changes. However, in recent years DVA has persistently refused to include ESOs into the distribution of Businessline that are relevant to claims processing. This means that ESOs are totally unaware of changes unless they have some other internal source of information. This is a ridiculous situation. DVA still entrusts ESOs to provide information to clients, but they refuse to ensure that there is ESO access to current information. Despite numerous requests DVA has declined to change this situation.

5.7.4 SUGGESTION

It would be easy and appropriate for the Businessline to be posted on the ATDP website. Interested parties could then be made aware of changes in a timely and consistent way. It is understood that DVA cannot have a direct line of communication with every ESO.

5.7.5 ISSUE- Poor Communication and Reduced Reliance on Trained ESO Representatives

There were previous agreements with DVA that, when a client has a nominated representative, any communication regarding the claim would go through that representative. This agreement is not being adhered to and DVA contacts the client directly by phone- even to ask complex questions of fact regarding the claim. Clients make their claims through representatives for a reason- mainly because they don't feel confident in dealing with complex issues themselves. Having DVA contact them directly often causes them significant concern.

5.7.6 SUGGESTION

DVA re-issue a protocol statement re dealing with clients who have representatives. This protocol is to be developed in consultation with ESOs and to ensure that the first point of contact is through the nominated representative.

6 The role of the Australian Defence Force — minimising risk

What obligations should be placed on the ADF and individual unit commanders to prevent service-related injuries and record incidents and injuries when they occur? To what extent do cultural or other issues create a barrier within the ADF to injury prevention or record-keeping?

The ADF is not financially accountable for the cost of compensation or for the cost of treating service-related injuries and illnesses after a veteran leaves the ADF. Is this a barrier to the ADF having an adequate focus on preventing injury and illnesses and providing early intervention and rehabilitation support? If so, how might this be remedied?

6.1 Recordkeeping, Inaccurate Claims Files and Mismanagement of Claims by the ADF

I also spoke about recordkeeping, inaccurate claims files and mismanagement of claims in a submission to an Inquiry into Mental Health of ADF Personnel:[81]

I commend to the Committee the 2010 ADF Mental Health Prevalence and Wellbeing Study. I note that it was hailed as the first comprehensive investigation of the serving ADF population. Of note is that the Study had almost half of the Australian Defence Force participate.

It was to be the foundation of a strategy for evaluating mental health interventions and services. I question what has become of the findings and how and to what extent they have been implemented.

To interpret rates of mental disorder in the ADF the study accessed mental health data from the Australian Bureau of Statistics (ABS). Community data was then matched to the demographic characteristics of the ADF Population.

The executive report stated that the estimated prevalence of mental disorders in the ADF over a 12 month period was of the same magnitude as that of the general community. However, the study was looking at all mental disorders and was not confined to the prevalence of PTSD alone.

81 Brian Briggs, Submission No 51 to Senate Foreign Affairs, Defence and Trade Committee, *Mental Health of Australian Defence Force Personnel*, 2 July 2015, 7-10.

American and British findings, meanwhile, have confirmed a significantly higher number of PTSD sufferers amongst returning ADF personnel.

The results of the ADF's 2010 survey suggested that one in five or 20% of the ADF population had experienced as mental disorder in the previous 12 months, which was a similar rate to that of a community sample matched for age, gender and employment from a 2007 National survey undertaken by the ABS.

The study, however, found that half of the ADF had experienced an anxiety, an affective or alcohol disorder at some stage in their life, which was significantly higher than the matching community rate.

I have serious doubts about the accuracy of such reports.

I base this on my experience in dealing with claims from my clients. It is widely understood that ADF personnel will not report mental health injuries for the following reasons:

(1) There is a perceived stigma with reporting mental health issues. Members remain of the view that they would be treated differently if they sought care and that seeking care would harm their career.
(2) Serving members do not wish to jeopardise their ongoing employment or future chances of deployment, promotion or career opportunities.
(3) Complaining of health problems is somehow letting down their mates and not being part of the team
(4) If time off work is needed they will be isolated, demoted, downgraded or given less meaningful jobs.
(5) An anti-reporting ethic of keeping silent, not being seen to be whinging, working in an environment of strong peer group pressure where members are expected to be strong and stoic despite living in the face of pain and emotional stress.
(6) A culture has been created where to seek help is an admission of weakness.

6.2 Inaccurate claims files and mismanagement of claims*:*

Clients regularly report that their medical and psychiatric records have information missing from them. We confirm that some of the files provided by my clients have many documents that do not appear on the official files that are used and forwarded to or by the DVA and the Department of Defence (DoD). It is difficult to comprehend all of the reasons for this problem. The conspiracy theories abound that certain documents are being deliberately lost or misplaced as a means to facilitate the frustration or denial of injury of illness claims. An alternative view is simply that the filing and claims systems are not being managed competently or diligently.

6.3 Case studies*:*

As one of my clients said of the handling of PTSD in and by the ADF:

> "I was belittled by my peers (for suffering PTSD). I was continually told to "harden up" and "to stop being a sook." This type of abusive culture was and still is common throughout the Australian Defence Force (ADF) and had a significant effect on me, to the extent of causing me to leave the ADF. I felt my only option was to stop seeking help due to embarrassment, so I began to bottle it up with the intent of never speaking about it again."

Another of my clients summarised his treatment by the ADF as follows:

> "A number of situations during my service after my diagnosis caused greater aggravation and deterioration of my injuries. These included:
>
> - Being ostracised by certain members of my chain of command and publicly humiliated in regards to having my condition.
> - Being forced into full work and even part time hours when I was unfit due to my worsening condition, which I had made clear.
> - Being placed on excessive guard duties (by the same certain members of my chain of command) even though I explained sleep was already difficult and I was under immense stress and anxiety. In this situation my interruption of sleep and being in this environment made me far worse resulting in significant symptoms.

- Being forced (by same certain members) to participate in training exercises on base around weaponry and infantry tactics despite worsening my condition.
- Being forced to work in the unit bar/café/shop, serving large numbers of people under pressure and around alcohol even though I had a problem with alcohol and being around people was very difficult.
- Being treated like a malingerer or worthless causing my already low self-esteem and self- worth to be worsened, contributing to multiple suicide attempts and permanent scarring resulted from these attempts."

I note the former Chief of the Army, Lieutenant General Peter Leahy, told the House of Representatives Committee in November 2012 that the ADF did not have a handle on psychological wounding, and that exact numbers were unknown. At that time he was of the view that PTSD was not a disorder and had based his opinion on journals and documents that argued it was a largely neurological reaction.

It would seem that opinion has since changed in the eyes of the ADF, but reports of these views sends confusing messages to both sufferers and the general public.

6.3.1 Aaron Gray

Aaron Gray deserves to be highly commended for initiating the Veterans' Suicide Register and his dedication commands respect. However, the task of recording instances of suicide amongst the post-service community should never have been the responsibility of an ex-Veteran to perform using social media.

The issue of record keeping has been a sore point for some years with the Veteran community. Defence has taken a stance in the past that it is not for them to record suicides following discharge. Similarly the DVA kept no figures on suicides of past servicemen and women. If an ex-Veteran not under umbrella of the DVA took their own life it was, up until recently, unrecorded. In recent years Facebook, through the Veterans' Suicide Register started by ex-serviceman Aaron Gray, has become the unexpected leader in this field. This is not the answer and I would submit, is an unacceptable means of record keeping given the needs of veterans and their families.

We welcome the "Transition and Wellbeing Research Programme" survey recently announced by Senator Ronaldson. However, I would question why such a comprehensive study has taken so long when the precedent had already been set by the 2010 Report. The Department of Veterans' Affairs seems to continually be reacting to pressures from the public and the Defence community rather than being proactive in this area and addressing very serious problems. The equivalent UK and US Departments are much further advanced in their response to these problems compared to Australia, even though we have been involved in many of the same conflicts over the past several decades.

We refer the Committee to the frequent summaries published by the UK Ministry of Defence, which have been compiling figures on the UK Armed Forces from at least the year 2000. Our own DVA should be taking guidance from these reports.

As at October, 2012 – Townville's Mater Hospital PTSD program reported admitting for care up to 24 soldiers each year, despite fears many more had not sought assistance. I am unable to provide the Committee with updated records from the hospital but I would anticipate that such information would be readily available to the Committee upon request.

I support the call from the Australian Defence Association for a Commonwealth-funded compulsory medical examination. However, I anticipate that making the examination compulsory will meet with resistance from ex-Veterans. After discharge, many of my clients only wish to distance themselves from the DoD, ADF and the DVA. Forcing them to attend appointments may not be the right solution to plug the current gap in reporting.

What is obvious from the findings from the US experience is that any assessment of the societal impact of a disorder must begin with a consideration of prevalence. Sadly Australia seems to be playing catch up with the recording of mental disorders, PTSD and suicide in the Veteran/ex-Veteran community. Various organisations have suggested various solutions but my thoughts are that a starting point should be the US findings contained in *The Invisible Wounds of War*. This report represents the most comprehensive study that I have been able to locate, mapping a path we should be following in our own reporting of mental health issues amongst serving and ex-serving Defence personnel.

To quote the report "unlike previous conflicts, such as the Vietnam War or Gulf War, on which prevalence studies were generally conducted years after service members returned home, in the current conflicts epidemiologic studies are being conducted throughout the course of the deployment cycle – i.e., a week before being deployed, while troops are in the theatre, and immediately upon their return. Comparisons of prevalence rates obtained across theses assessments may provide unique insights into mental health and cognitive conditions in the military in general and how the experience of these conditions may be related to deployment."

Suggested possible solutions to our current problems include:

(1) Annual mental health surveys conducted via a GP or Allied Health service, both during a member's service and regularly thereafter – see Submission 1 of *Invisible Wounds of War*.
(2) A community-based co-ordinated approach to gathering a sharing information – proposed by Soldier On CEO John Bale.
(3) Participation in the Australia Veterans Suicide Register.
(4) A Commonwealth-funded compulsory medical examination – suggested by the Australian Defence Association.
(5) Better pre-screening of recruits for physical and mental health issues.
(6) Organising a National forum and formation of a peak recording body for the prevalence of mental health issues amongst the Defence and ex-service community.
(7) Creation of a National network of drop in centres where recording could be undertaken and entered into a comprehensive National database system.

The starting Point to Accurate Reporting should come from the DVA, as it would have the most complete details due to their receipt of funding requests by various representative organisations in the field.

7 Providing financial compensation for an impairment

Is the package of compensation received by veterans adequate, fair and efficient? If not, where are the key shortcomings, and how should these be addressed?

Is access to compensation benefits fair and timely? In particular, are there challenges associated with the requirements in the MRCA and DRCA that impairments be permanent and stable to receive permanent impairment compensation? How could these provisions be improved?

Is there scope to better align the compensation received under the VEA, MRCA and DRCA? In particular, could the provisions for permanent impairment compensation and incapacity payments in the MRCA and DRCA be made consistent?

Are there complications caused by the interaction of compensation with military superannuation? How could these be addressed?

What is the rationale for different levels of compensation to veterans with different types of service in the MRCA? Should these differences continue?

For those veterans who receive compensation, are there adequate incentives to rehabilitate or return to work? Are there examples of other compensation schemes that provide support for injured workers and successfully create incentives to rehabilitate or return to work?

