Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

COMPENSATION AND REHABILITATION FOR VETERANS

MR R FITZGERALD Commissioner
MR R SPENCER, Commissioner

TRANSCRIPT OF PROCEEDINGS

AT MERCURE BRISBANE, 85-87 NORTH QUAY, BRISBANE
ON WEDNESDAY 27 FEBRUARY 2019 AT 9 AM

INDEX

	Pages
AUSTRALIAN WAR WIDOWS (QLD)	**1050 - 1063**
AUSTRALIAN VETERANS ALLIANCE	**1063 - 1078**
ROYAL UNITED SERVICE INSTITUTE (QLD)	**1078 - 1085**
RSL QUEENSLAND	**1085 - 1107**
RSL QLD BRISBANE NORTH DISTRICT	**1107 - 1121**
ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS	**1121 - 1131**
VETERANS OF AUSTRALIA ASSOCIATION	**1131 - 1148**
DEFENCE FORCE WELFARE ASSOCIATION (QLD)	**1148 - 1165**
GO2 HEALTH	**1165 - 1176**
NEIL ROBSON	**1176 - 1183**
FIONA BRANDIS	**1184 - 1191**
TERENCE FOGARTY	**1191- 1197**
KATHY AND STEVE BARTON	**1197– 1206**
NEIL CLANCY	**1206 - 1208**

COMISSIONER FITZGERALD: Good morning, everybody. Welcome and thank you very much for attending. I've just got a brief opening statement which we make at the beginning of all of the presentations. So, firstly, thank you for participating in this, the public hearing of the Productivity Commissions Inquiry into Veterans' Compensation and Rehabilitation, following the release of our draft report in December last year.

I'm Robert Fitzgerald, and I'm the presiding Commissioner, and my colleague is Commission Richard Spencer. The purpose of these rounds of hearings is to facilitate public scrutiny of the Commission's work, and to get comment and feedback on the draft report. We're very mindful of the fact that the draft report was very extensive, with large numbers of recommendations, and substantial documents to read, and so we're very grateful that so many of you have been able to respond in a very short time frame to that complex report.

We've held hearings so far in Melbourne, Hobart, Adelaide, Perth, Darwin, Wagga Wagga, Canberra, and Sydney. And following the hearings here in Brisbane, which will be heard today and tomorrow, we will be in Townsville and possibly a public hearing in Rockhampton. We'll then be working towards completing a final report to government in June, and that report will be delivered to the government in the last week of June this year. And we will have considered the submissions and the discussions, including the evidence that is presented at these public hearings in formulating our final report.

Participants and those that have registered their interest in the Inquiry will automatically be advised of the final report's release by government. The draft report is released by the Productivity Commission, the final report is released by the government. But it must be released in full, within 25 parliamentary sitting days after the completion of the report.

We like to conduct all hearings in a reasonably informal manner, even though some people would say this is not very informal. Nevertheless, I just remind participants that a full transcript is being taken. For this reason, comments from the floor can't be taken, and at the end of the proceedings today, and again tomorrow afternoon I'll provide an opportunity for any person wishing to make a very brief presentation. If you'd like to do so, just see our staff at the back of the room some time during the day.

Participants are not required to take an oath, but the Productivity Commission Act does require that the remarks are truthful. Participants are welcome to comment on the issues raised in other submissions, and we

certainly welcome that - that feedback. The transcript will be made available to participants, and will be available from the Commission's website following the hearings. Submissions that are currently being received, and need to be in fairly shortly, will also be available on the website.

I'd like to also note than a counsellor from Open Arms is in attendance, and I would encourage you to use those services if you feel the need. In relation to Occupational Health & Safety, I think there's only one exit, and that's out the back. And if it does start to do it's normal bleeping, then follow the instructions and the hotel staff.

So, I would just - so we'll get underway. The format for the day is pretty simple. Each participant will be given the opportunity to make a very short opening presentation, around 10 minutes. A couple of organisations just a few minutes longer than that, and then Richard and I will raise some questions. We've got a full day, but we will get through it on time, and as I said, we will also be here again tomorrow, for another, you know, I think three-quarters of the day.

So, if I could have the first participants, which is the Australian War Widows Queensland. Are they here? And if you just come over. So, Natasha?

MS OICKLE: Yes.

COMISSIONER FITZGERALD: Are you here with anybody else, or just by yourself?

MS OICKLE: I'm on my own today.

COMISSIONER FITZGERALD: So if you want to grab the first microphone.

MS OICKLE: Sure.

COMISSIONER FITZGERALD: So, the microphones are both for recording, but also for amplification. But you don't have to move them, just leave them, it should be fine. Okay, so, Natasha, if you can give us your full name and the organisation that you represent.

MS OICKLE: So, my name is Natasha Oickle, and I'm the CEO for Australian War Widows Queensland.

COMISSIONER FITZGERALD: Terrific. And if you could just give us ten minutes of your key points.

MS OICKLE: Sure. Well, thank you for having me here today. There are two main points that I felt, and the organisation felt, were, I guess, most important for us, as the War Widows. The first one being, and you might have had a look at it, if you've read the War Widows' submission. The first one is a challenge that I think many of you can relate to, and that is difficulty with accessing funding to help the people that we're servicing.

Because there are so many ESOs, thousands, all competing for a small pool of funding, what we find is that the funding's not always necessarily going to the ones that have the best governance systems in place. And simply put, I guess what I'm, you know, wanting to put forward, is that when I came into this industry, I was a little bit surprised at the lack of governance and quality systems that need to be in control to help ESOs to, I guess, service their members, and service the people that they're providing assistance to, in a way that is sustainable, and you know, in a way that provides some quality assurance for how the funding is being utilised and reported on.

And, you know, we all know the benefits of the government for, you know, organisations that have good governance systems, and can provide, you know, real data to the government, to help inform government themselves, on police making, and gathering statistics, and all of those important things that - that we need to develop good strategies. Now, I came from a sector that was very highly regulated, and I'm not saying that we should, you know, become, you know, completely controlled industry, as such.

However, at the moment, to apply - I don't know how many of you have applied for funding in your organisations, how many of you have noticed that there are, pretty much other than being registered with ACNC or, you know, ASEC, there are no other requirements to access this funding, other than being able to write a good grant submission. There is, you know, there's no, I guess, process for -for demonstrating that you have appropriate policies, procedures, and more importantly, that you're following them.

So, I do think there needs to be a look at compliant standards, quality standards, you know, that are aligned to the ISO standards at the very least. So that organisations that are managing their organisations in the, I guess, the correct way, in a sustainable way, that goes from the grassroots up, and who have based their services on research and industry

consultation and participant needs, that they're the ones that are getting the funding.

And I think that a lot of ESOs here probably feel the same way. It's something that's being talked about a lot. It's something that a lot of people are feeling a bit - I guess that there's a bit of disparity there. So that was my first point. So do I just go onto my second point, or? And the details are in the report.

The second point is about our war widows. Now, I was - when I read the review, I don't think I saw war widows mentioned even once. And there are over 59,000 war widows in Australia. That's a lot of people. And they're being grouped in, if you look at the - the review, they're just being grouped in with veterans. But they're different. And the war widows feel that they are invisible. You've got a cohort of mostly older ladies, they don't generally stand up for themselves, and they come from a culture where they're used to just accepting that they're invisible. And that's just the way it is.

And in a sense, a lot of them just give up. War widows have really different needs. And although we can label those with the same, you know, technical names, you know, PTSD, depression, anxiety, social isolation - the way that manifests for these ladies is very different to the way it manifests itself for a veteran. War widows don't become war widows only when their partners pass away in the course of duty. They might have spent 20 years dealing with domestic abuse, having to care for someone who is extremely mentally unwell. Having to take care of their family, get the groceries, keep everything afloat, keep the smile on their faces.

I mean, any male here, and I'm saying - I'm not denying males are widowers, but the majority of them are females. And any man here who is married knows that without the support of his wife, the family breaks down. So, you know, it - it's the woman, generally, and let's not kid ourselves by trying to be, very, PC about it, the woman generally runs, you know, the emotion of the household. But when she spends years and years and years caring for others, and then her partner passes away, she has her own mental needs now accompanied with grief.

And she has spent a lifetime being isolated, she hasn't had the opportunity to build up a network of friends, and she doesn't have anywhere to go, no career to fall back on, so it is really hurtful to them to look at the reviews, and not even see that they're mentioned. And this is - I really cannot understand how war widows cannot have their own mention. And not just

their own mention, there's no research about them. So government can't really talk about them, because there's never been proper research funded.

Now, we at War Widows Queensland would love to be able to do some research, but, obviously, there needs to be, you know, firstly, an awareness of what a war widow is. If you ask someone on the street, "What is a war widow?" They will say, "Ah, a really, really, really old lady who lost her husband, you know, forty years ago." They don't know that it could be a 38 year old woman with four children who is trying to juggle a career, who just lost her husband six months ago. And that's the reality.

And I do believe that there needs to be some individual attention for the - these individuals, and really importantly, some structured research and study about them. Find out what are their challenges. Get some quantifiable data. How many of them suffer from depression? You know, qualitatively, just speaking to them every day, and going around our 27 branches, talking to them - I can tell you, the majority of them are suffering from depression that has been so entrenched in their lives, that they don't - they just think that that's the way life is.

So, I - I really, very passionately believe that the core issue here, for war widows, is that there's not enough awareness of them. And this is really apparent when I read all of the DVA document, when I read, you know, the - the Commission review, when I just don't even see them - them labelled. And you know, I've been told, you know, they are veterans and families. Well, I think there's enough of them, and they've suffered enough, that they don't need to be lumped in with veterans and families.