7.1 Methodology of Permanent Impairment Assessments

In talking about the offsetting methodology used by MRCA/SRCA when assessing permanent impairment, I commented in a submission to DVA's Inaugural Legislation Workshop in 2017 that[82]:

I would submit that any legislation improvements need to examine the methodology used by the DVA (as per the GARP M) when 'bringing across' SRCA points to MRCA permanent impairment assessments. Since its inception in July 2013, we have seen frequent examples of injustice caused by the methodology impacting on decisions. As it has retrospective application, an applicant's previous assessment can be revisited in a new claim or if a reassessment is submitted.

This has arisen from the general complexity of having potentially three acts cover a person's injuries (SRCA/DRCA, VEA and MRCA) - however, I would suggest that care should be taken with combining the legislation and I am certainly not encouraging an amalgamation of the new DRCA into the MRCA with the restrictive SoP's or less favourable GARP M guides to assessment of injuries.

7.1.1 The Methodology

Under the old method, the MRCC would subtract the actual amount received under SRCA or VEA from the MRCA nominal amount.

Under the new method, the MRCC will subtract the amount which would or could be payable under the MRCA (a "notional amount") for the SRCA/DRCA or VEA conditions from the MRCA compensation amount.

82 Brian Briggs, Submission to Department of Veterans' Affairs*, Inaugural Legislation Workshop*, 27 October 2017, 16-17.

The new methodology impacts on all MRCA permanent impairment decisions where the client has claims under the MRCA and SRCA/DRVA/VEA. This makes decisions quite complex and difficult to comprehend.

On several matters in instances where a client has received compensation prior to 1 July 2013, we have received "reassessment" letters from MRCC when we have lodged new claims or P.I. reassessment applications. On occasions, while we wait for the new claim or reassessment to be determined, MRCC would re-examine the file and apply the new methodology to the previous P.I. assessment. DVA will deduct the "notional" amount, rather than the actual amount, and come up with a new weekly entitlement.

In certain matters we have noted that this will result in the client being assessed as having a lower weekly entitlement. Whilst this has no immediate impact as DVA will not seem to recover any money previously paid, we have found that when new claims are accepted and we proceed to P.I. or when the reassessment claim is determined, many of the clients will have no entitlement to further compensation, as the client needs to get the weekly amount back up to the previous amount and then to exceed it. This represents how the new methodology prejudices and disadvantages those who may have suffered more injuries, diseases, or conditions as a result of their service.

We are also often seeing conflict between MRCA and SRCA/DRCA assessments of the same injury where the MRCA notional assessment greatly exceeds the SRCA assessment actually paid. Indeed, 'notional' points can be included of a SRCA/DRCA injury in a MRCA assessment, in cases where SRCA/DRCA compensation will never actually be payable. A good example of this is compensation for tinnitus.

Often, the ultimate outcome is less money in the hand for the MRCA claimant.

7.2 Lifestyle Effects Criteria under GARP and GARP (M)

The RSL Queensland Branch, in their submission to the DVA'S legislative Workshop 2017, raised the issue of the lifestyle effects criteria under GARP and GARP (M):[83]

7.2.1 Areas of Contention

Chapter 22 of GARP and GARP (M) provide for the assessment of lifestyle effects for accepted conditions.

There are three options provided for the assessment of lifestyle effects-

1. The veteran self assess via form D2670
2. DVA delegate allocates a lifestyle rating. "This should not be less than the higher of the ratings contained in the shaded area of Table 23.1 of Chapter 23
3. The veteran completes a lifestyle questionnaire form (D2669) and the delegate allocates a lifestyle from the answers.

There have been few changes to the Lifestyle Effects criteria since GARP was first developed in 1986. The criteria were developed predominantly for WW2 veterans. They do not have a great deal of relevance for our younger veterans who are being assessed under GARP (M). For example, asking a 25 year old about their ability to undertake gardening, playing cards or knitting is not necessarily establishing the true extent of the effect of accepted conditions on their lifestyle.

7.2.2 Pain Points

In some instances, claimants either under assess- they do not adequately identify the limitations on their lifestyle- or they over asses or exaggerate their lifestyle limitations. However, in a clear majority of cases the lifestyle fits neatly within the shaded area of Chapter 23, table 23.1. The pain comes when a claimant is seeking a lifestyle outside of the shaded area. This involves going through an appeal process, which usually takes a long period of time and usually is for little pension variation or gain to the claimant.

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83 Queensland Branch of Returned and Services League of Australia, Submission to Department of Veterans' Affairs*, Inaugural Legislation Workshop*, 27 October 2017.

This proposal is that the Lifestyle process only be retained for those who are seeking Extreme Disablement Adjustment (EDA). In all other instances the assessment should only rely on the higher option of the shaded area (Table 23.1) This will save time and confusion with the process. It will also save expense in relation to appeals. Over time there will be no further veterans who meet the VEA requirements for EDA and then lifestyle as it applies to MRCA can be completely removed from the assessment process.

Legislation

Legislative change would involve a change to Chapter 22 of GARP which could clearly identify that what is currently Option 2 is the only available option except when the claimant is seeking EDA. The requirements would remain the same as identified in s22 of the VEA for EDA.

MRCA assessments could also rely on the top of the shaded area. There is no reliance on Lifestyle for SRDP or for maximum compensation s20. Reference to Lifestyle would need to be amended in s74.

7.3 The 'Alone' test as applied in s24 of the *Veterans Entitlements Act 1986* (Cth)

In their submission to the DVA's Legislative Workshop 2017, RSL Queensland Branch raised the issue of the 'alone' test under s24 of the VEA:[84]

Subsection 24(c) provides that it must be the veteran's war-caused injury or war-caused disease, or both, alone, preventing the veteran from continuing to undertake remunerative work that the veterans 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.

7.3.1 Area of Contention

The meaning of the word 'alone' has been considered in many courts.

84 Ibid.

The RSL queries the application of this 'alone' provision when a veteran has injuries or diseases which have been accepted under MRCA and/or SRCA, in addition to conditions accepted under the VEA. A veteran who has multiple accepted conditions because of a long career in the ADF can be precluded from Special Rate considerations because some conditions have been accepted under another legislation and hence the 'alone' test in the VEA is not satisfied.

7.3.2 Pain Points

There are instances where some veterans are seriously disadvantaged by this provision. They may be prevented from working due to their injuries, cannot qualify for the Special Rate under the VEA, but equally cannot qualify for incapacity payments under SRCA/MRCA because the conditions accepted under those Acts may not be conditions which predominantly prevent the person from working.

This proposal suggests that a veteran who is no longer able to work because of service related incapacity should not be disadvantaged just because their service spans a number of complex legislative rules. The proposal notes the appropriate offsetting should occur to ensure there is no 'double' dipping' but importantly, there should be no disadvantage to a career veteran.

7.3.3 Legislation

It is accepted that the changes to legislation may be quite complex, however, the issue this situation is causing should be acknowledged and rectified.

8 Helping people to transition from the ADF

Are transition and rehabilitation services meeting the needs of veterans and their families? Are veterans getting access to the services they need when they need them? What could be done to improve the timeliness of transition and rehabilitation services, and the coordination of services? What changes could be made to make it easier for ADF personnel to transition to civilian life and to find civilian employment that matches their skills and potential?

Veterans who are medically discharged are generally in higher needs categories than people who access other rehabilitation and compensation schemes, and have exhausted options for return to work in the ADF. How should this be reflected in the design of rehabilitation services for veterans?

How should the effectiveness of transition and rehabilitation services be measured? What evidence is currently available on the effectiveness of transition and rehabilitation services? How can the service system be improved?

In some countries, rehabilitation services are provided to the families of severely injured and deceased veterans. Is there a rationale for providing such services in Australia? If so, what evidence is there on the effectiveness of these services?

8.1 The Transition Phase

At the Senate Committee on Foreign Affairs, Defence and Trade References (2 February 2017), I highlighted the issues surrounding the transition phase between military service and civilian life:[85]

> As the committee is already well aware, the transition from military to civilian life is a challenging but crucial time. I welcome increased focus from DVA on helping Defence Force members to navigate this difficult period. An important step in this transition phase is rehabilitation and the employment programs offered by DVA and Defence. There are

85 Commonwealth, *Parliamentary Debates*, Senate Foreign Affairs, Defence and References Committee, 2 February 2017, 27-28 (Brian Briggs).

serious concerns about the rehabilitation programs currently administered by Defence and DVA. An Australian National Audit Office audit found in 2013-14 that the return-to-work rate for veterans is significantly lower than the national average: 54 per cent and 55 per cent for DVA and Australian Defence Force respectively, compared with a 77 per cent average for the general public. For DVA rehabilitation clients this coincided with a significant decline in the rate of transition to civilian work, from 66 per cent for the general public down to 48 per cent. Despite rehabilitation services being a core business for DVA, there is no comprehensive data available to indicate whether rehab services are effectively meeting the needs of veterans. The solution is to improve rehabilitation programs and record whether they are making a real difference. I note the following from the 2015-16 annual report. DVA have stated that they are:

> … working together to implement an early engagement model which will allow DVA to make contact with ADF members at appropriate times during their careers, to ensure that they are aware of the care, services and support available and to help us provide a smooth transition …

The report stated that as at January this year DVA would know and connect with all transitioning members. I query if this has actually occurred. The report goes on:

> DVA has also trialled a program called the Veterans' Employment Assistance Initiative, which aims to improve the rehabilitation process and provide employment opportunities to recovering veterans who are able to return to work. The initiative was trialled in South Australia and Victoria and involved conducting early assessments of vocational rehabilitation needs and aligning ADF skills and experience with civilian employment. It enhanced vocational rehabilitation within our whole-of-person rehabilitation programs and identified opportunities for the Department to better support clients, employers and rehabilitation service providers. Evaluation of the trial will lead to recommendations for a national approach to improving the rehabilitation process.

As DVA notes:

> The benefits of employment in the prevention and management of mental health conditions are widely recognised.
>
> DVA believes:
>
> > Improvements will help clients become job-ready and increase their likelihood of obtaining sustainable civilian work post discharge.
>
> I welcome the government announcement on forming the Industry Advisory Committee on Veterans' Employment. It is a positive step to recognise those businesses through annual awards. As the committee is aware, suicide prevention and meaningful employment are closely entwined.

In my submission to a Senate Inquiry into Suicide by Veterans and Ex-Service Personnel, I observed in relation to the DVA's and ADF's efforts in transitioning veterans into civilian work:[86]

The ANAO [Australian National Audit Office] audit [2016] found that the return to work rate is significantly lower than the national benchmark—54 per cent for DVA and 55 per cent for the ADF, compared with the Australian average of 77 per cent in 2013–14. There has also been a significant decline in the rate of transition to civilian work for Veterans' Affairs rehabilitation clients from 66 per cent to 48 per cent over the same period. The performance measurement framework for the ADF Rehabilitation Program is poorly developed and does not measure performance against all key indicators.

86 Brian Briggs, Submission No 160 to to Senate Foreign Affairs, Defence and Trade Committee, Suicide by Veterans and Ex-Service Personnel, 7 October 2016, 37.