Women are the ones that are, really, on the front line when the men come home. And I'm not discluding that there are a lot of female veterans, that's not - and I'm certainly not discluding the pain, and the - the ongoing issues that veterans face. I'm very aware that that's an important issue that I'm sure many of you are going to be addressing. But for war widows, I think that from what I've seen, there just isn't, really, much awareness at all about them.

COMISSIONER FITZGERALD: Thank you very much.

MS OICKLE: Thank you.

COMISSIONER FITZGERALD: If I can just ask you a couple of questions, and you've given us a submission, and Richard will pose some questions. If I can go to the last issue first, you're absolutely right. War widows were considered extensively by the commission, but in the

context of the notion of families. And so, just like partners of living veterans, we will be much more explicit in our final report in relation to that.

MS OICKLE: Yes, thank you.

COMISSIONER FITZGERALD: But, we did in fact meet extensively with war widows, and we did in fact have a round table which looked at the needs of partners, families, war widows and others prior to the draft. So, we did try to get an understanding of the particular needs, but can I just got to a couple of things you've said in relation to the system itself..

MS OICKLE: Yes.

COMISSIONER FITZGERALD: The first one you make is research. So, am I understanding that you don't' believe there's any significant research at all, or that you're aware of, that's been conducted in recent time as to the - the current or contemporary needs of war widows. Is that right?

MS OICKLE: Um, I don't believe that there is significant research about war widows, or I can't see it. Because it's really not widely available, and I have looked, and I've called DVA and asked them. The only thing that I've been able to find is a few cursory studies, a couple of mentioned of them. But I haven't been able to find anything specifically that will assist them, in particular around their mental health needs. And social isolation issues.

COMISSIONER FITZGERALD: So, can I just deal with that issue. We had your - your National organisation present yesterday.

MS OICKLE: Yes.

COMISSIONER FITZGERALD: And we have had war widows at some of the public hearings. But what is it in the system that you now need - that needs to be there that currently isn't? And can I just focus on it, is it in the area of mental health and support for people that are under stress, or, you know, living with anxiety, or depression. That sort of area. Is that the key area of concern for contemporary widows today?

MS OICKLE: Well, I think the key area of concern is not just for contemporary. I think that there are a lot of differences between the two, but they do share the same issues. Um, the older war widows, say, face more issues. So, one that's overarching for both areas is mental health. And the second one, which is for the majority of the war widows from the World War II war widows, which makes it the majority of war widows in

Australia, is social isolation, which is linked, obviously, to mental health, and their inability to get out and meet people. Transport is a huge issue for our ladies. Huge.

COMISSIONER FITZGERALD: So what do you think actually needs to - to happen in that space? So can I just deal with the mental health issue, as I understand it, widows and widowers are able to access services through Open Arms. That's correct?

MS OICKLE: Yes, but you - I guess what we have to look at is the unique culture that these ladies have developed. They are not going to go to an organisation that doesn't have war widows, because that's out of their comfort zone for a lot of them. So, if you - if I were to say, and I already have, "Okay, well you can go to this organisation and get mental health counselling," they just won't do it. It's not in their comfort zone, because they have developed a culture where they - they believe that only war widows can relate to war widows. And I think that's understandable. Because they have had a very similar history, and it's human nature. You go toward those who, you know, share - have shared experiences with you.

COMISSIONER FITZGERALD: So many of the war widows, but perhaps not all, would have received a Gold Card.

MS OICKLE: Yes.

COMISSIONER FITZGERALD: And entitlements.

MS OICKLE: Yes.

COMISSIONER FITZGERALD: So some people might say, well, the Gold Card gives them access to a whole range of both medical and mental health services, and they might say, well, that's sufficient. But I gather from what you're saying, your organisations and others that that's not sufficient.

MS OICKLE: Yes, going to a doctor doesn't really help with socialised - well, unless they're going there to have a chat with their doctor for social purposes. Because, health problems can be fixes, but mental health problems cannot be fixed, if people are not leaving their homes.

COMISSIONER FITZGERALD: So have you developed - you and your colleagues developed a model of mental health services that you think would be more appropriate to meet the needs of war widows and widowers?

MS OICKLE: Yes.

COMISSIONER FITZGERALD: So what is it? In brief, what's that?

MS OICKLE: Well, in order to do that we need to have access to funding, firstly. But I'm not here to talk about that. But we would like to be able to link with other community - with other community services, or other community service organisations, and develop referral systems, and awareness of war widows, so that when we do refer on, people know who are the war widows, what are the - the issues they're facing. We're in discussion with the University of Queensland to look at finding out through surveys and qualitative interviews, what are war widows - are actually feeling.

Not in a, you know, "Are you depressed?" But asking questions and markers where, you know, "How often are you getting out?" You know, "How often do you meet friends?" You know, "How do you feel about your future?" And then compiling evidence that we can give to DVA - "Okay, these are the issues that the ladies are facing." You know, 80 per cent of them are suffering from depression. 20 per cent, you know, can't get to the supermarket to buy groceries. They don't have families. These sorts of issues.

COMISSIONER SPENCER: Natasha, if I can go back to the first major point that you raised. That is, largely around the role of ESOs, and we will have more to say about this in the final report. As you're probably aware, Robert Cornell was running a report, mainly around advocacy, but it also touches on the broader issues of the roles of ESOs. And I think it's an issue that will come up many times today about what does the future look like. What you're pointing to is a much more strategic focus by governments about the roles.

MS OICKLE: Yes.

COMMISSIONER SPENCER: Now, non-government organisations, what they choose to do and how they choose to do it in many ways is up to them.

MS OICKLE: Yes.

COMMISSIONER SPENCER: It's part of civil society as we know.

MS OICKLE: Within a framework.

COMMISSIONER SPENCER: Yes, and it's a good thing for us. It brings in volunteers and community effort and empathy. But the role of government is often about who do we speak to, who do we engage with in terms of what should happen. And, secondly, and a very important issue, who do we fund? So government is able to leverage the work that's done by ESOs, and I think what struck us, and just by commentary and then I will come back to you - - -

MS OICKLE: Yes.

COMMISSIONER SPENCER: - - - and ask you for your thoughts on this, but it struck us that the landscape there – there has been two things. One, the level of focus strategically about what to support in the ESO community, beyond advocacy, to us doesn't – we struggle to find a strategy for it.

MS OICKLE: Yes, of course, yes.

COMMISSIONER SPENCER: There are small grants that go out, and it's often not clear why.

MS OICKLE: Yes.

COMMISSIONER SPENCER: Secondly, what has struck us is that it's a really important part of the system. The system can't be just a government system, it's a much larger system than that.

MS OICKLE: Yes.

COMMISSIONER SPENCER: And the value that ESOs and other organisations bring to that space is profound and important, because, as you've highlighted, in peer-to-peer work, reaching out, finding the people most isolated, most in need of services, who won't engage with government agencies, but will respond to peer approaches, what we sometimes describe as soft entry points, is an extremely important part of a comprehensive system. So when we look at that – and then we hear there are 3,500 ESOs, and we go, gosh, what do you do with that?

MS OICKLE: Yes.

COMMISSIONER SPENCER: And what you're pointing us to is how does government get more strategic about funding.

MS OICKLE: Yes, because at the moment what we've got is, you know, a 5,000 word puzzle and no picture on the front of the box about what

picture this is supposed to form. Really, we've got everyone kind of – you know, with all their little pictures and there's no overarching strategy. Now, I'm not saying that government needs to come in and, you know, dictate everything. Obviously every ESO has to have their own strategic plan. They have to have their own operations. But, as a CEO, I can't just go off willy nilly and do what I want, without the board setting the strategic direction.

I believe that the government should be setting the strategic direction, and then we take – you know, our ESOs have to, you know, align to that. And that strategic direction, part of that should be governance. It should be this is what is expected, these are the standards, this is what quality service should be. It shouldn't be the board saying what the participants need. It should be very much like the NDIS scheme in a way, the good parts of the NDIS. You know, what do the participants need? How have you based your strategies for your organisation on that? What research is that based on? What policies do you have in place? What training do your staff have?

These are not, you know, methods that would control what an organisation does. These are methods that control how they align to an overarching set of quality standards that enable government to see how the puzzle pieces fit to that picture on the box, and that is what we're missing, and that is why there are so many ESOs out there who are doing completely different and unrelated things, and we don't know, you know, who's doing what because there's no overarching organisation. I mean, we can even see this on the rugby field. You know, there has to be a strategy, and I don't see that there is anyone that could do that other than government really.

COMMISSIONER SPENCER: Well, Natasha, you've just given a terrific summary of a review that we did last year to Human Services because those same issues come up in a range of Human Services across Australia. How does government best leverage the range of organisations throughout? They're doing great work but - - -

MS OICKLE: I think accreditation.

COMMISSIONER SPENCER: What is it exactly? Accreditation but also who does it choose to fund? So, look, we - - -

MS OICKLE: I think that the people who apply for funding, it has to be a free and open market for those who are accredited. So if I want to apply for funding for a grant to buy – you know, to get buses for my ladies, okay, where are those buses taking them? What are they doing for them? How does this align to your strategic plan? How does it align to the actual

needs of your participants? And I think that much like the education sector, an RTO gets registered, they get accredited, then they can apply for funding as a second step.

COMMISSIONER SPENCER: Can I just ask you around that, because a very important point that you've made is the on-the-ground experience, the frontline experience of what works and what doesn't work, is critically important across a whole range of services. So that is the notion of government really in a significant way talking to exploring with those organisations on the frontlines of services. What are your thoughts and ideas, what should inform the strategy? That comes before, you know, any determination about funding and other things. So as it currently stands, do you feel that the DVA and others reach out to you to have those sorts of conversations?

MS OICKLE: No.

COMMISSIONER SPENCER: How could we assist you? What are your thoughts?

MS OICKLE: I can rarely even get to the right person on the phone when I call DVA. I have to – I think I called through to four or five different people just to find someone who knew that they had statistics on their own website. It is very difficult, and I know it's a very big organisation so that is, you know, somewhat understandable, but really I think that this is a very – I was very happy that this was happening. The first thing is to be informed, to listen to as many voices as possible.

But, secondly, look at other industries and what they've done and what's worked for them. Look at other countries and what they've done and what's worked for them. And as I pointed out before, the education sector went through this exact same – from a systems point of view, this exact same process. We had schools opening up that were, you know, giving our qualifications without proper study. And then, you know, we had the ATQF standards, and it became the ASQA standards, and then there became auditing. All of a sudden, the ones that weren't up to par, left the industry.

Then, you know, we have some quality assurance, so that when the funds are given out, we know, you know, this organisation has proven, not just with paperwork but through audit and speaking to the staff, they've proven that they are utilising this funding. They're reporting on the outcomes of the funding so that it contributes to government decision-making. There are no – you know, we will always have employees who are doing things that we are not aware of, but you know, you can't control

that. But from the point of view of governance, it's to put the systems in place, and then have people address them. And if that bar is there, a lot of people won't even reach step 1.

COMMISSIONER SPENCER: Look, just to put this into a broader context, and I'm sure you're aware of it, one of the observations we would make generally is just the paucity of information, data, information which demonstrates outcomes.

MS OICKLE: Yes.

COMMISSIONER SPENCER: That's missing from a whole range of issues.

MS OICKLE: Yes.

COMMISSIONER SPENCER: So you're highlighting a general issue.

MS OICKLE: I'm highlighting an issue that really looks like a revamp of the entire sector. It's looking at rebuilding the sector around quality standards and making sure that organisations are building their policies and their strategic plans based on needs of participants, not based on what they want to do. That is the purpose of an ESO.

COMMISSIONER FITZGERALD: Just a couple of things. Yesterday we heard in Sydney, and we've heard previously, that some ESOs believe a national peak body of ex-service organisations, broadly defined, is required. And that government should, in part, fund that, as it does in all other Human Service areas. This is a very unusual sector. It hasn't learnt and grown from other parts of the Human or Community Service sector, so it's quite different in the way it operates. So the first question is, do you have a view about a national peak body?

MS OICKLE: Yes, I think it's a bit of a risky thing to do, because then you have to look at who's on that peak body. I don't think that this should be – I think you have to be very careful about that because I've seen that happen and it generally doesn't turn out very well. I kind of disagree that this is a unique sector from the point of view of what I'm talking about. I think that anyone that runs a business - - -

COMMISSIONER FITZGERALD: When I said unique, unique as to its current lack of structure compared to some of the other human service areas, which have taken on some of these points much earlier.

MS OICKLE: Yes. I really think it should just be a matter of this is the consultation, this is what we've learned, and from what we've pulled, you know, apart, you know, obviously you guys are tired, travelling around, you've heard a lot of feedback. Okay. We're putting in a governance structure for the industry. It is an industry, and this is what it's going to be. I really have quite a black and white view on this. If there are ESOs out there who cannot satisfy these very basic standards, then I have to wonder, you know.

COMMISSIONER FITZGERALD: But, again, just taking Richard's point, in relation to government, government is only really interested in those organisations which it wishes to fund, in many senses, either for services or for recognition. So if there's 3,000 ESOs, government isn't necessarily concerned by that. What it is concerned about is where does it target its investment.

MS OICKLE: Yes.

COMMISSIONER FITZGERALD: That's the crutch.

MS OICKLE: That's right.

COMMISSIONER FITZGERALD: So if you want to set up an ESO, you can certainly do that and the Commission thinks that's perfectly fine.

MS OICKLE: But the gate to accessing funding is through those quality standards and being accredited, and having the accredited bodies registered. These are the people that met the accreditation process. You're not pushing any ESOs out. What you're saying is, here's the door, fit through it. Yes.

COMMISSIONER FITZGERALD: I would imagine you would understand that this is a very – your views are very contentious within the ESO community.

MS OICKLE: I haven't found that.

COMMISSIONER FITZGERALD: You can see they (indistinct).

MS OICKLE: I've found that it's only contentious with people who would see it that way. I've found that most of the ESOs that I've spoken to are – have the same concerns and the same views.

COMMISSIONER FITZGERALD: So just as my final question, do you think there is a shift within the ESO community generally to not

necessarily all of what you're proposing, but the general direction that you're proposing?

MS OICKLE: Yes. The ones that are not in favour of this are often the ones that don't think that they could meet the quality standards. I'm sorry, but this is – you know, it's - - -

COMMISSIONER FITZGERALD: That's all right.

MS OICKLE: - - - just say it like it is. It's true.

COMMISSIONER FITZGERALD: No, that's good. And just the final question. In relation to War Widows specifically, yesterday – we've heard around the traps, you know, people asking for different things. One of the proposals by War Widows is an extension of the gold card to people that have reached 80 years of age, I think, and other extensions. In relation to the benefit system, itself, have you got any particular issues that you wish to raise with us today?

MS OICKLE: No. I'd rather focus on the broader things because I think that once the broader issues are looked at, then the smaller ones are easier to deal with.

COMMISSIONER FITZGERALD: Sure.

MS OICKLE: I don't see a purpose in going into the smaller issues when, you know, we don't even have a picture for the front of the puzzle.

COMMISSIONER FITZGERALD: Sure. Well, thank you very much for that.

MS OICKLE: Thank you.

COMMISSIONER FITZGERALD: That perspective is very important. Can I just make the comment, one of the issues that I think we're all struggling with is that the Productivity Commission is required to look at systems and structures for - - -

MS OICKLE: Yes. Yes.

COMMISSIONER FITZGERALD: - - - big issues as well as small details. So we haven't got the luxury of dealing with one or the other. But what we are struggling with is a lot of people within the sector have not ever thought about the systemic or structural nature of the actual sector.

MS OICKLE: Yes.

COMMISSIONER FITZGERALD: I suspect what you're saying is – and others have said it yesterday, is the time has come for everybody to engage in a very different conversation.

MS OICKLE: Yes.

COMMISSIONER FITZGERALD: Which is not the same conversation that has been had for the last 20 or 30 years. So, again, thank you for raising those issues with us.

MS OICKLE: Thank you.

COMMISSIONER FITZGERALD: Good. Thank you. That's good. Thanks very much. That's good, yes. Good. If we could have Brad Campbell. Thanks. Brad, if you could give your full name and the organisation that you represent, please?

MR CAMPBELL: My name is Bradley James Campbell, and I'm a representative of the Australian Veterans' Alliance. That's kind of an umbrella service organisation. My particular organisation is Veteran Call Back.

COMMISSIONER FITZGERALD: And you're representing the Alliance today. Is that correct?

MR CAMPBELL: That's correct, yes.

COMMISSIONER FITZGERALD: Terrific. Brad, if you can just give us 10 minutes of a précis of your key points, that'd be terrific.

MR CAMPBELL: No worries. Good morning, Mr Chairman, distinguished guests. I come to you today to ask for your assistance and guidance on an important matter that is affecting a vulnerable section of the community. My name is Bradley Campbell and I'm speaking to you not only for myself but on behalf of all invalided veterans, many of whom, due to their disabilities, are not in a position to be able to have their individual voices heard.

Mr Chairman, disabled veterans are being negatively impacted and are suffering because of the systemic misreporting of the invalidity payments administered by the CSC. These systemic actions are being compounded by the actions of other government departments that are reliant on the

incorrect information being provided by the CSC. In many cases these actions are resulting in invalided veterans being forced to live below the poverty line. The systemic actions of the CSC are causing a great stress on a vulnerable section of the community at a time of increased veterans' suicide.

Mr Chairman, I'll explain these actions in more detail in a moment, but the majority of what I'm asking for help with today centre around the CSC misreporting of reviewable invalidity payment that can be raised, lowered or cancelled at any time as a permanent lifetime pension. This is of particular importance to the recipient because a reviewable payment under law is treated far differently for the purposes of taxation and family law, than a permanent lifetime payment.

It's important to note at this time that the veteran community is not asking for anything extra, nor are they asking for any laws to be introduced, cancelled or amended. All the veteran community is asking for is a fair, just and equitable application of the laws that are currently in place. I don't believe we need a new department or total revamp on the system. What we need is a cultural change within governmental departments, one where they uphold the model litigant standards, act with a morally and ethically guided compass, and apply the law as it should be. Arbitrary decision-making is death by a thousand cuts.

Mr Chairman, you hold in your hand the power to right this wrong, and we humbly ask you for your help and assistance. I will now go through the issues. The scope, as applied to DVA, is not being met by CSC. The problem. I see the exclusion of the CSC from the scope of the Commission as one of the serious issues I have faced when dealing with CSC, their wrongdoing and government interplay. Every time an issue is raised with an MP, senator or government agency, there is no will or want to correct them. It is essentially swept under the carpet.

The CSC was the only superannuation fund explicitly excluded from the Royal Commission. Why? We have no voice. Neither the Commissioner or the Royal Commission, nor government, had the will to include them. The government response was that CSC would be part of the Productivity Commission hearings, and this was from a discussion with the Minister for Veteran Affairs. I was told that – I asked for a senate inquiry at minimum. I was told this was the place to raise my issues.

It is troubling to me to see the exclusion of CSC from the scope as it's applied to DVA. CSC have failed in a number of areas. They are not veteran centric. The decision-making is from unsound and unethical medical practice. They have failed in providing effective governance,

administrative and service delivery in the sense that administrative decisions flout the law.