8.2 Transition Taskforce

In response to Recommendation 14 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I said in regards to the Transition Taskforce:[87]

The 'Transition Taskforce' was established in the last election. The Transition Taskforce is comprised of DVA, Defence and Commonwealth Superannuation Corporation representatives. The Transition Taskforce was intended to 'identify barriers to effective transition and suggests actions to address those barriers'. The Government response noted:

> A variety of activities are being undertaken including workshops and interviews with current and former serving ADF members, and representatives of other organisations external to government that provide services or support during transition. The Transition Taskforce is also being informed by the work of AIHW and their analysis of suicide among the serving and ex-serving ADF personnel, which provides a strong evidence base from which we can target our efforts to those most at risk.[88]

8.2.1 Focus:

8.2.1.1 Discharge with Documentation

- Central to the work undertaken by the taskforce is the 'Discharge with Documentation' Policy. This proposal will replace the current system where defence force personnel can leave the Defence Forces without the necessary documents that they need to claim benefits from other government agencies, including the Department of Veterans' Affairs.[89]

87 Slater & Gordon Lawyers Response to Recommendation 14 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

88 Government response to NMHC report, pp 39-40.

89 Access: https://www.liberal.org.au/coalitions-policy-support-veterans-and-their-families

- Defence also indicated that the Discharge (Separation) with Documentation policy was being implemented through 'mandating Individual Transition Plans and Separation Checklists for all separating members'. This was intended to ensure members transitioning had all needed documentation to commence their civilian lives.[90]

8.2.1.2 Early Engagement Model

- The Government response to the NMHC noted that Defence will support the Early Engagement Model by notifying DVA at agreed events during a member's career including events such as enlistment, involvement in a serious incident, medical separation, or retirement. This information would allow DVA 'to expedite the claims process whenever a current or former member applies to DVA for assistance'.[91]

8.2.1.3 Recommendation 14 – Slater + Gordon Comments

- Slater + Gordon recommend the 'Transition Taskforce' conduct seminars for Veterans' leaving the ADF to assist them to transition to civilian life
- Slater + Gordon recommend the DVA make readily available information to Veterans' any available avenues for medical services and income support.
- Slater + Gordon recommend the DVA make readily available, through the Transition Taskforce, information about relevant compensation claims that may be made by the Veteran to ensure this does not exacerbate any injuries, mental or physical, as time progresses.
- Slater + Gordon recommend a legal body, specialising in Military Compensation, can inform Veterans, during exit seminars, of the different grounds for compensation.

90 Submission 156, Supplementary submission 1, p.2.

91 Government response to NMHC report, p. 39.

8.3 Two-track Transition Programs

In response to Recommendation 15 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I commented the following on two-track transition programs:[92]

8.3.1 Current Recommendation

The committee recommends that the Department of Veterans' Affairs develop a two-track transition program for serving members leaving the ADF. Those identified as being in 'at risk' groups or requiring additional assistance due to their circumstances should be able to access intensive transition services. These intensive transition services should include additional support:

- claims case management;
- healthcare, mental health and wellbeing support;
- employment assistance programs;
- social connectedness programs; and
- health and wellbeing programs.

8.3.2 Weaknesses of this Recommendation

While Slater + Gordon appreciate the aim of this recommendation, it raises a plethora of questions and practical difficulties that need to be considered more deeply. This includes:

- How will the Department of Veterans' Affairs identify 'at risk' groups or those requiring additional assistance due to their circumstance?
- What is the extent of the additional support offered to the identified groups and does it risk detracting the services available to those falling outside this category?
- Will members need to apply to receive the higher level of support? If so, how onerous and efficient will this process be?
- A two track transition program risks increasing confusion amongst veterans as to what services are available to them upon leaving the ADF. The senate committee repeatedly acknowledged the difficulties that veterans currently have in accessing information and

92 Slater & Gordon Lawyers Response to Recommendation 15 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

services under the single-track system. [93] Without an even greater emphasis on promoting the available transition services, a two-track system could have a confusing and consequently detrimental effect for members of the ADF.

8.3.3 The Current Transition Program

The Department of Veteran Affairs provides a range of services to help ex-service men and women transition in to civilian life.[94] DVA's services include:

- Advisory services
- Rehabilitation and compensation
- Health services
- Counselling support
- Income support
- Veteran Employment Assistance Initiative (trial)

There are also a range of support services available through government and independent organisations such as: [95]

8.3.3.1 Australian Department of Defence - Transition Centre

- Career Transition Assistance Scheme[96]
    - Supports career transition of members from service to suitable civilian employment
    - Enhances ability of members to competitively market themselves
    - Enhances and makes the best use of members' existing skills gained from ADF service
    - Assessed during the last 12 months of service up to 12 months after termination
- ADF Member and Family Transition guide – a Practical Manual to Transitioning[97]

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93 Senate Report, *Suicide Amongst Veterans, A Constant Battle,* [6.97].

94 ADF Member and Family Transition Guide: A Practical Manual to Transitioning, Australian Government Department of Justice, 47.

95 ADF Member and Family Transition Guide: A Practical Manual to Transitioning, Australian Government Department of Justice, 47.

96 Access: http://www.defence.gov.au/PayAndConditions/ADF/Chapter-2/Part-2/Div-1.asp

- Outlines the Defence transition experience to ensure ADF members and their families are more informed, organised, and confident before entering civilian life

- Transition seminars to aid members in their transition to civilian life[98]
  - Held periodically in Australian capital cities and some regional centres
  - Provides awareness to service members on various matters requiring consideration prior to termination of service
  - Includes topics such as finance, superannuation, health, relocating, employment, and ex-service organisation support[99]
- Career Transition Training[100]
  - Eligible members can receive access and funding for vocationally-oriented education and training to transfer skills and experienced gained from member's ADF career to the civilian sector
  - Training must be specifically aligned to post-termination employment
  - Courses for post-termination employment and employment-related work skills
  - Face-to-face tutorial attendance and online correspondence
- Career Transition Management Coaching[101]
  - Available nationally
  - Also known as outplacement counselling
  - Offers coaching before leaving the military and 12 months after separation
  - Develops a career plan for separating members based on their unique skills, interests, and career aspirations
  - The career transition management coaching package may include:
    - Identification of transferable skills
    - Stress management
    - Job options and job placement advice

97 Access: http://www.defence.gov.au/DCO/_Master/documents/Transition/ADF-Transition-Handbook.pdf

98 Access: http://www.defence.gov.au/PayAndConditions/ADF/Chapter-2/Part-2/Div-3.asp

99 Access: http://www.defence.gov.au/dco/transition/

100 Access: http://www.defence.gov.au/PayAndConditions/ADF/Chapter-2/Part-2/Div-5.asp

101 Access: http://www.defence.gov.au/PayAndConditions/ADF/Chapter-2/Part-2/Div-6.asp

        - Job search strategies
        - Coaching to develop a curriculum interview
        - Developing a career transition plan
    - Helps members meet administrative requirements and leave with all documentation including service, medical, and training records
- Curriculum Vitae (CV) Coaching[102]
    - Helps members develop and maintain a CV
- Financial Counselling[103]
    - Available for members who have left the ADF compulsorily for any of the following reasons: medically unfit to continue service, declared redundant, or management-initiated early retirement

8.3.3.2 Veterans and Veterans Families Counselling Service - Stepping Out (Transition Program)[104]

- A 2-day program developed for ADF members and their partners who are about to, or have recently, separated from the military
- The program examines the transition process and what it means to go from military to civilian life for service members and their families, considering both practical and emotional impacts
- The program is free and considered as 'on duty at another location' for current ADF members
- It is run by VVSC psychologists and social workers
- The program focuses on:
    - The experience of change as part of life
    - The transition from the ADF to civilian life
    - Skills for planning ahead
    - Skills for staying motivated and adaptable

102 Access: http://www.defence.gov.au/payandconditions/adf/chapter-2/part-2/div-7.asp

103 Access: http://www.defence.gov.au/PayAndConditions/ADF/Chapter-2/Part-2/Div-8.asp

104 Access: http://www.vvcs.gov.au/Services/GroupPrograms/stepping-out.htm

- Expectations, attitudes, and troubleshooting
- Maintaining relationships and seeking support

- VVSC also offer individual, couple, and family counselling and group programs [105]

8.3.3.3 The Salvation Army – Transitional Support Service [106]

- The Transitional Support Service (TSS) is a voluntary and free service that supports young people (between 15 and 25 years of age) in the transition between care and independent living
- Offers:
  - Information and advice on health, employment, and education
  - Family support
  - Access to accommodation
  - Recreational opportunities including camps
  - Life skills and financial sustainability advice
  - Links to other support agencies

Glide Outplacement[107]

- Supports ADF members move from a military career to civilian employment, and assists partners on postings to secure employment
- Provides ADF Defence career transition coaching programs, CV coaching and resume writing services

8.3.4 International Perspective

As far as we have been able to ascertain, most major foreign defence departments do not presume whether a particular leaving member of the defence force is part of an 'at risk' group, nor do they categorise their members and divide available services accordingly.

Take for instance the United States Department of Veteran Affairs. It provides a significant range of support and information services to help all of its ex-service personnel transition to

105 Access: https://www.dva.gov.au/factsheet-vcs05-transition-civilian-life

106 Access: http://www.salvationarmy.org.au/tss/

107 Access: https://www.outplacement.net.au/defence-transition/defence-career-transition-programs/

civilian life. Veterans struggling with the transition and are at risk of homelessness or suicide have access to additional support services such as:

- Supportive Services for Veteran Families Program[108]
    - Awards grants to private non-profit organizations and consumer cooperatives who can provide supportive services to low-income veteran families living in or transitioning to permanent housing
    - Grantees provide outreach, case management, and assistance to eligible veterans and their families in obtaining VA and other benefits, including the following services:
        - Health care
        - Daily living
        - Personal financial planning
        - Transportation
        - Fiduciary and payee
        - Legal
        - Child care
        - Housing counselling
- Homeless Veterans Community Employment Services (CECs)[109]
    - A platform for businesses and industries to find, interview, and hire job-ready Veterans exiting homelessness
    - CECs pre-screen veterans with a variety of skill sets and from all education levels
    - CECs increase veterans' likelihood of employment success by connecting them to job-related resources and career opportunities and a range of supports from VA and the community, including health care, housing, and social services
    - CECs identify gaps in competitive employment services for homeless veterans
- Veterans Crisis Line[110]
    - 24/7 access to counsellors via toll-free hotline, online chat, or text

108 Access: https://www.voa.org/supportive-services-for-veteran-families

109 Access: https://www.va.gov/homeless/hvces.asp

110 Access: https://www.veteranscrisisline.net/

- Suicide Prevention Coordinator[111]
    - Assists veterans during times of crisis and ensure veterans receive the health care and support they need

To compare this to what is proposed in recommendation 15, the position in the US is not to assess who is and is not 'at risk' upon leaving the army and divide available services accordingly. Instead, all members have access to the same support upon leaving the army, and anyone struggling can reach out for further help if they need.

8.3.5 Recommendations

Slater + Gordon support the notion of providing additional support to veterans, especially those at risk. While we agree with the premise behind recommendation 15, the recommendation with the greatest respect seems in its current form unfortunately to be tacked on, ill thought through, and lacking in detail. With that said, Slater + Gordon propose the following recommendations:

- An examination into the practical functionality and advantages of a two-track transition program. This examination could be tied in with recommendation 14 as an additional task to be undertaken by the Transition Taskforce.
- Rather than limiting additional programs to those DVA deem 'at risk', consider making these additional support programs available to all veterans who are struggling to transition to civilian life.