Point 2. Treatment of invalidity benefits as though they are lifetime pensions. The problem. Ignorance of the law. Many of these issues faced by injured veterans are centred, as previously highlighted, around one fact, these are not lifetime pensions. There is no guarantee these benefits are paid for life. They have review periods as enacted in the legislation. It's legislated. It's in their trust deed and it's in the legislation that their trust deed is formed from.

COMMISSIONER FITZGERALD: Yes.

MR CAMPBELL: CSC openly admits these benefits are reviewable and described them as, and I quote:

> *Members classified as class A or class B are not guaranteed an invalidity benefit for their lifetime and may be subject to periodic medical reviews by CSC or its delegate until the member reaches age 55.*

And that was from their financial report, 2016/17, tabled to Parliament. Interestingly, their language has changed in the 17/18 financial report. The effect. CSC are misreporting these benefits in the realms of family law disputes and the way the benefit is reported to the ATO. This means veterans' invalidity benefits are subsequently valued incorrectly and split in the family courts, and are taxed at the marginal rate, rather than having the compensation aspect recognised under the superannuation lump sum taxation regime.

Solution. Report the true nature of the benefit to the various agencies that deal with veteran invalidity benefits. Veterans deserve to be afforded their rights at law. The next point from page 507 and 508 of the draft report. The blurring of defined benefits and invalidity payments. The effect of Campbell v Superannuation Complaints Tribunal. The problem. It was noticed that during divorced proceedings the reviewable invalidity benefit was being reported and valued as though it was a defined benefit interest.

The problem is the legislation stated that the definition of a defined benefit interest in the family law superannuation regulations excluded such benefit from being paid if the benefit was paid on the grounds of death or invalidity. So essentially an invalidity benefit is not a defined benefit interest for the purpose of family law. ComSuper were reporting it as such. This was confirmed in my Federal Court action, Campbell v Superannuation Complaints Tribunal.

Through the complaint process I raised the issue with the CSC, who dismissed the complaint. They refused to listen. I was referred to the Superannuation Complaints Tribunal who came to the conclusion my concern was frivolous and without merit. Go away, we don't know what you're talking about. I was directed to the Federal Court where the CSC again advised me I was wrong and would face a negative cost order if I proceeded. Threatening, bullying and intimidation.

I continued as a self-represented litigant and the court found that I was, in fact, right. It is not a defined benefit interest but, rather, than accumulation interest. The CSC did not appeal the decision but, rather, continued to provide information to its members as though invalidity benefits were still a defined benefit interest. They essentially ignored the court's findings. A court's ruling is law, l-a-w, law. They continued to report the benefits as defined benefit interest after a federal court judge found it did not apply.

There has been no investigation into this. I've raised this with government. I've raised this with many people. No one has had a look at it. They did this, I believe, knowing that the Attorney-General's office was busy with their help in drafting retrospective legislation to circumvent my court action. The retrospective legislation ensured or tried to ensure that the mistake that was made would be covered back to 2005, so some 15 years of mistakes were no longer mistakes.

However, the legislation enacted draws its authority from regulation 43A. I won't bore you with that. The authority deals with lifetime pensions, so the authority for them to cover their mistake deals with lifetime pensions. The issue is that they treated a non-lifetime pension as a lifetime pension. It doesn't make sense. Effect. Even today the CSC continues to apply the retrospective legislation and fails to acknowledge these benefits are not lifetime pensions. So still today veterans are still going through the family law process and their benefits are still being valued using a valuation method that only applies to lifetime benefits or defined benefits.

This forces veterans to take the matter to court, rather than being able to settle amicably. Hundreds of thousands of dollars are being spent by veterans to protect their right to their income, and that's what these invalidity benefits are, it's compensation for lost income. I've been told it's not, yet it is offset, as you know, dollar for dollar, any incapacity payments through DVA.

COMMISSIONER FITZGERALD: True.

MR CAMPBELL: So I've been told by their legal representation from ComSuper and there are people in the audience who would be able to confirm this, that this is not insurance, it's just superannuation. But it has been reported as an insurance payment, compensation payment, in your report. Everyone else acknowledges it, except for ComSuper. So this forces veterans to take the matter to court. Veterans effectively have no super. Their super is foregone, and in its place an invalidity benefit is paid on a fortnightly basis from consolidated revenue. The invalidity benefit is of a compensatory nature.

In effect, a person's compensation is split with another party who has no injury. In effect, the non-veteran spouse – and this is not gender-specific, we do have female veterans that have gone through this – will be awarded a guaranteed fortnightly payment for life. The veterans' invalidity benefit, however, is still reviewable and may cease. So a person without injury is now guaranteed the compensation payment for life. The person with the injury can still lose it. This is not a fair, just, nor equitable situation.

The result of this is the government is now compensating two people for one injury. One without the injury. The veteran is able to access their entitlement to incapacity payments – that only changed in 2016 – which now sees the government paying more in total for the compensable injury. So rather than paying, let's say, 60,000 a year in an invalidity benefit, 20,000 may go to the non-veteran spouse and then the veteran may be topped up by another 10,000. So now the total compensation package is $70,000, with 20,000 going to a person with no injury.

The non-veteran spouse is essentially in receipt of superannuation without having met any of the three requirements of accessing super. Those are attaining retirement age, death or grounds of invalidity. They're the only three reasons you can access your super. It is not uncommon for the non-veteran spouse to be awarded a benefit in the vicinity of 20,000 per annum. To earn $20,000 in super you must have a job that pays $222,222. That is not a requirement. The spouse receives this regardless of their working situation. So they could be in employment and then receive $20,000 a year on top.

Solution. The true nature of the benefit is that of an accumulation interest. It is not a lifetime pension and, therefore, meets the definition of an un-splittable interest. The law is already in place, it just needs to be followed. The authority and subsequently the methods and factors used to value the invalidity benefit, do not apply.

COMMISSIONER FITZGERALD: You've only got two minutes to go before we can have a bit of a chat about these, and I know you've got a substantial submission which you are going to give to us, I believe.

MR CAMPBELL: Yes.

COMMISSIONER FITZGERALD: And you've given us some talking points. So just a couple of minutes on the key other issues that you would like us to talk about.

MR CAMPBELL: Okay. Well, the other key points is the CSC review processes. I accept that CSC is not mentioned in the CSC process, as discussed. The problem is the initial classification process if flawed. They operate very much like an ordinary compensation claim, which is fair enough, given the task they do. What has occurred is akin to the Cominsure fiasco of several years ago, doctors' comments for cash.

In my own case, I was medically discharged with multiple skeletal injuries. I have a report from Defence saying this person's body is knackered. I go to their doctor, the report they give me, running at the Olympics, class C, nothing. I have to review that process, but in the review process you're not allowed to rely on any information that has been tabled. You have to come up with new evidence. How do I prove evidence that has been proven through surgery? The evidence is there. It's quite simply been ignored. So through ignorance I've now got to prove something that has already been proven, just through the flawed process. They don't use the medical evidence that's available to them.

The information sharing between CSC and DVA. The draft recommendation is that that should occur. I believe that should occur. The other anomaly is that DVA will send you to their doctors and they will say, "Yes, you've got all these injuries. These are the levels. Here's your compensation." ComSuper are saying, "Nothing wrong with you." How is that possible? It's medically impossible and it all comes down to the process in the review, and if that information was shared between the two entities, this wouldn't happen.

Then if the information is shared, we wouldn't reach the situations where there's overpayments and that overpayment, because the two entities don't talk, results in double taxation. You've paid tax on the overpayment, DVA want the entire overpayment repaid, including the tax that you've already paid to the tax office. They then take tax out of that. You pay it with post-tax dollars – you pay it back with post-tax dollars, so you pay tax twice. They then don't give you a PAYG summary stating that you've

paid tax twice. Unless you know, you just pay the tax twice. And when you ask DVA, they go, "We don't know." So that's just - - -

COMMISSIONER FITZGERALD: Sorry, we might just stop there and we will read the rest of the submission. Can I just ask a couple of questions specifically? Superannuation is not within our terms of reference, per se, but the interaction between superannuation and DVA is, or Veterans Affairs, to some degree. So we can only enter this discussion in a very narrow way, and I think you appreciate that. That's just the way the terms of reference are. But I do want to deal with a couple of issues.

The current payment that, as you say, has been determined by the court to be an accumulation payment, is currently reviewable, and I presume that means that if your health changes, your health status changes during your life, then, in fact, the payment that is paid under the invalidity arrangements changes. Up and down .

MR CAMPBELL: Correct, and can cease.

COMMISSIONER FITZGERALD: And can cease. So your contention is that your significant disadvantage, relevant to the person that wasn't injured or didn't suffer ill health, who gets a lifetime payment. Is that right? On that superannuation.

MR CAMPBELL: That's correct.

COMMISSIONER FITZGERALD: So what is the logic, do you think, where the payment – sorry, can I go back to it? What's wrong, in your mind, with the notion of a reviewable payment for invalidity? So just why do you think that is fundamentally a wrong principle?

MR CAMPBELL: I don't think it is – no, I think it's okay. If you have the capacity to work and you're back in – you're back working and you're earning an income, you should be reviewed because it's paid on your - - -

COMMISSIONER FITZGERALD: Right.

MR CAMPBELL: The classification is done on your qualifications.

COMMISSIONER FITZGERALD: Okay.

MR CAMPBELL: So if you gain a new qualification, you're back in employment, the payment can cease, yes.

COMMISSIONER FITZGERALD: So you're not objecting, Brad – it's just my – to just get clarification, that you're not objecting to the reviewable nature of the payment, itself?

MR CAMPBELL: No. Well, the issue that occurs is if you're on an invalidity benefit and you go to the bank for a loan for a house or a car, they look at it and go, "But this is a reviewable payment. It's not guaranteed."

COMMISSIONER FITZGERALD: So that's where the – is that where there's an adverse consequence?