8.4 White Cards

In response to Recommendation 16 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I observed the following in regards to white cards:[112]

8.4.1 Current Recommendation

The committee recommends the Australia Government issue all ADF members transitioning into civilian life with a DVA White Card.

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111 Access: https://www.coatesville.va.gov/services/Suicide_Prevention_Coordinator.asp

112 Slater & Gordon Lawyers Response to Recommendation 16 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

- Slater + Gordon are concerned with the practical implications of the White Card. That is, while the card may appear beneficial in theory, the issue is whether there will be any practical benefit to the advantage of veterans given that those suffering from psychological injuries can already access a non-liability health care card.
- Whilst having the White Card immediately available on discharge will certainly benefit the veteran in accessing treatment is suggests that liability has already been accepted without the claim process being undertaken.
- For Slater + Gordon to reach a useful conclusion regarding this topic, more information needs to be provided as to the nature of the White Card and what it provides to the Veteran. Importantly, consideration must be given as to how the card is implemented.

8.4.2 Current Health Services

There has been general consensus that the current system which deals with health care services for Veterans is inefficient, timely and restrictive. Considering the three main legislative schemes, *Veterans Entitlement Act 1987* (VEA), the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) and the *Military, Rehabilitation and Compensation Act 2004* (MRCA) were established with the purpose of benefitting Veterans and ensuring their smooth transition into civilian life there are obvious problems.

Generally, Health services to DVA clients are provided through Gold and White Cards. These cards provide access to a range of public and private health care services.

- The Gold Card provides eligible veterans with access to a wide range of public and private health care services within Australia for conditions accepted as 'war or service related'.
    - To be Eligible[113]
        - The Eligibility requirements for the Gold Card are restrictive.
        - Certain Criteria must be met by the Veteran seeking health benefits under the Gold Card before they are eligible. The DVA website outlines the particular requirements.

113 Access: https://www.dva.gov.au/factsheet-hsv59-eligibility-dva-health-card-all-conditions-gold-or totally-permanently-incapacitated

- What are they entitled to[114]
  - There are a range of entitled that can be accessed by Veterans' once they have obtained a Gold Card. Within which, is the entitlement to access 'psychology' services. This will assist in the mental health of returning veterans.

- Comparatively, the White Card provides access to a more restrictive range of health services. That is, access to certain services is in response to a particular clinical need.
  - Eligibility and Entitlements[115]
    - All current and former members with continuous full-time service (CFTS) are eligible for treatment of any mental health condition.
    - Additionally, current/former members may be eligible for treatment of Cancer (Malignant Neoplasm) and Pulmonary Tuberculosis if certain additional criterion is satisfied.[116]

8.4.3 Non-Liability Health Care[117]

The current 'Non-Liability Health Care' is accessible through the current 'White Card'. Once the Veteran has applied for the White Card and been processed successfully, they are eligible for mental health assistance and additional health services. Further, the applicant-Veteran may be eligible for Specific Conditions accepted as war or service-caused injury or disease.

114 Access: https://www.dva.gov.au/factsheet-hsv01-health-services-available-veteran-community

115 Access: https://www.dva.gov.au/factsheet-hsv61-dva-health-card-specific-conditions-white

116 Access: https://www.dva.gov.au/dvaforms/Documents/D9215.pdf

117 Senate Report, *Suicide Amongst Veterans, A Constant Battle,* [2.23].

8.4.4 Senate Report, Suicide Amongst Veterans: A Constant Battle, Statements

As stated in the Senate Report, *Suicide Amongst Veterans: A Constant Battle,*

> In the 2016-17 Budget, the Government announced that it would extend non-liability health care for certain mental health conditions to all current and former ADF members, irrespective of their date, duration or type of service. From 1 July 2017, this was extended to treatment of all mental health conditions.[118]
>
> …This could include treatment from a general practitioner, medical specialist, psychologist, social worker, occupational therapist, psychiatrist, hospital services, specialist PTSD programs, pharmaceuticals, or oncologist services as required. Veterans who are eligible are issued with a DVA Health Card – for specific conditions (White Card).[119]
>
> Treatment under the non-liability health care arrangements is delivered through the provision of a DVA White Card. Services available under these arrangements may include general practitioner, psychiatrist, psychologist, medication, public or private hospital, and counselling.[120]

8.4.5 What does the 'White Card' Provide?

The Committee has recommended that *all* transitioning ADF members should be provided with a DVA White Card to facilitate access to non-liability health care, serve as veteran identification and as a platform for data collection.[121]

Therefore, the new recommendation to provide the White Card to every ADF member leaving service will allow veterans to have easier and quicker access to mental health service. That is, the time-consuming process of applying for a White Card under the existing system is avoided.

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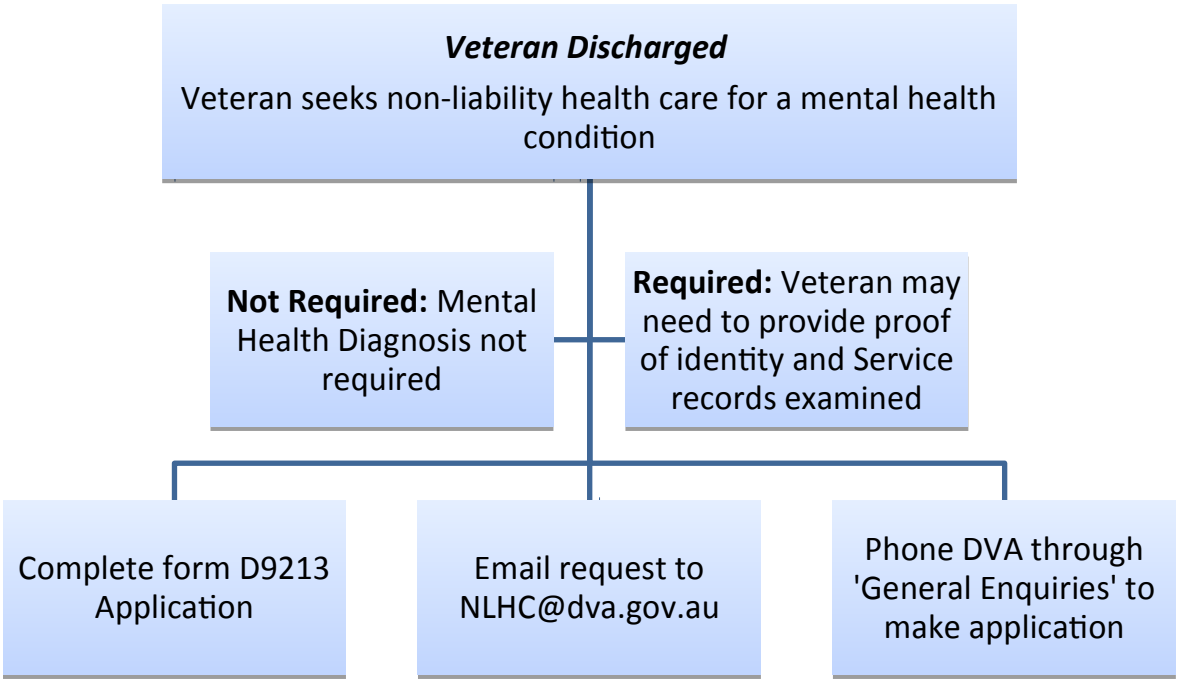
118 Senate Report, *Suicide Amongst Veterans, A Constant Battle,* [2.23].

119 Senate Report, *Suicide Amongst Veterans, A Constant Battle,* [2.24].

120 DVA, 'Mental health treatment for current and former members of the Australian Defence Force – expanded access', Budget 2017-18, p. 1.

121 Senate Report, *Suicide Amongst Veterans, A Constant Battle,* [6.100].

Presently, a Veteran seeking assistance for Mental Health related conditions must apply for a card. The current processes are set out below:



The new White Card will not require any of the above processes. Rather, as *soon* as the veteran is discharged they will be issued with a White Card that allows them access to mental health assistance. That is, from the outset the White Card will be the central way veterans can access these services.

8.4.6 Recommendation 16 – Slater + Gordon Comments

- Slater + Gordon endorse immediate access to mental health treatment upon discharge of Veterans from the ADF and other military positions
- Slater + Gordon endorse *no* distinction to be made between difference forms of service, and endorse the blanket acceptance of mental-health aid by the DVA to veterans;
- Slater + Gordon endorse the amendments to the White Card as put forward in Recommendation 16. However, we are unsure how this will fit in to the fabric of the existing entitlements, and are concerned of the pragmatic over-lapping between already existing cards.

8.5 Veteran Work Experience

In response to Recommendation 17 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I suggested the following regarding veteran work experience:[122]

8.5.1 Current Recommendation

The committee recommends that the *Career Transition Assistance Scheme* include an option for veterans to undertake a period of work experience with an outside employer.

8.5.2 Existing Career Transition Assistance Scheme in Australia[123]

Currently, the *Career Transition Assistance Scheme* ('CTAS') offers minimal flexibility for Veterans. While CTAS is a good starting point, the work-experience available to veterans should be flexible and have a veteran-centric and practical approach.

Currently, CTAS does not provide or support a period of paid work experience with outside employers. Hence, there is little pragmatic opportunity offered by the ADF for the veteran to undertake a short term period of outside employment to gain on-the-job experience. In providing this experience, this will be a mutually beneficial between employer and employee, as the employer has training costs subsidised by the scheme, and the veteran obtains prospective employment.

8.5.3 Eligibility Requirements for CTAS

To be eligible for this scheme, the member must:

1. Provide proof of their intention to separate from ADF within 12 months
2. Determine level of assistance by evaluating following factors
    a. Total period of qualifying service at the date of termination
    b. Type of termination
3. Qualifying service for the CTAS may be an aggregate of periods of service. This may be in one or more Services of the ADF. There may be a break between periods of service.

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122 Slater & Gordon Lawyers Response to Recommendation 17 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

123 Available at : http://www.defence.gov.au/PayAndConditions/ADF/Chapter-2/Part-2/

4. Eligibility for levels of assistance[124]

Eligibility		
Item	**If the member has completed…**	**Then the assistance level is…**
1.	Less than 12 years' service	Level 1
2.	12 but less than 18 years' service	Level 2
3.	18 or more years' service, or has left the ADF compulsorily for any of these reasons. a. Medically unfit to continue service b. Compulsory retirement age. c. Management-initiated early retirement. d. To meet the needs of the Service (i.e. declared redundant)	Level 3

Depending on which level the veteran falls into, different assistance is available to them. This is a weakness in the current system. That is, the semantic approach towards 'eligibility requirements' defies the purpose of the Scheme, which is to get returning veterans into the workforce.