MR CAMPBELL: There's an adverse consequence. What the government is turning around and telling other government agencies is that, no, this is a lifetime pension.

COMMISSIONER FITZGERALD: Right.

MR CAMPBELL: Well, if it's a lifetime pension, why can't I get a loan? If it's a guaranteed lifetime pension, why – if I go back to working and you review me, is there a guarantee that I'm not going to lose my benefit? No, there's not, so it's not a guarantee. It is not being paid as a lifetime pension. A lifetime pension dictates it's paid for life.

COMMISSIONER FITZGERALD: So is it the categorisation by government agencies that's concerning you, or is it actually the way in which that payment is actually made?

MR CAMPBELL: It's not necessarily how the payment is made. It's the classification.

COMMISSIONER FITZGERALD: Okay.

MR CAMPBELL: ComSuper know it's not a lifetime pension but they're treating it, reporting it as though it is, and that has negative outcomes for veterans in various aspects of their life.

COMMISSIONER FITZGERALD: So the second thing is, and this has been raised by a number of other organisations, and I'm sure it will be raised in the next day or so here, is that an invalidity payment under the superannuation scheme is offset against an incapacity payment under the Veterans Affairs Scheme, and some people have submitted they think that's unfair, and we've examined that and come to a view, but I'm sure there's going to be lots of disagreement about that. What is your view

about that, the offsetting of the incapacity payments received in DVA and this invalidity payment under super?

MR CAMPBELL: Well, that's a government policy direction. That's what the government want. I agree, we shouldn't be compensated twice for the one injury, and that's a mechanism that stops this occurring. But as I've highlighted, what is occurring now is that they're compensating two people for the same injury, and one person without injury. Incapacity, being injured, you're entitled to, at a minimum of 75 per cent of your retirement wage after 45 weeks, if you're under MRCA. Under DRCA it's 70 per cent. One or more points was the five per cent reduction, which is just nonsense. So as a whole, the compensation package should be offset against each other, but at a minimum you should be paid at minimum your 75 per cent.

COMMISSIONER FITZGERALD: Okay. The third point just related to that is we have looked at whether or not the determination of the invalidity payment under super should, in fact, be brought within the administration of DVA or the Veteran Services Commission, whatever there is in a few years' time. And am I right in saying you think that's a good idea or did you – or you don't have a view on that?

MR CAMPBELL: I see there's merit in it, as long as there is a mechanism within the total compensation package for you to be compensated for your loss of ability to earn superannuation as well. No one joins the military expecting to hit retirement age living in poverty. So if I had served my 40 years, 45 years out in the army, I would have had a reasonable standard of retirement. Because my employment was cut short by some 30 years, I now have no – I'm in receipt of my super, but this is only increasing at the rate of CPI.

COMMISSIONER FITZGERALD: Yes.

MR CAMPBELL: So if I do rely on this, so essentially I understand what you're saying but if we – if you remove the benefit out of super, and that part of - - -

COMMISSIONER FITZGERALD: It's administration out of super.

MR CAMPBELL: Yes, yes, out of super, there needs to be something to replace the member's super at retirement age. That is just a consideration that needs to be - - -

COMMISSIONER FITZGERALD: Well, and I will need to think about that just a little bit further but if I can come back to the fourth point,

and then Richard may have some questions, given this is a very complex area. But the fourth point is we have heard from many people that at the present time you have to have an assessment by the Defence Force doctors, a doctor nominated by DVA, and a doctor nominated by ComSuper. Now, that's changing. There are, in fact, some pilots to change that at Holsworthy and at Townsville. But at the present time that's possible. So your view is that that needs to be brought together so that there's only one assessment. Is that right?

MR CAMPBELL: Yes.

COMMISSIONER FITZGERALD: Yes, and do you see any practical implications for that? I mean, these trials that are currently being examined, I understand are joint ventures between Defence, DVA and ComSuper, to try to deal with that issue, but they're only pilot projects at the present time. But do you see any downsides with that approach of only having a single assessment for the three agencies, and the three purposes? It would change the nature of the assessment because at the moment each of those are held for different purposes, but if you could get a common set of purposes, would that work?

MR CAMPBELL: I think it would work, as long as the underpinning principle that I didn't get to talk about is ethical. The word ethical is - - -

COMMISSIONER FITZGERALD: Just talk to me about that.

MR CAMPBELL: Yes. So ethical is a serious submission. It should be noted that a key government principle of acting ethically has been omitted from the Commission's report. If ethical behaviour were to be entrenched behaviour within various departments, then the issues we face would not exist. As long as by having – if the doctor's appointment was veteran-centric and they weren't there as doctors for comment, which does happen – cash for comment. And a true reflection of that person's injuries and capabilities was reported to the various agencies, then there would be no issues. But the problem is that we do have issues with this because doctors - - -

COMMISSIONER FITZGERALD: If I can just follow on from that, and then Richard will have some questions. You say that they should act ethically. Well, we agree, absolutely, and if we haven't said it, we will, because that's an underpinning of all of our approaches to both private and public enterprise. But why will it change? I mean, at the moment we've heard people say that DVA doctor shops. It finds the doctors that are going to give it its answers. People don't say that necessarily in Defence, but they do have views about doctors. And I'm sure if we spoke to

enough people around Super, they would have that view. So, yes, we can say they should act ethically, that is both the practitioner and the government agencies, but in practice would it make a difference?

MR CAMPBELL: It's hard to say. I guess it just depends if they're going to act ethically or not, because in my case they didn't. ComSuper withheld my medical evidence and didn't give it to the doctor. So I sat there and explained all my injuries to the doctor and they said, "There's no medical evidence. You've provided me no evidence." I didn't have that evidence. One thing that does need to occur is that part of the discharge process is that ex-ADF members, medically retired need to be informed on how best to interact with what's coming, and that's an issue.

You're just thrown out the door. And being a good digger, you go, "Does that hurt?" "Kind of." Because our pain threshold is a lot higher than the average because we've had to endure a higher pain threshold. So when a doctor says, "Does it hurt?" "Yes," but it's screening, so we don't generally say, "Yes, my shoulder hurts. My back really hurts." It's just like, you know – but that's what you – when you're fresh out of Defence, that's your mindset. It's not until 10 years later when you talk to people and go, "You've done yourself a disservice there," you know at the time. But that legacy goes with you.

COMMISSIONER FITZGERALD: Sure.

MR CAMPBELL: I understand what you're saying. I don't see any issues. There's not going to be as many other issues going to the single doctor, as there are issues that we face today. That comes down to the system.

COMMISSIONER FITZGERALD: Sure, and I just want to be clear right at the moment, each of those referrals have a slightly different purpose, so you have to rejig the nature and purpose of the assessment for that to happen.

COMMISSIONER SPENCER: Brad, you described earlier how you went through a system of appeals through the superannuation group and then up to the Federal Court. This may be out of scope for the VRB but did you at any stage go to the VRB around any of these issues, or was it exclusively through the superannuation pathway to get the reviews that you wanted?

MR CAMPBELL: ComSuper doesn't come under the VRB process.

COMMISSIONER SPENCER: Yes. Yes.

MR CAMPBELL: So it's purely Superannuation Complaints Tribunal.

COMMISSIONER SPENCER: Yes.

MR CAMPBELL: I've been to ASIC. ASIC said, "Bugger off."

COMMISSIONER SPENCER: Right.

MR CAMPBELL: I've been to AHPRA. It's a single complaint. Every government agency we've been to don't want to know about it. I went to the Attorney-General's office. He sent me to my local member. My local member refused to raise it as an issue in Parliament.

COMMISSIONER SPENCER: Right.

MR CAMPBELL: So my representative in my State wouldn't do anything. All the legal entities that are set up, the tribunals, the Superannuation Complaints Tribunal said, "It's frivolous and without merit". And when I raised the issue about the authority, well, this is not a lifetime pension. The second time in court my own legal team wouldn't even raise that as an issue, so I don't know what's going on there.

COMMISSIONER SPENCER: So what you're describing is, you know, like, a series of events that have, in a sense, gone wrong from day one, and then just compound and you're describing to us the experience you've had through that sort of journey you've been on. If we go back, I mean, I just come back to what Robert referred to earlier, that is some efforts of cooperation between DVA, CSC and Defence around the transition issue and the joint medical and there's this Holsworthy trial that Robert referred to.

Cooperation is good. We don't think it goes far enough because it relies often on just goodwill between people, so that things don't fall between the gaps. A benign explanation of some of this can be things just fall between the gaps or there can be other things going on. So one of our recommendations is a joint transition command to say there needs to be – somebody needs to take responsibility for the transition process, and all aspects of that transition. As you know, we have said that ADF does most of that at the moment, but ADF should be responsible for a period through that.

There should be a much more proactive series of steps and engagements, both for the veteran and their families. Families in the widest possible sense. And that should go for a period afterwards of about six months.

Some have suggested to us a period of 12 months. Do you think – and the responsibility – because often what happens between different areas of government is nobody is responsible or it's unclear who's responsible.

So just around that particular issue, right at the beginning at the sort of journey you've been on, we're trying to get responsibility and saying it should be with the ADF, it should be with Defence, it will go to DVA or CSC whichever body comes afterwards later on. Does that make sense to you? Do you think that would be helpful, to try and ameliorate some of these things that seem to go wrong from day one?

MR CAMPBELL: Well, I've been out 12 years or 11 and a half years now, so I believe Defence has changed a lot since I was in. We basically just got kicked out the door, see you later. I believe now they do have transition cells, and what you're discussing is being worked on. I'm not – I don't work in that space. I don't think I'm really qualified to give an opinion on where it should go. I'll leave that to the ESOs that actually work in that space.

COMMISSIONER SPENCER: Sure. Okay. No, fair enough.