124 Available at: http://www.defence.gov.au/PayAndConditions/ADF/Chapter-2/Part-2/Div-2.asp

8.5.4 Other government initiatives

The Prime Minister's Veterans' Employment Program was launched in November 2016, announcing a number of initiatives alongside it:

- An Industry Advisory Committee on Veterans' Employment to provide advice and employment information to veterans;
- The Prime Minister's Veteran's Employment Annual Award, recognising employers creating jobs for veterans;
- Ex-Service Organisation Industry Partnership Register, partnering with industries on projects to promote veteran employment;
- Initiatives with the Department of Defence, DVA, APS and Department of Employment to facilitate a smoother transition into employment by ensuring veterans have appropriate documentation and providing them with access to tools and employment information. This also included the addition of a 'defence force experience desirable' filter on the Government's *jobactive* website. [125]

Regarding this last point, in June 2017, the Office of the Minister for Veterans Affairs boasted in a media release that there were over 1,000 jobs for veterans on the *jobactive* website using its new 'defence force experience desirable' flag.[126] In October 2017, this very same search with no additional filters only produces 20 jobs for veterans across the whole of Australia. Of these positions, 10 were for part-time Sydney bus drivers while 4 were only temporary casual roles. The Prime Minister's Veteran' Employment Program is, in theory, a positive and encouraging initiative, however it's clear that it has not generated the required industry awareness to maintain a continuous stream of veteran job opportunities. Furthermore, the purpose of this initiative is to demonstrate to employers the value of the unique skills and experiences of ex-servicemen and women. Yet while there's commendable attention toward preparing veterans for the civilian workforce, this must be complemented with steps toward overcoming any negative stigma among employers regarding the capabilities of veterans in order to facilitate a constant flow of meaningful and skilled work for ex-service personnel.

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125 Available at: https://veteransemployment.gov.au/

126 The Hon Dan Tehan MP, 'More than 1,000 jobs for veterans flagged' (Media Release, 17 June 2017).

8.5.5 RSL Queensland's Pilot Employment Program

RSL Queensland has begun running a Pilot Employment Program. Currently its scope is limited to Veterans in Townsville, but by early-mid next year it is expected to be rolled out across the entire state. In addition to being a resident of Townsville, to be eligible for the Pilot Employment Program the applicant must have already accessed all entitlements under CTAS, accessed all available PEAP funding, and not engaged in DVA Medical rehabilitation program. Unlike CTAS, the Pilot Employment Program differentiates the level of support and assistance provided to applicants on the basis of need, not solely on the amount of service provided and the circumstances of discharge:

- Lane 1 applicants will have their access to employment fast tracked, so that the applicant receives limited assistance but is quickly linked to suitable employers.
- Lane 2 applicants who require additional support may receive additional career counselling, CV development, and training.
- Lane 3 applicants will be referred to the RSL Well-being team and may be referred to specialised partner organisations in addition to receiving support in excess of that provided to lane 2 applicants.

The Program also seeks to inform, educate, and accredit employers in order to incentivise Veteran hiring, and the provision of suitable workplaces for Veterans. Partners seeking to obtain employment or education are also accommodated by the Program.

While it is too early to assess the impact or success of the Pilot Employment Program, it seems to represent a useful avenue for Veterans who have not obtained sufficient assistance from CTAS to achieve gainful employment. Ascertaining eligibility for levels of assistance on the basis of need of the individual Veteran is a positive step away from the arbitrary requirements of CTAS, which inevitably leave some Veterans with more support than they need, and others with less. We would encourage DVA to monitor this initiative, and if it is successful, to roll out similar programs across the contrary. Other state RSLs should be utilising funds to implement similar programs. It is well established that if Veterans are engaged in meaningful and fulfilling employment then they are less inclined to contemplate taking their own lives.

8.5.6 Slater + Gordon Comments on Recommendation 17

- Slater + Gordon supports the recommendation that CTAS provide an opportunity for veterans to undertake a period of work experience.
- Slater + Gordon recommend options for work experience made available during the Transition Process and information provided through transition seminars.
- Slater + Gordon recommend that eligibility for CTAS assistance levels be primarily based on need, and that time-served and circumstances of discharge should operate as guidelines only.
- Slater + Gordon recommend that DVA monitor and assess the performance of RSL Queensland's Pilot Employment Program, and implement similar programs nationwide if it is successful.

8.6 Public Sector Work Experience

In response to Recommendation 18 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I made these observations about public sector work experience:[127]

8.6.1 Current Recommendation

The committee recommends that the Australian Public Service Commission conduct a review into mechanisms to further support veteran employment in the Australian Public Service and the public sector.

8.6.2 Current System in Australia

Apart from Centrelink, there are a number of organisations presently, or will be in the future, assisting Veterans when it comes to Veteran employment. In Slater + Gordon's response to Recommendation 17, we agreed with Senate Inquiry Committee that CTAS should provide an

127 Slater & Gordon Lawyers Response to Recommendation 18 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

opportunity for veterans to undertake a period of work experience. We recommended that it be made available during veteran's transitional process and that eligibility be primarily based on need.

In addition to the wider government agencies, the *Defence Community Organisation: For ADF members and their families,* is an example of a community organisation that is supported on the Department of Defence website.[128] While it mentions the different 'skills and capabilities' of Former Defence Force personnel and their applicability to the civilian workforce, it provides no job opportunities for veterans.

New South Wales has initiated the *Veterans Employment Program*. This program is aimed at providing Australian veterans with jobs in the NSW Government. The number of available jobs is capped at 200.[129] The Victorian state Government has committed to the *Public Sector Veterans Employment Strategy*,[130] with a public sector employment target of up to 250 roles. The program provides some specific guidance for veterans seeking to apply to public sector jobs, including how skills obtained during service can be transplanted to selection criteria.

Both the Victorian and the NSW programs, while positive and aspirational, are limited in some key respects:

- The number of roles that will actually be filled is not certain because only soft targets have been set, not quotas.
- There is no direct engagement with Veterans, and there does not appear to be any coordination with DVA or Defence.
- The support provided to Veterans is highly limited, and mostly consists of generic advice provided to all applicants to public sector work.

128 Access at: http://www.defence.gov.au/DCO/Transition/Veteran-employment/

129 Access at: http://www.vep.veterans.nsw.gov.au/

130 Access at https://www.dpc.vic.gov.au/index.php/veterans/public-sector-veterans-employment-strategy

More needs to be done to ensure veterans are given access to the workforce from the moment they are discharged. Slater + Gordon submit that the programs need to be more proactive rather than simply providing information on how to apply for positions.

8.6.3 United States Model

In the United States, American Veterans seeking work in the public sector may be entitled to preference over non-Veteran applicants depending on whether they meet eligibility requirements. These depend on the nature and length of service, the presence of permanent disabilities, and whether or not the applicant is the sole-survivor in a military family.[131] Having preference over other applicants does not entitle Veterans to the role. While having some sort of preference system in Australia would be of substantial benefit to Veteran applicants, a cautious view of the eligibility requirements should be taken, as these could potentially seem arbitrary. It seems that the skills, work ethic, and values that Veterans have obtained through service should be of more concern than the manner in which their service took place.

8.6.4 Australian Capital Territory Model

In a bid to increase the number of former military personnel employed by the public service sector, the ACT government took steps in September to introduce a policy to flag job vacancies with "Defence Force experience desirable."[132] The policy was encouraged by Gordon Ramsay, ACT's veteran affairs minister, who referred to former military personnel as a "natural fit" for the territory's public service. Other suggested initiatives in the policy include establishing a mentorship program for veterans within the ACTPS, promoting jobs at ADF transition seminars, and using a rank-level match matrix to compare levels of ADF experience with ACTPS capabilities. It has also been suggested that the government will partner with the Veterans Advisory Council and the Defence Industry Advisory Board to identify other ways to get more veterans into the workforce. Unfortunately, there are no guarantees the policy will be implemented. The ACT public servants will be undertaking an all-staff survey before the end of the year to determine the number of veterans within their ranks. Results from the survey will determine if and how the public service will be able to recruit more Veterans.

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131 Access at: https://www.usajobs.gov/Help/working-in-government/unique-hiring-paths/veterans/

132 Access at: http://www.canberratimes.com.au/act-news/defence-force-experience-desirable-the-push-to-get-more-veterans-in-the-act-public-service-20170912-gyg3an.html

8.6.5 Queensland Model

LNP member, Tim Nicholls, launched Queensland's first Veterans' Affairs Policy in Queensland in June this year.[133] The plan is said to improve services, provide greater opportunity for retired military personnel, and introduce Queensland's first Minister for Veterans' Affairs. Nicholls suggested that by appointing a Queensland Minister for Veterans Affairs, the government will be able to develop better strategies targeted to Queensland veterans. He highlighted that Queensland is home to more veterans than any other state (around 50,000 veterans), so a state-based policy is necessary. Such a policy would include a public service veterans target to increase the number of ex-service personnel working in the Queensland public service. Nicholls promised to appoint a senior representative in the public service as the 'Veterans' Champion Mentor' who would establish a network of veterans in the public service. He also promised to ensure that the relevant websites are updated to provide information to ex-ADF personnel regarding jobs specific to their skill set and to maintain the Queensland Veterans' Advisory Council. The government is also said to create a $2 million Veterans Transition Grants program for ex-service and defence welfare organisations to access and fund programs which will help veterans transition back to civilian life and take on new careers.

8.6.6 Slater + Gordon Comments on Recommendation 18

As stated in our submission to the Report, *The Constant Battle*,[134] the reason for Veteran suicide is a multidimensional issue. That being said, there are key factors that need to be addressed if we are going to achieve a decline in suicide rates. Research undertaken by the Australian Institute for Suicide Research and Prevention suggests that Veterans' difficulty in obtaining employment once they return to civilian life is a major risk factor, as it contributes to feelings of disengagement and uselessness within the community.

It is the view of Slater + Gordon that this recommendation, along with recommendation 17, should be given a high priority by the government and the DVA. A training program which addresses employment after service should be created for implementation while Veterans are

133 Access at: https://www.omnipathways.org/public/14/system/newsAttachments/Queensland's%20first%20Veterans'%20Affairs%20Policy%20Sunshine%20Coast.pdf

134 Submission 160.

involved with the Transition Taskforce. Along with other programs the Taskforce may be able to facilitate, the push for meaningful and long term employment for veterans is vital.

- Slater + Gordon support Veteran employment in the Australian Public Service and the public sector.
- Slater + Gordon recommend that all State Governments adopt quotas for Veteran hiring in the public sector.
- Slater + Gordon recommend that a preference system for Veteran public sector job candidates, similar to the US model, be investigated.

8.7 Support of Partners

In response to Recommendation 19 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I said the following in regards to recommendation concerning the support of partners of service members:[135]

8.7.1 Current Recommendation

The committee recommends that the Department of Veterans' Affairs review the support for partners of veterans to identify further avenues for assistance. This review should include services such as information and advice, counselling, peer support and options for family respite care to support partners of veterans.

8.7.2 Weaknesses of Recommendation

- The Recommendation fails to address the disjointed nature of the Australian Model. Unlike the UK which has moved towards establishing a National Veterans Mental Health Network. It is our suggestion that a similar network be established in Australia following the tried and tested results from the UK.
- Recommendation 19 recognises the important avenue of partner assistance, but does nothing further to effectively make available the different help available to families.

135 Slater & Gordon Lawyers Response to Recommendation 19 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

8.7.3 Australian Model

The wealth of online resources spread across multiple platforms can be overwhelming to those seeking support and not enough has been done to address the disjointed nature of carer support in Australia.

The DVA has created a platform, 'At Ease' as a way of providing mental health information for 'Serving and Ex-serving personnel and families' to the public.[136] Within which, the DVA provide information in regards to:

- Counselling Services for Eligible Veterans and Family Members (VVCS)
- Relationship Support in the Community for Partners and Children of Veterans
- Information about parenting and parenting skills
- Family Violence Prevention Programs
- Resources for Carers

The DVA's 'At Ease' is a promising step towards establishing an integrated support network for families of veterans. There are extensive resources available on the platform aimed at promoting the health and wellbeing of veterans and their families and carers. The Veterans & Veterans Families Counselling Service additionally provides an avenue of support for the families of veterans.

The Department of Veterans Affairs should also be commended for its use of online training through the HIGHRES platform which aims to promote coping mechanism and strategies for promoting mental wellbeing. Notably, there is no training specifically targeted at equipping carers and families with the tools needed to manage their unique situation.

The support network in Australia falls short of the standards set by the UK and the US. The US in particular has an extensive, cohesive program of direct carer assistance that centralises support and employs multiple platforms to provide hands-on coaching for families of veterans. In addition to internal programs, these systems established by the Department of Veterans Affairs (US) play a crucial role in connecting carers with external support services.

136 Access: https://www.dva.gov.au/health-and-wellbeing/mental-health

The UK National Veterans Mental Health Network and particularly the Veterans Trauma Network similarly centralises and streamlines the process by which carers can access mental health services.

Veterans Affairs Canada integrates families into the support services provided for veterans in specialist clinics. They also administer a support program to assist families transitioning out of service.

8.7.4 Current Australian Independent Services

- Legacy
- Returned Serviceman's League (RSL)
- RSL LiteCare
- The Partners of Veterans' Association of Australia

Adequate funding of these organisations is an issue and extends to smaller support network groups.

8.7.5 Research into UK Model

8.7.5.1 Overview

The UK has been proactive in establishing the National Veterans Mental Health Network and Armed Forces Networks with the aim of filling gaps in service provision throughout the country. [137] The concern is the provision of care and services should not in itself become a bureaucratic web where all the groups compete for public, private and Government funding. However, the UK has established two Networks, the Armed Forces Networks and the National Veterans Mental Health Network (NVMHN). As the National Health Service appears to be focusing on the NVMHN, this system will be dealt with in detail, and the AFN will not be looked at in detail.

8.7.5.2 National Veterans Mental Health Network (NVMHN)[138]

Set up in 2010, these NHS-funded teams, see around 3,500 people a year and aim to get the veterans and their families to get the right treatment. [139] This is addressed through treatment through GP, Hospital, Mental health service or other charities.

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137 Website Available at: https://www.england.nhs.uk/commissioning/armed-forces/contacts/

138 Access:

http://www.nhs.uk/nhsengland/militaryhealthcare/pages/militaryhealthcare.aspx

The Ministry of Defence published an Armed Forces Covenant Annual Report commencing in 2012.[140] From which, the Ministry of Defence has further published leaflets explaining 'What the Armed Forces Covenant means for Service Families'.[141] The leaflet states the Covenant is a promise between the Government, the Nation and the Armed Forces. The Secretary of State for Defence is legally required to report annually on the effect of service on armed forces. This means the government is held to account every year on its duty under the Covenant to reach their targets.

8.7.5.3 NHS Mental Healthcare[142]

Following engagement with Veterans and their families, NHS England launched a new Veterans Trauma Network in November 2016. The new network aims to provide an additional level of support for trauma-recovering Veterans and transitioning Service personnel, so that their specific and life-long healthcare needs are met efficiently, effectively and in an integrated way by the NHS. Once a Veteran is identified and referred to the network team (via their GP or key Service charities – The Limbless Veterans (Blesma), Blind Veterans UK, or Style for Soldiers**),** the team will be able to offer professional advice, supporting that patient (and their family/carers) via a specialist with access to integrated services with the appropriate NHS Major Trauma Centre specialists, close to where they live, or into other networks/service providers; including mental health. The early use of the pathway is providing better outcomes for patients, families and carers, as well as supporting GPs.

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139 Access: https://www.england.nhs.uk/commissioning/armed-forces/armed-forces-net/

140 Access: www.mod.uk/covenant

141 Access: https://www.gov.uk/government/publications/what-the-covenant-means-to-you-leaflets

142 Access: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/588140/30012016_AFC_Report_FINAL_WEB.PDF

8.7.5.4 Combat Stress[143]

This is a Veterans' Mental Health Charity in the UK. Combat Stress offers the main inpatient PTSD treatment programme in the UK with three main treatment centres. The charity receives support from the Minister of Defence.

8.7.5.5 Combat Stress- Families [144]

The website acknowledges the stress of living with someone with a mental-illness. Combat Stress provides a 24-hour Helpline for anyone affected by Service-related mental health, including family members. Secondly, it refers to 'Ripple Pond' which is a peer support group for adult family members. It refers family members to the website.[145] In Summary, Ripple Pond provides a peer-led service which organises group meetings and buddy systems for 'parents, spouses, siblings' or 'any adult family member who feels they would like support'.

8.7.5.6 Help for Heroes

As one of the most recognised psychological and wellbeing service providers established in the wake of the conflicts in Iraq and Afghan, Help for Heroes provides charitable donations for other military charities and individual grants with support of the main service rehabilitation centres throughout the UK.

8.7.5.7 Research into US Model

8.7.5.7.1 Overview

The US Department of Veterans' Affairs operates the nation's largest integrated mental healthcare system with more than 1400 sites of care. Similar to Australian Veterans, USA veterans are not accessing existing mental health services.

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143 Access: http://www.combatstress.org.uk/

144 Available at: http://www.combatstress.org.uk/veterans/families/

145 Access https://www.theripplepond.org/about-the-ripple-pond/

The US Veterans' Affairs policy is to continue to increase accessibility and address barriers to the provision of care. In 2012, President Obama signed an Executive Order that pledged to improve access to mental health services for veterans, service members and military families.

8.7.5.8 Research into Canadian Model

Caregiver Program

The Department of Veterans Affairs Caregiver Program 'offers training, educational resources, and multiple tools' to help family members and carers promote the wellbeing of veterans and to care for their own mental health. It encompasses a range of initiatives.[146]

8.7.5.8.1 Peer Support Mentoring

Peer Support Mentoring and the Compassionate Connections Program connect carers of veterans with others who are in the same situation, allowing them to act as either mentors or mentees.[147] 'Mentors are volunteers with the Voluntary Services Department within the local VA medical centre and receive training before being paired with another Caregiver.'[148]

8.7.5.8.2 Building Better Carers

VA also provides a free, 6 week online workshop, 'Building Better Carers' that aims to educate carers and families on healthy strategies to care for their own wellbeing and the wellbeing of the veterans in their lives. 'The program has been recognized for its ability to reduce caregiver stress and depression, and increase caregiver overall well-being.'[149]

8.7.5.8.3 Support Line

The VA caregivers support line aims to coordinate support services for veterans and their families. As the VA website provides, 'caring licensed professionals staffing the support line can connect you with VA services, a Caregiver Support Coordinator at your nearest VA medical center, or just listen if that's what you need right now.'[150] The Caregiver support line also conducts monthly telephone education groups 'where caregivers can discuss self-care tips and ask questions on a variety of topics.'

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146 Access: https://www.caregiver.va.gov/index.asp

147 Access: https://www.caregiver.va.gov/Connect_Others.asp

148 Ibid.

149 Access: https://www.caregiver.va.gov/Care_Caregivers.asp

150 Access: https://www.caregiver.va.gov/Care_Caregivers.asp

8.7.5.8.4 Coaching into Care

Through The Mental Illness Research, Education and Clinical Centres established by congress,[151] VA has also developed Coaching into Care (CIC), a national telephone service 'which aims to educate, support, and empower family members and friends who are seeking care.' Coaching is provided by licensed psychologists or social workers and aims to help families, 'get information about mental health, services at the VA and tips on how to begin the conversation about treatment with a loved one who is a Veteran.'[152]

Steven Sayers, founding director of CIC identifies the following as key services provided by CIC responders:

- Encouragement and information about getting an evaluation and services.
- Coaching to help callers develop an empathic understanding of the Veteran's experience and ideas for improving communication with the Veteran.
- Suggestions about self-care and education about Posttraumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI).
- Problem-solving in how to try different approaches and address unmet needs.
- Referrals to services and support resources for Veterans and their family members or friends.[153]

In partnership with the Psych Armour institute, VA also provides an accompanying online course which 'equips caregivers with tools to identify potential struggles, and better understand problems with traditional approaches like ultimatums and forceful discussions.' The course aims to 'breakdown barriers and enhance conversations about well-being,' and 'includes concrete examples of what [carers] can do.'[154] CIC also provides extensive additional web resources.

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151 Access https://www.mirecc.va.gov/index.asp

152 Access: https://www.mirecc.va.gov/coaching/

153 Access: http://careforyourmind.org/coaching-into-care-va-mental-health-coaching-service-for-family-and-friends-of-veterans/

154 Access: https://psycharmor.org/courses/coaching-loved-one-care/

One of the most important functions of the program is that it centralises support services for families and makes it easier to connect veterans and their loved ones to mental health service providers.

8.7.6 Recommendation 19 – Slater + Gordon Comments

8.7.6.1 'At Ease' Platform

- Slater + Gordon recommends the DVA build on the existing platform 'At Ease' rather than start a new online platform. Slater + Gordon recommend the 'At Ease' Platform be the basis for all information for carers and veterans seeking information regarding mental health facilities. Further, we recommend the 'piece-meal' approach that is currently in operation be synthesised so there is one 'port of call' where veterans and veteran's families can seek assistance.
- To achieve a more 'holistic' approach, Slater + Gordon recommend 'At Ease' join with existing Australian Independent Services, such as Legacy, RSL, RSL LiteCare and the Partners of Veterans to ensure veteran families are aware of local help available to them.

8.7.6.2 Training Program for Families (Canadian Model)

- Slater + Gordon recommend DVA adopt a training program for similar to the Canadian model, whereby families of veterans have access to a program which provides information and guidance on how best to deal with Veteran PTSD.

8.7.6.3 UK NVMHN Based Approach

- Slater + Gordon recommend that DVA adopt approach similar to NVMHN UK system. That is, it recommends veterans and families of veterans to seek treatment from a General Practitioner. That way, the veteran/family of veteran will receive treatment for a variety of medical conditions and can be given holistic medical advice.
- Slater + Gordon recommend the 'At Ease' platform publish one page brochures that provide information to Veteran families, emulating those published by NVHM UK.[155]

155 Access: https://www.gov.uk/government/publications/what-the-covenant-means-to-you-leaflets

9 Income support and health care

Is health care for veterans, including through the gold and white cards, provided in an effective and efficient manner? Has the non-liability coverage of mental health through the white card been beneficial?

Is there scope to simplify the range of benefits available, and how they are administered? Are all of the payments available necessary and beneficial? Are they achieving value for money outcomes?

What are the benefits of having generally available income support payments also available to veterans through DVA? What are the costs?