COMMISSIONER FITZGERALD: So the aim of that transition authority or transition would be that it would have DVA and ComSuper in it.

MR CAMPBELL: Yes.

COMMISSIONER FITZGERALD: So that right from the beginning of the transition process, the key players – and there may well be others – that all should be sitting around in the same place, are making, you know, the whole process easier, and there's no reason why that can't happen. It can happen. What is missing is a structure by which that can happen. What is missing is a structure by which that could happen and again I go back to my original point, you can keep recommending doing things but if you don't have the right system and the right structure it won't happen and that's what we've been looking, structural issues so it may be of comfort.

Just in relation to one issue, can I just clarify this: are you receiving an impairment payment, not incapacity payments but impairments through the DVA system as well?

MR CAMPBELL: No, I'm under DRCA so I'm one of the forgotten children.

COMMISSIONER FITZGERALD: You're the DRCA.

MR CAMPBELL: I don't get anything other than a lump sum, that's it, see ya later.

COMMISSIONER FITZGERALD: Well, sorry, can I just ask that question. Did you receive a lump sum?

MR CAMPBELL: I have received a lump sum.

COMMISSIONER FITZGERALD: So the answer to my questions I, yes you were, you were on DRCA and you received a lump sum but under DRCA you can't put that into a periodical pension. One of the proposals that we're for is that MRCA and DRCA will come together in one combined Act and there are some technical issues in relation to that, including working out what the level of benefit would be but one of the things we do see is that people should have the choice of being able to take a lump sum or a periodic payment; it's for life or at least for a significant part of that.

Would that have made a difference to you or would you - and, I mean, you may not be able to answer this because it's history but at the moment, as you say, DRCA doesn't give you that right, you have to take the lump sum. Do you think that moving towards at lease optional position where you can take a period payment, would be a good thing?

MR CAMPBELL: I believe, been given the option, yes. Not being given an option you have no choice. At least if you're given the option you can make that choice and that's a very individual choice. For myself, I possibly would have taken a lifetime fortnightly payment rather than a lump sum but I didn't get that option. One thing I didn't get to touch on is the Gold Card, I can't get a Gold Card. It doesn't matter how banged up you are under DRCA, you could be worse than the guy next to but can't get a Gold Card.

COMMISSIONER FITZGERALD: And do you receive a White Card?

MR CAMPBELL: I have a White Card, yes.

COMMISSIONER FITZGERALD: All right.

MR CAMPBELL: But the White Card doesn't take into account the complexities of sequela conditions where you may have an ankle and knee problem which invariably will lead to a hip problem. Rather than being able to just go and get that hip looked at, because once you start getting joint problems every other joint goes, so then it's a process and every time

another joint goes, you've got to back to DVA, go through the whole process, it takes a year, another year to go through the "fix you up stage", whereas when you start getting those niggles, get on top of it, if it starts - - -

COMMISSIONER FITZGERALD: Just so I can understand this, as the impacts of your injuries start to evidence themselves and become more severe, even under DRCA you can go back and put additional claims as those conditions become evident, is that right?

MR CAMPBELL: That's correct.

COMMISSIONER FITZGERALD: And again if DRCA stayed as it is, you would receive additional lump sum payments subject to acceptance, that's correct?

MR CAMPBELL: That's correct.

COMMISSIONER FITZGERALD: The White Card gets, and correct me if I'm wrong, but the White Card also gets adjusted for those conditions that have been accepted by DVA, is that right?

MR CAMPBELL: That's correct.

COMMISSIONER FITZGERALD: So the White Card is not (indistinct)?

MR CAMPBELL: No.

COMMISSIONER FITZGERALD: So what's the problem with that from your point of view, Brad?

MR CAMPBELL: Well, the problem is, (a) DVA actually have to accept that position.

COMMISSIONER FITZGERALD: Correct.

MR CAMPBELL: There's a lot of - they're not exactly veteran centric at times. And, (b) you've got to go through the whole process again and it's a very stressful process. I've only just had my back covered. My treating specialist stated it was lumbar spondylosis and they said, "No it's not" so it's like, I've got it - it's in black and white (indistinct) so the difficulty with getting injuries accepted, until you go through the process you'll never understand it.

COMMISSIONER FITZGERALD: Sure.

MR CAMPBELL: And that's a big thing. It's fine for the policy makers and the decision makers to say this or this, until you actually go through the process you'll never understand or fully appreciate the difficulties.

COMMISSIONER FITZGERALD: Sure. Well, I accept that although I must say we've now heard from hundreds of people that have been through the process so I have a slightly better understanding but you're absolutely right, having not been through it I can't fully appreciate it. Is there a final comment you'd like to make, we're just out of time?

MR CAMPBELL: Essentially, and I know this probably isn't the arena for me to raise these issues, but I've been given no choice, I was advised by a governmental minister I can raise my issues with ComSuper. I'm not sure if you read my submission that I wrote for the Prime Minister, that was largely ignored. It's very frustrating when you see issues in the veteran community that can be very easily fixed, all it is is apply the law, and just through the ignorance of trying to tell someone there's a lifetime pension when you could ask anyone on the street. If you went up and said, "Hey, if I can stop your payment, is that a lifetime pension?", I'll give a million bucks if you find someone that says yes.

COMMISSIONER FITZGERALD: Sure. All right. Thank you very much, Brad.

MR CAMPBELL: Thank you.

COMMISSIONER FITZGERALD: Good, thank you for that. You're a very generous audience. Nobody claps in any of the other public hearings we've had so you don't have to if you don't wish to but you're very generous. If we could have Peter and Ron, the Royal United Services Institute please. You might grab the furthest microphone.

MR MAPP: This one?

COMMISSIONER FITZGERALD: This one.

MR MAPP: Sorry.

COMMISSIONER FITZGERALD: No, that's fine. And are you Peter or Ron?

MR MAPP: I'm Peter Mapp.

COMMISSIONER FITZGERALD: Peter, all right. So, Peter, if you could just give your full name and the organisation you represent?

MR MAPP: Peter James Mapp.

COMMISSIONER FITZGERALD: Thank you and the organisation?

MR MAPP: I represent the Royal United Service Institute Queensland where I'm the president.

COMMISSIONER FITZGERALD: Good, thank you. And if you could just give us ten minutes in relation to the key points you'd like to raise?

MR MAPP: May I tell the audience what "RUSI" is in case there's a misunderstanding.

COMMISSIONER FITZGERALD: Yes, please do.

MR MAPP: RUSI is not an ex-serviceman organisation but a not for profit incorporation with the object in matters of defence and security. The core membership, being retired military people and serving military people, and we desire to formulate considerate opinions regarding the Productivity Commission outcomes. RUSI Queensland may not reflect the opinions of the national federal body which maintains contact with government.

In fact, we don't relate or have an arrangement with the Department of Veterans Affairs but deal on a one to one basis with the Department of Defence. We have an office maintained in Canberra in the Department of Defence. We are headquartered in Victoria Barracks, Brisbane. Members who are clients of the Department of Veterans Affairs, are part of our core membership and we are aware that there are veteran issues which are in need of updating or reviewing.

One point of view stated was that the Department of Defence should hold greater responsibility from recruitment through transition and then through to the retirement for all of life. There was an opinion on the onus of responsibility in processing a claim with the Veterans' Affairs should not be that of the veteran but that of the Department of Defence or perhaps in terms of duty of care.

Of concern to members of RUSI who are recipients of DVA, there is a desire for integration of the passing of information between the two departments. There was points of view from very high levelled military

officers that there wasn't sufficiently good processing of information in the processing between the various departments, this at the level of brigadier and major general. Of concern to members of RUSI, who are recipients and clients of the Department, is desire that the integration of the Department of Veterans' Affairs into another government department should not take place.

I have had conversations with the Defence Force Welfare Association, DFWA, and I have been briefed very completely by that organisation. I have no wish to put anything on the table which would take from their submission so will hold back in that point of view. For your information, I am a life member of the RSL, I am secretary of the Darra and District RSL Sub-Branch Incorporated. I have held the positions of a Sub-Branch president, a district delegate, a district vice president, over a period of 20 years. I have lived and participated in the life and activities at the RSL, heard the complaints, guided people in advocacy, observed where the Department came under unfair criticism, and observed the behaviour of various RSL members regarding DVA issues.

The reason RUSI decided we needed to have a point here is simply that the basic member of an RSL, and I am not speaking officially from an RSL perspective, I am speaking as the president of the RUSI, that be understood because the RSL are presenting their own paper or letter today, but the groundswell of general level RSL members does not understand or understand how the process takes place and there is nobody that can be held responsible other than that member. So what we're speaking about here is where the member fails or the organisation fails and who's responsible? I think that's about what we need to say.

COMMISSIONER FITZGERALD: Thank you. can I just understand the relationship between your organisation; Defence, you have your office and you're embedded within the defence department by way of convenience.

MR MAPP: Yes, we are.

COMMISSIONER FITZGERALD: And do you receive funding from the Defence department?

MR MAPP: We do, yes. It's in the terms of - I have a grant system which will undertake operations of seminars.

COMMISSIONER FITZGERALD: Sure.

MR MAPP: We will run a seminar in July of this year which will not involve anything other than the issue of defence and security however four years ago we ran a very successful seminar on post traumatic stress and one of your speakers later today, Dr Khoo, who will be able to verify that we brought people from all over the nation.

COMMISSIONER FITZGERALD: Sure.

MR MAPP: And New Zealand and then we had a Canadian speaker who resolved the issue of how post-traumatic stress is being focused upon and where the direction of all the participants, whether they be a sufferer or a doctor or an administration, and how the process is handled.