9.1 Alternative Therapies

In response to Recommendation 20 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I said the following in regards to a recommendation to provide alternative therapies to veterans:[156]

9.1.1 Current Recommendation

The Committee recommends:

- the Australian Government expand the Veterans and Community Grants program to support the provision of alternative therapies to veterans with mental health conditions; and
- the Department of Veterans' Affairs (**DVA**) consult with ex-service organisations and the veteran community regarding avenues to reform the Veterans and Community Grants program to support the provision of alternative therapies to veterans.

156 Slater & Gordon Lawyers Response to Recommendation 20 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

9.1.2 Weaknesses of the Recommendation

Expansion of the Veterans and Community Grants program is a positive move towards embracing the increasing use of alternative therapies. However, the Veterans and Community Grants program already has scope to include alternative therapies, and such a reform does not do enough to improve access to alternative therapies by veterans.

DVA does not sufficiently incorporate alternative therapies into Health Card arrangements available to veterans. Under the Gold and White Cards arrangements, veterans cannot access funding for services offered by alternative therapy providers.

DVA cites a lack of research as the reasoning behind this funding limitation. However no recommendation has been made to undertake further research into the health benefits of alternative therapies. Further research into what qualifies as an alternative therapy that is viable for funding by the DVA is required.

9.1.3 Current DVA Funding

9.1.3.1 Veteran and Community Grants

The Veteran and Community Grants program aims to maintain and improve the independence and quality of life for members of the veteran community by providing funding for projects that support activities and services to sustain or enhance health and wellbeing. The Grants are open to ex-service organisations, veteran representative groups and other organisations.[157]

Currently there are no strict restrictions on the activities which may be funded by the Veteran and Community Grants. Projects seeking a Grant are assessed based on their achievement of certain outcomes, including whether they:

- promote and enhance healthy lifestyles, particularly physical activity and mental health well-being;

157 https://www.dva.gov.au/consultation-and-grants/grants/grant-and-bursary-programs/veteran-and-community-grants

- support quality independent living at home;
- encourage involvement in community activities;
- reduce social isolation;
- encourage supportive and safe communities;
- increase access to community services;
- address gaps in local services;
- support carers;

- promote nutrition;
- increase social connectedness; and
- improve mental wellness.

We believe the explicit inclusion of projects that utilise alternative therapies is a positive improvement to the Veteran and Community Grants program, as it will ensure that veterans can access a range of alternative therapy services.

However, such a reform will not make any significant changes, as projects for veterans that utilise alternative therapies are often already able to access these grants if they achieve the above outcomes.

9.1.3.2 Health Cards

Under DVA Health Card arrangements, alternative therapies currently include:[158]

- acupuncture and acupressure;
- aromatherapy;
- homeopathy;
- hypnotherapy and hypnosis;
- massage or therapeutic touch;
- meditation;
- music therapy;
- reflexology and relaxation therapy;
- reiki;
- tai chi; and
- yoga.

Under the Gold and White Cards, entitled veterans **cannot** access funding for services offered by any alternative therapy providers, such as masseurs, naturopaths or homeopaths.

9.1.3.3 Benefits of Alternative Therapies

A number of submissions to the Senate Inquiry highlighted that alternative therapies are currently being utilised by veterans, including yoga, meditation, assistance dogs, equine therapy and medical cannabis. Mates4Mates noted that Veterans Affairs agencies in the United States, Canada and the United Kingdom have been more flexible in providing funding to programs and initiatives exploring alternative therapies, and that this approach should be followed by DVA.[159]

158 https://www.dva.gov.au/factsheet-hsv131-alternative-therapies

DVA undertook a comprehensive review in 2010 of alternative therapies, and concluded that there is a lack of proven health benefits, such that funding for veterans could not be expanded to apply to alternative therapies.[160] This is on the basis that funding for treatment by DVA is provided based on clear evidence, as DVA has a duty to veterans to ensure that treatment is safe and clinically effective.

However, DVA has not undertaken any additional research into the benefits of alternative therapies since 2010, in spite of the strong evidence from veterans and health practitioners that they are a viable avenue for recovery. Further research into the health benefits of alternative therapy in veteran recovery should be undertaken to confirm these claims.

The Joint Standing Committee on Foreign Affairs, Defence and Trade in their report on 'Care of ADF Personnel Wounded and Injured on Operations', recommended that DVA 'accept complimentary therapies as legitimate treatment for psychological injuries if there is an evidence-based clinical reason to do so'.[161] A number of submissions to the Senate Inquiry also recommended that further research into non-clinical treatment options should be undertaken by DVA.[162]

9.1.4 Slater + Gordon Comments

We agree with the Committee, and recommend that the Veterans and Community Grants program should be expanded to explicitly include projects that utilise alternative therapies. We agree that this expansion should be done in consultation with ex-service organisations

159 Mates4Mates, *Submission 173 to the Inquiry into Suicide by Veterans and Ex-Service Personnel,* 3.

160 Government response to Joint Committee on Foreign Affairs, Defence and Trade report, *Care of ADF Personnel Wounded and Injured on Operations* (December 2013) 4.

161 Joint Committee on Foreign Affairs, Defence and Trade, *Care of ADF Personnel Wounded and Injured on Operations* (June 2013) 74.

162 Returned and Services League of Australia, *Submission 216 to the Inquiry into Suicide by Veterans and Ex-Service Personnel*, 17.

and the veteran community.

However, veterans are currently not able to access direct funding for alternative therapies under DVA Health Card arrangements. We believe that this recommendation does not do enough to provide funding for veterans to directly access alternative therapies that are providing them with health benefits.

We recommend that further research be undertaken by an independent body into the benefits of alternative therapies, and their viability for funding by DVA under current Health Card arrangements.

We recommend that this research should be utilised by DVA to expand the funding available for alternative therapies under White and Gold Cards, so that veterans utilising alternative therapies in their recovery process can access funding, and continue to achieve positive health outcomes without an additional financial burden.

9.2 **Animal Assistance**

In response to Recommendation 21 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I observed the following about recommendations to provide veterans with animal assistance:[163]

9.2.1 Current Recommendation

The committee recommends the Australian Government fund a trial program that would provide assistance animals for veterans with Post Traumatic Stress Disorder (PTSD) stemming from their military service in order to gather research to support the eventual funding of animals for veterans with PTSD and/or mental health conditions through the Department of Veterans' Affairs

163 Slater & Gordon Lawyers Response to Recommendation 21 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

9.2.2 Weaknesses of Recommendation 21

- Trial Program
    - There is no need for a trial program to be undergone as there are existing organisations, such as Young Diggers, Ruff Love and Dog Squad that provide assistance animals to veterans which demonstrate its success.
    - By relying on the existing programs success as proof the 'Animals for Veterans' will have successful results, it will save money by avoiding a trial program.
- Through the DVA
    - Rather than placing the 'Animals for Veterans' program with the DVA, it would appear to be more efficient to merely adopt or support existing organisations with proven success.

9.3 Existing Organisations

9.3.1 Young Diggers

Young Diggers provides a variety of support services and programs to help serving and ex-serving personnel of the Australian Defence Force, their dependents and direct family members. Through Young Diggers, there is a program called 'The Dog Squad'. The Dog Squad is aimed at helping Defence families to better cope with the effects of PTSD and saves the lives of many rescued dogs. As stated on the website, the reason for the dog 'is to assist you to control, overcome and cope with your combat stress'.[164] Applications are made directly to Young Diggers Organisation. To be eligible you must:[165]

- Service Member
    - A serving or ex-serving member of the Australian or New Zealand Army, Navy or Air Force, and Australian Federal Police who have served on

164 Access: http://www.youngdiggers.com.au/dog-selection

165 Access: http://www.youngdiggers.com.au/membership-online-application

peacekeeping missions, post-1975
    - If ex-serving, have an honourable discharge certificate
- Family Member
    - An immediate family member of a serving or ex-serving man or woman who would qualify for membership as a 'Service Member'
- Associate Member
    - An ex-serving member of the ADF or NZDF or their immediate family pre-1975. Serving and ex-serving military personnel and their immediate family from other Allied countries. Or be an individual or organisation who is interested in and supports Young Diggers and wants to be kept informed

9.3.2 Ruff Love Rescue[166]

Ruff Love Rescue (RLR) is a non-profit, 501(c)(3), no-kill dog rescue and foster care organization dedicated to the care of abused, neglected and abandoned dogs. Ruff Love provides a Foster program through which you can foster a dog. Unlike Young Diggers, this is not solely motivated in proving Veterans' with dogs in an effort to combat PTSD, Depression or other mental illnesses. This is a more generic form of adopting dogs.

9.3.3 Assistance Dogs Australia[167]

Assistance Dogs Australia are placing PTSD Service Dogs with first responders and defence force personnel living with post-traumatic stress disorder. These dogs are trained to provide a combination of physical task-oriented and emotional support to assist their owner and help them overcome fears.

PTSD Service Dogs undergo a unique training placement, where they are trained to work with the very individual and specific needs of their owner, in particular detecting signals of anxiety, or their owner's 'trigger''. Upon sensing their owner's trigger, the dog is trained

166 Access: http://www.ruffloverescue.com/

167 Access: http://www.assistancedogs.org.au/pages/ptsd-service-dog.html

to perform a specific cue to help alleviate the symptoms of this trigger, for example, engaging in eye contact and body contact to comfort their owner and divert their attention.

The dogs can master bespoke cues to help their owner overcome psychological trauma linked to specific situations, including but not limited to:

- Standing in front of their owner offering a barrier and space.
- Positioning itself behind their owner, a technique known as “posting” which helps to ease hyperawareness, the feeling of being constantly on edge.
- Entering a room before the owner and turning on the lights so they don’t have to enter a dark space.
- Entering a room or house and sweeping it for people or intruders, alerting its owner by barking.
- Providing physical contact if their owner suffers a nightmare.
- Diverting their owner's attention to the dog, a technique known as "anchoring", helping to bring their owner back to the present moment.
- Providing continuous companionship and a sense of routine.

A PTSD Service Dog has an impact on not only the client it is matched with, but the whole family too. Assistance Dogs Australia works with families in the training and placement process,to share experiences together and welcome their newest addition to the family.

However, due to the overwhelming demand of PTSD Service Dog, the process to apply under this program is on hold. They are attempting to reopen. This Organisation received ‘Outstanding Achievement – Winner 2016’ of the Australian Charity Awards.

9.3.4 Equine Psychotherapy Institute & Horses for Hope

Although less prevalent than therapeutic dog programs, equine therapy is available through a number of organisations in Australia. The Equine Psychotherapy Institute is one provider. They conduct horse therapy sessions ‘supporting a variety of mental health and personal development needs,’ including anxiety, depression, trauma and stress.[168]

168 Access: http://www.equinepsychotherapy.net.au/psychotherapy/

Horse for Hope in Victoria is another organisation using 'equine-assisted learning and therapy to assist people with a range of issues. The program's clients may be victims of abuse or trauma or have experienced an accident or natural disaster.'[169]

9.3.5 Evidence of Success

There is strong evidence of success that veteran/domestic dog partnerships help veterans to manage PTSD, trauma and depression. Traditional PTSD treatments have focused on reducing symptoms such as hyperarousal, intrusive thoughts, nightmares, and anger.[170] Common, evidence-based treatments for veterans and military personnel diagnosed with PTSD include cognitive therapy, prolonged exposure therapy, and eye movement desensitization and reprocessing (EMDR).[171] An emerging approach to treating veterans with a history of PTSD and/or TBI is the use of dogs.