COMMISSIONER FITZGERALD: Sure. Just clarify one issue, our recommendation wasn't that Veterans' Affairs system comes under Defence, it was the policy moves to Defence but the administration of the scheme be independently and reportable to the Minister for Veterans' Affairs but putting that aside, what do you think the role of Defence is in terms of its duty of care to serving and non-serving veterans? And the reason I put this is, one of the most surprising things in this inquiry was not that people have opposed us moving the Veterans' Affairs policy into Defence, but the strength of that argument based on a whole range of issues in relation to Defence itself.

Many people have questioned Defence's commitment to its personnel once they're on a transition path. People who have questioned Defence's ability to actually make a policy in the space. They've talked about conflicts of interest and the proposal we have is we think that one of the interests of Defence is in its personnel, both serving and non-serving, which we thought was unexceptional, that has been hotly contested. So I was wondering whether your organisation has a view as to what is the duty of are of Defence, not DVA, of Defence to serving and non-serving veterans?

MR MAPP: It has been discussed at RUSI level. My opinion would be that once you start service and you go through the process of - even if you're not deployed and then you go through transition and then into retirement, Defence started the problem and will ultimately have to take moral responsibility. Whatever the system does to take it through these three process doesn't necessarily meet the standards that people that are transitioning seem to expect.

I have been involved in several meetings of other ESOs that put points of view about how transitioning should be different. Always you could find

that they didn't follow the process but how you explain that to some of these people I really can't tell you.

COMMISSIONER FITZGERALD: So could I ask this, Peter, do you believe that there's been any significant change in relation to Defence's approach to dealing with and transitioning of serving veterans, particularly those that are being medically discharged?

MR MAPP: Yes.

COMMISSIONER FITZGERALD: And in what way has that changed?

MR MAPP: The process I understand came on after more modern wars and we heard it said today by the previous speaker, but I think there is genuine consideration. I do know of incidents some time ago where the officer passing the fellow into transition signed off on issues that he shouldn't have signed off on.

COMMISSIONER FITZGERALD: And does your membership, by and large, comprise of serving or non-serving veterans?

MR MAPP: Both.

COMMISSIONER FITZGERALD: Both. And if I could just talk a little bit further about Defence, one of our concentrations in our report has been about a dealing with preventable injuries and we understand there's always going to be a level of injury within the defence forces, and the reporting of those and the dealing of those both through health rehabilitation services and I was just wondering whether you have any particular view about the defence force's attitudes in those areas?

MR MAPP: I think it's responsible. Again, I'm not serving - sorry, I'm 79 and I finished serving at 25. There's a very big gap of reality here. In fact, the compassion that was there when I served to the compassion level that's now is enormous.

COMMISSIONER FITZGERALD: Enormous for the better?

MR MAPP: Yes. I can tell you when I pulled out of the military, you were on the back of a truck and they said, "Jump off", Victoria Barracks. I don't think that would be happening in this day and age.

COMMISSIONER SPENCER: Just a couple of questions. You mention at the beginning in your submission that you don't see yourself as

an ex-service organisation so we use that acronym, ESO, all the time so I was a bit curious about that because your members do tend to be current and ex-service people so why that distinction when you say - - -

MR MAPP: Okay , the constitution - the Royal United Service Institute originated after the Napoleonic wars. It's legendary and its operation is in Great Britain. It arrived in Brisbane in 1893. It's operated through that period with the sole objective of the defence and security of Australia. So when we speak to Defence, we talk to them and speak to them on those issues, those issues which will concern us, and influence government and have a point of view. Our vice president in Brisbane served eights years at the military attaché in Indonesia so he's pretty well informed. He's only been out of the military since mid-last year.

COMMISSIONER SPENCER: So when we look at, and as we were saying earlier we're going to be - we'll have more to say in that final report about ESOs, presumably you would be encouraging us to think a bit more broadly than that, which organisations could provide a service that is ultimately directed to the wellbeing of those serving or having served because you're currently funded by Defence but (indistinct).

MR MAPP: Yes, I wouldn't move away from the factor of our Defence arrangement, maybe that's not going to be always secure but I'm sure that if we went to the Department of Veterans' Affairs they wouldn't see us in the same light as an ESO.

COMMISSIONER SPENCER: And, Peter, in terms of your membership do you have a cross-section of - what you're describing I think is people from a range of different backgrounds and experiences but do you have a younger group of veterans as part of your organisation?

MR MAPP: We have a dynamic which we're attempting to address in that membership (indistinct) off far too high in age group. I think this was a generality of just about any organisation, which is a community organisation to be honest.

COMMISSIONER SPENCER: And just one last question: with having a presence, a physical presence, within the department, but beyond that do you find that the department reaches out to you, is seeking your advice on a range off issues, do they - - -

MR MAPP: We meet with them on a regular basis. RUSI has a federal organisation, a federation. We take points of view to the national level. We speak to the minister periodically. We're not about making policy. To give you an example, in July of this year we are running a seminar purely

based on Australia's position in the South Pacific and Indonesia. This is being overlooked at this point in time, more in favour of what the problems China has to offer. The bigger element of where Australia's influence has been is that our area of influence now covers from the Indian Ocean, all of the South Pacific and well into the North Pacific. We need to be on notice that the community at large understands these sort of issues. You won't do it without some criticism.

COMMISSIONER FITZGERALD: So just to clarify, you wouldn't be consulted - it's a question, would you be consulted by Defence in relation to issues relating to the wellbeing of serving or non-serving members or veterans?

MR MAPP: The federal body will be.

COMMISSIONER FITZGERALD: And you've expressed a view about concerns about putting Veterans' Affairs within defence, and I understand that, but do you take a more broad issue in things like transition, those sorts of things we've been talking about, or not really?

MR MAPP: Under my presidency I must point out to you that that hasn't occurred.

COMMISSIONER FITZGERALD: Sure.

MR MAPP: They are issues we must address in the future. RUSI has a responsibility to itself because it's quite capable of imploding as organisations like it, that the demographic, which is the young existing servicemen, doesn't necessarily see an organisation like RUSI as other than quite a group of old men.

COMMISSIONER FITZGERALD: Sure. Well, one of the things that has become very clear during this inquiry, and it's indisputable, is that the veterans' community is very much split across ages and the ESO community similarly so.

MR MAPP: Yes.

COMMISSIONER FITZGERALD: And it's more stark than I've ever accounted it in any other inquiry I've done and there are two streams and people bring very different views to the table from those two streams. So the issues that you've raised about your own future and that of the age group as well, I think the whole sector is probably trying to come to grips with at the moment.

MR MAPP: Yes.

COMMISSIONER FITZGERALD: But as objective outsiders, we see this extraordinary two streams within the veterans' community - - -

MR MAPP: Some will tell you that organisations like the RSL will go through a gap from when you're serviced to when you find an interest in veterans' affairs and veteran issues and I know that's the case in the sub-branch that I'm involved in.

COMMISSIONER FITZGERALD: Sure.

MR MAPP: I also think that the modern younger person, and I take into consideration that we had 35 years of very little military activity and suddenly there's a generation gap in how we approach life.

COMMISSIONER FITZGERALD: Well, we're experiencing that. Peter, thank you very much for presenting.

MR MAPP: Thank you.

COMMISSIONER FITZGERALD: We very much appreciate it. We will now break for ten minutes and we'll be back in ten minutes time, thank you.

SHORT ADJOURNMENT **[10.23 am]**

RESUMED **[10.40 am]**

COMMISSIONER FITZGERALD: Thank you very much for returning, and if we could - we already have our friends from the RSL. If you could both give your names and the organisation that you represent, please.

MR DENNER: So Scott Denner. I am the state secretary and general manager of operations for RSL Queensland.

MS JENYNS: And Margaret Ann Jenyns. I am the veteran services support manager for RSL Queensland.

COMMISSIONER FITZGERALD: Can I just do one thing? Can we just move the other microphone so you have both got microphones. That's it.

MS JENYNS: Thanks very much, Doctor.

MR DENNER: Thank you.

COMMISSIONER FITZGERALD: Just there will be fine. I am multi-talented with microphones. If you could just now give us a ten to 15 minute overview of your key recommendations, and we are very grateful for your submission, and also your participation in previous forums with the Commission.

MR DENNER: Thank you. RSL Queensland Branch has read and considered the draft report released by the Productivity Commission and appreciates the opportunity to respond to the issues which are raised. RSL Queensland has been supporting our Defence veterans and community since 1916. We were originally formed by soldiers returning from World War 1, and RSL Queensland is still run by veterans, for veterans. Our members are young and old, female and male. They have serves overseas and at home in armed conflict, peacekeeping missions and disaster recovery, and what they have in common is service.

RSL Queensland is the largest ex-service organisation in Queensland with 35,000 members in more than 240 sub-branches in ten districts. We offer advice, support and comradery to all current and former ADF members and their families. We help veterans the broader Defence family in real and practical ways, whether they are members or not. Our services range from assisting with DVA claims to funding vital research into PTSD and veteran mental health, from easing the transition to civilian life to providing opportunities for members of Queensland's Defence family to connect with each other.

RSL Queensland's submissions to the Productivity Commission align with objects 1 and 6 of our constitution by recommending pathways to support the effective rehabilitation and lifelong dignity of current service people, veterans and their families, and concurrently ensuring that current and future members of the ADF serve in a well-resourced, trained and fit organisation which maximises their success on the battlefield and minimises battlefield casualties. RSL Queensland supports many of the findings of the Productivity Commission relating to the complexity of the current processes. However, some of the proposals, whilst not costed, appear to significantly reduce access to benefits and processes which are currently available to veterans. As an ESO which has campaigned

strongly for veterans' recognition and for their access to appropriate care and support through DVA, we will not support any proposals which lessen the value and availability of benefits provided under the existing structure, unless there is a clear benefit gained from simplifying processes and making benefits more accessible and fit for purpose.