Anecdotal reports depict how dogs assist veterans to feel less irritable, become more patient, calmer, happier, and increase their emotional control.[172]

- Researchers are accumulating evidence that bonding with dogs has biological effects, such as elevated levels of the hormone oxytocin. "Oxytocin improves trust, the ability to interpret facial expressions, the overcoming of paranoia and other pro-social effects—the opposite of PTSD symptoms," says Meg Daley Olmert of Baltimore, who works for a program called Warrior Canine Connection.[173]
- Melbourne clinical psychologist Dr Damon Ashworth has asserted that assistance dogs can help to re-establish safety in the first phase of treating PTSD.[174]

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169 Access: https://www.kildonan.org.au/social-enterprises/horses-for-hope/

170 Cukor J, Olden M, Lee F, et al. Evidence-based treatments for PTSD, new directions, and special challenges: evidence based treatments for PTSD. Ann NY Acad Sci. 2010;1208: 82–89.

171 The Veteran's Administration National Center for PTSD. Treatment of PTSD. 2017 [cited 2017 May 5].
Available from: http:/www.ptsd.va.gov/publid/treatment/therapymed/treatment-ptsd.asp

172 Yeager AF, Irwin J. Rehabilitative canine interactions at the Walter Reed National Military Medical Center. US Army Med Dep J. 2012;57–60.

173 Access: http://www.smithsonianmag.com/science-nature/how-dogs-can-help-veterans-overcome-ptsd-137582968/#c9zsAyGFXtvCZ2CQ.99

- The US Department of Veterans Affairs has propounded the direct correlation with owning a dog as a method of coping with PTSD.[175]

Although there is not enough clinical research to definitively say whether therapy animals help to treat PTSD, the positive impact on the lives of veterans is clear. US MG David Rubenstein, citing the lack of quantifiable scientific evidence, asserted that "for now the anecdotal evidence of its overwhelmingly positive impact is not only encouraging, but also substantial enough to support its continuation."[176]

9.3.6 Recommendation 21 – Slater + Gordon Comments

There is positive and cumulating academic and public evidence demonstrating dogs can assist in people dealing with PTSD.

- Slater + Gordon recommend there is no requirement for a trial program in determining whether 'assistance animals' for veterans with PTSD would be successful.
- Slater + Gordon recommend abandoning the trial program as it will save money and no added insight can be gained by undergoing a trial period.
- It is clear, when looking at the US Department of Veterans Affairs recommendations[177] and current Australian Independent Organisations that there is a strong correlation between improve mental health and the ownership of a pet.
- Slater + Gordon recommend an "Animal Assistance Program" *not* be centrally controlled by the DVA.
- Rather, Slater + Gordon recommends that existing organisations, such as 'Young Diggers' and 'Assistance Dogs Australia' be partnered with to establish an efficient and effective Animal Assistance program, using existing platforms.

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174 Access: http://www.abc.net.au/news/2015-05-22/companion-dogs-provide-new-hope-for-ptsd-patients/6490252

175 Access: https://www.ptsd.va.gov/public/treatment/cope/dogs_and_ptsd.asp

176 Rubenstein D A, Perspectives: Commander's Introduction, US Army Med Dep J. 2012;1.

177 Access: https://www.ptsd.va.gov/public/treatment/cope/dogs_and_ptsd.asp

9.4 Public Databases

In response to Recommendation 22 of the Foreign Affairs, Defence and Trade References Committee's 'The Constant Battle: Suicide by Veterans' Report, I commented on recommendations to assist counselling services by providing public database of information:[178]

9.4.1 Committee Recommendation

The committee recommends that the Australian Government provide funding to support the Veterans and Veterans Families Counselling Service:

- Create and maintain a public database of services available to veterans; and
- Provide an information service to assist veterans and families connect and access appropriate services provided by ex-service organisations and others

9.4.2 Weaknesses of the Recommendation

The committee has recommended a public database be created to provide a centralised point of access for veterans to connect with relevant services.

Whilst we agree that creating and maintaining a public database of services available to veterans has it merits, we believe that in today's age of mobile phone applications this recommendation needs to be taken a step further. We would strongly propose the development of an interactive application suitable for smart phones that can be downloaded for free providing a list of services in the immediate vicinity of veterans using GPS technology. Such an application could not only provide an informative service, but also alerts, offices, concessions group meetings and forums, and availability of many services.

9.4.3 Government Response

The Government has not agreed to provide funding to the Veterans and Veterans Families Counselling Service to create a centralised public database and provide an information

178 Slater & Gordon Lawyers Response to Recommendation 22 of Foreign Affairs, Defence and Trade References Committee's *The Constant Battle: Suicide Amongst Veterans*.

service to assist veterans and their families with accessing services. The Government has merely highlighted an existing website, the Engage website. In our response to Recommendation 11, we highlighted that finding information on this website is complicated, and the search functions are not useful for accessing relevant information about issues such as the Statements of Principles. The fact that the Government has failed to fundamentally address the committee's recommendation indicates a lack of consideration of the issues raised in the Senate Report.

9.4.4 Other approaches

In contrast, the US Veteran Affairs has a wide range of mobile apps specially designed for veterans and their health care professionals. Notable apps include: [179]

- **VA Video Connect** – Helps remote veterans by facilitating a secure video connection between veterans and their health care team.
- **Veteran Appointment Request** – Lets veterans book and manage primary care and mental health appointments.
- **ACT Coach** – Veterans communicated with a mental health coach for Acceptance and Commitment Therapy
- **Concussion Coach** – Helps manage and monitor the symptoms of concussion
- **Ask a Pharmacist** – Provides quick access to information on pharmacies and medication
- **Caring4WomenVeteran**s – Access to care team for women with physical and mental health concerns.
- **Anger and Irritability Management Skills (AIMS)** – Guides and interactive assist to help veterans cope with anger problems.
- **Mood coach** – Guides and exercises to help veterans practice mindfulness.
- **CPT Coach** – Helps work with a therapist during cognitive processing therapy to reduce symptoms of Posttraumatic Stress Disorder
- **Exposure Ed** – Provides a host of information for veterans that may have been exposed to dangerous substances.
- **PE Coach** - Work with a mental health professional during Prolonged Exposure

179 Full list of VA mobile apps available at: https://mobile.va.gov/appstore

therapy.

- **Stay Quit Coach** – App specialised for veterans to help quit smoking.
- **Vetchange** – Helps veterans better understand the effect of alcohol on their mental health and provides steps on how manage their alcohol consumption.

Such a modern and integrated approach to providing access to services should be replicated in Australia, and given the ease of access and use of mobile phone apps, greater assistance could be provided to veterans and their families.

9.4.5 Slater + Gordon Comments

Slater + Gordon recognize that there is merit in expanding interaction and access through websites and social media in an effort to raise awareness of available support services. However, Slater + Gordon believe that websites such as the Engage website, or any website for that matter, are not the appropriate mechanism to achieve increased awareness.

Slater + Gordon recommend that the Australian Government and DVA create a free, interactive smartphone application which uses GPS technology to provide veterans with a list of services in their vicinity. Such an application would provide not only information services, but also alerts, offices, concession group meetings, forums, availability of services, and employment vacancies. Participating businesses, retailers, and service providers could contribute ongoing funding by advertising revenue to the development and continual upgrading of the app. In addition, the app could also alert veterans who are within the vicinity of a participating service provider, retailer, or business. Another benefit of a mobile application is on-the-go accessibility, which is particularly beneficial for veterans who may need immediate assistance and do not have access to a computer.

Various defence community forums providers could be encouraged to provide information, and collaborate and engage with veterans as opposed to just being a database of information. We consider that this ability to interact through an app would be far more likely to assist at-risk veterans who would be able to access in an instant services and benefits. In addition an application could alert the members to employment opportunities

and vacancies. We would suggest that the only impediment to the content of the application wold be the developers' imagination and the suitability of services being offered.

9.5 Extension of Non-Liability Health Care (NLHC) to cover Malignant Neoplasms and Pulmonary Tuberculosis

In their submission to the DVA's Legislative Workshop 2017, RSL Queensland Branch made these comments regarding an initiative to extend NLHC:[180]

The initiative to extend NLHC for all mental health conditions to all serving and former serving members is noted and appreciated The way this change is being administered by the DVA is also appreciated by veterans and their advocates.

9.5.1 Area of Contention

This is a request to extend NLHC further to cover all veterans for malignant neoplasms and pulmonary tuberculosis as well as for mental health conditions.

Section 85(2) of the VEA provides:-

(2) A veteran is eligible to be provided with treatment under this Part for malignant neoplasia or pulmonary tuberculosis from and including the date that is 3 months before the date on which the application to be provide with that treatment is lodged at an office of the Department in Australia in accordance with section 5T

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9.5.2 Pain Points

Veterans who have entitlements under MRCA and who are suffering from malignant conditions find it difficult to understand the differing treatment entitlements between the VEA and MRCA.

9.5.3 This Proposal

That treatment entitlement for all malignant conditions and pulmonary tuberculosis should

180 Queensland Branch of Returned and Services League of Australia, Submission to Department of Veterans' Affairs, *Inaugural Legislation Workshop*, 27 October 2017.

be extended to all veterans who have served.

9.5.4 The Legislation

This could be achieved under the provisions s88A where a legislative instrument could extend the treatment for all mental health conditions to also include treatment for malignant neoplasms and pulmonary tuberculosis.

10 **Conclusion**

I trust that the Commissioners will find this summary of the issues of assistance so that it is not necessary to review the many submissions as listed on the covering letter.

The report titled '*The Constant Battle: Suicide by Veterans'*, by the Senate Foreign Affairs, Defence and Trade References Committee, which triggered this specific inquiry, highlighted how the current legislative framework and supporting architecture for the compensation and rehabilitation of veterans may no longer be 'fit for purpose'. This submission has sought to further explore challenges veterans face when attempting to seek support through the current compensation and rehabilitation schemes including, but not limited to, the complexity of the support mechanisms, the lack of deemed time periods and the interpretation of statements of principles.

In reviewing the current system, I urge the Commission to take into account the issues raised in this submission and how they inhibit the compensation and rehabilitation schemes from being truly 'Veteran-centric'.

The area of compensation and rehabilitation services provided by veterans' affairs has caused much angst over many years. To the credit of the various governments, no matter which side of politics they are from, the consensus is that our veterans must be cared for not only during their service by until they pass away.

I often hear the expression of 'caring for our veterans from the cradle to the grave'. Perhaps now is the time that the Department of Veterans' Affairs should be using this as a model for the provision of their services into the future. We at least owe this to those who have dedicated their lives, or part of their lives, to the service of this nation.

11 Acknowledgements

I would like to acknowledge:-

- The insight of the Queensland Branch of the Returned and Services League of Australia who I have referred to and cited in this submission.
- The assistance I have received from:-
    - Xannel Mangahas, a student from The University of Queensland's Pro Bono Centre.
    - Jennifer Jacomb, Secretary, the Association for The Victims Of Abuse In The Australian Defence Force Inc

I thank the Commissioners for reviewing this submission.

Yours sincerely,

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