While there is much within the draft that, if implemented, would enhance the support to veterans, RSL Queensland strongly rejects the new governance arrangements, most particularly the establishment of a single ministry which the draft report describes as bringing the long-term wellbeing of serving and ex-serving members into consideration of broader Defence policy. RSL Queensland believes that in developing the draft report, the Productivity Commission has failed to conceptually separate the mission of the ADF with that of DVA, and indeed has approached the review from the perspective that the ADF operates in a matter akin to other large organisations within Australia.

The mission of Defence is to defend Australia and its national interests, while the mission of DVA is to support those who serve or have served in the defence of our nation. Combining two departments which have such fundamentally different goals may result in a short-term (indistinct) to the current account, but in the medium and long-term will neither enhance the defence of Australia and its national interest, reduce risk, or better support veterans.

As an example, RSL Queensland notes with concern the observation in the draft report that a change to who pays for veterans' compensation and rehabilitation by levying a premium on Defence for uniformed ADF personnel would provide an additional incentive. A premium is, in effect, a price signal about the real costs, lifetime, not short-term, of service-related harm. We believe that price signals will drive a perverse short-term approach to preparing personnel to defend Australia and its national interests. Personnel in the Army and those in the RAAF and RAN who are required to engage in close combat are, in effect, tactical athletes. Continuing with the sporting analogy, whilst a professional sports team would look to preserve their team by training in a manner that increases the likelihood that the majority of team members will be available for competition, this is secondary to ensuring that those who do take to the field are stronger, faster, and have greater endurance than their opponents. This is even more important for close combatants where physical superiority may literally be the decider between life and death.

We note in the draft report that the Commission appears to infer that a reduced injury rate associated with reducing marching speeds or running distances is implicitly a good thing. RSL Queensland categorically refutes

this assumptions based on the lived experience of our members. Whilst physical training should be graduated and conducted utilising world-leading sport science principles to reduce injury and increase performance, the physical performance characteristics required of close combatants must be based on their efficacy and survivability in combat, and not a simple reduction in compensation payments. To do risks the lives of Australians.

Separately, although not germane to the overall thrust of the Commission's report, RSL Queensland notes the fallacy of the comment within the draft report that although the member is technically compelled to go on a deployment if ordered to do so, in practice, deployments are highly sought after and there is often an element of choice involved. This observation may hold for isolated instances where the number of personnel required for deployment is comparatively low, but is not reflective of the Australian experience of war since Federation, including of conscription, mobilisation of CMF and Reserve units, and enforcement of the provisions of the Defence Act 1903 and the Defence Force Discipline Act 1982. Thank you.

COMMISSIONER FITZGERALD: Good, thank you very much. We have a detailed submission from you, and we will come to some of those matters in a moment. Can I just deal with the issue in relation to Defence? It is one that you will have heard that we have raised several times. As you are well aware, DVA and the Defence Department exist within the Defence portfolio already.

MR DENNER: Sure.

COMMISSIONER FITZGERALD: One of the things that has happened in this public hearing is many people have not understood that, and it has come as a revelation to many that DVA already is in the Defence portfolio. For many years now, the Minister has been the same person both for Defence personnel and for veterans.

MR DENNER: Correct.

COMMISSIONER FITZGERALD: One of the issues for us is the policy making between Defence and DVA in relation to serving and non-serving veterans is not coherent, not consistent, and it certainly doesn't deal with the lifelong needs of the veteran. We were coming from a very simple position: how can we better integrate policy - not administration of the scheme, which was never going to go within the Defence department - to better account for the whole life of the serving, non-serving veteran, based on the government's definition of a veteran being anyone who has

served more than one full day. That is a decision of government, not the Productivity Commission. So what is it about Defence that you think - that makes it so ill-equipped to be able to deal with planning? Now, you've named one issue, which is about a conflict of interest of a conflict of purpose.

MR DENNER: Yes.

COMMISSIONER FITZGERALD: But I won't go on, other than to say that is not so in New Zealand, where in fact Defence does in fact have responsibility for veterans policy, and it is not consistent with some other armed forces across the world, where they actually have the twin goal of defending their nation and ensuring the wellbeing of their service personnel throughout life. The Australian construct is not unique, but it is not the only model. I just throw that back to you to just sort of understand your concerns about policy going into Defence, because that is all that we were putting in.

MR DENNER: Yes, sure. I will go to your last point first, and I agree that there are other models that are in use around the world. The UK have some similarities to the New Zealand model as well. Simply because another nation is using a model is not, in my mind, an indication that it is an effective or correct model.

COMMISSIONER FITZGERALD: Sure.

MR DENNER: One of the key concerns that we have from that perspective, as we note, is the effective conflict of interest that it creates between supporting veterans in their rehabilitation who are wounded, injured in defence of the nation. I use the statement that the Productivity Commission made about the price signals that you are intending to create. Our concern is that at a point in time, operating under a single budget in a single department, choices will end up being made between providing an increase to a disability payment, to a pension, or buying equipment that serves for the defence of Australia. We think that that is a wicked problem, and not a problem that should be created by a machinery of government change.

COMMISSIONER FITZGERALD: Just in relation to the price signal, all employers around Australia today, including yourselves as the RSL, have multiple incentives to create a safe workplace, contextualised to the industry. Some of those industries are high risk and the likelihood of injury is high. We understand fully that the military environment is unique and there are a number of factors that indicate that injury is likely to occur in certain circumstances, particularly training and operational

issues. But the notion that the employing body - and again, we acknowledge that Defence Force personnel are members and are in fact servants of the Crown. It is the only body that is exempt from bearing the financial responsibility of the injuries that occur to its personnel.

MR DENNER: Yes.

COMMISSIONER FITZGERALD: Your sporting analogy, which I think is an interesting one about athletes, they are all subject to workers' compensation.

MR DENNER: Sure.

COMMISSIONER FITZGERALD: The question is whether or not any of the professional sporting teams in Australia, to use your analogy, are in fact perversely impacted on their training of elite athletes. I am not aware the evidence is there. What I am saying is that organisations that actually are engaged with athletes, professional sports people, people in high risk businesses, are subject to both regulation and a price signal, and there is no evidence that that has in fact downgraded the quality or skills or the performance of their workforce. So why is it in ADF that this fear is so great? I am not disagreeing with you, but I want to understand what it is about ADF that is so special. Because the evidence at the moment is both good quality regulation, and I acknowledge there is some poor quality, and appropriate and reasonable price signals actually seems to work in a positive way, not in the negative way. Yet many people put your proposition to us.

MR DENNER: Sure. So the fundamental difference between the armed forces and any of the other organisations that you make is that people in the armed forces are trained to kill people and operate in areas where they may be ordered to do something that will definitely result in their injury or death. That is the fundamental difference. So you know, the term tactical athlete is utilised increasingly frequently to describe the fact that their performance on the battlefield will be a decider between life and death for them. A mechanism that may deliberately or not deliberately influence the training such that the training of personnel is suboptimal, in order to reduce a health premium, as example, will actually have a long-term consequence on the health and safety and indeed the life and death of service personnel.

COMMISSIONER FITZGERALD: That is assuming that the price signal, and a premium is a price signal but that is not a sin, the evidence that that would occur is not clear to us. Now, if I can go back a little bit. In 2011 when the full effect of the workplace safety laws were introduced

to the ADF, everyone has said to us in the ADF that there has been a significant change in the way in which training and safety is dealt with. Most people have said positive things. It is equally true that there are some that have said to us they think it has softened training, and had an effect in that way. But the evidence is not clear. What is clear, there has been a reduction in the level of preventable injuries in certain areas, such as down at Kapooka where we visited the army training school and so on. So the question I just want to ask again, I suppose, is that people would have said at the time those regulations would have the same dampening effect or dilution of, you know, our force capability. But the evidence isn't clear that that is the case. And I just wonder whether or not you might be overly cautious in your view about what a premium would do to ADF.

MR DENNER: Look, I agree on overly cautious when it comes to the lives of Australians, and that is what we are talking about. So this isn't an experiment that we can just run to see if it works or not. Australians have paid with their lives by doing that before. We were poorly prepared in the leadup to World War 2, and literally thousands of Australians died because of that, particularly the CMF serving in PNG because they didn't have the same physically robust training standards as the AIF that was in North Africa. So as a country, we have got a lived experience of that. I agree that I am being very conservative about it, but I care about the lives of Australians.

COMMISSIONER FITZGERALD: Sure, and so do we, and I am sure that we have a collective mission in relation to this. And the RSL, as I understand it, have agreed with basically our goals and principles that underpin both outcomes for veterans and the scheme itself. Can I just go to a couple of others that flow from that? You have linked, and I may be incorrect, but just in your opening statement, those issues about physical performance and a reduction of payments. We have basically, as you know, retained the VEA.

MR DENNER: Yes.

COMMISSIONER FITZGERALD: With very minor modifications. We were looking at bringing MRCA and DRCA together, and the only issue there is what is the level of payment, and we will make a recommendation subject to all of these hearings about that, but it is likely to actually benefit many veterans. And nobody that is currently entitled to a Gold Card or other sorts of healthcare would have that removed. So when you say reduction of payments, there is nothing in our report that indicates that that would be the case. So what are you referring to specifically? There are some allowances we have certainly said we should

look at, and there is about a dozen of those. Some of those we think should be paid out, some of those we think should be incorporated into the main benefits. But when you say reduction of payments, which ones are you specifically referring to?

MR DENNER: Are you talking about the opening statement that I made - - -

COMMISSIONER FITZGERALD: Yes.

MR DENNER: - - - or detail within our report? So what I referred to in the opening statement is not about individual payments, but the consolidation of the budget of DVA and Defence into a single budget. It is perhaps a fig leaf, but certainly the government talks of the budget for DVA as being uncapped. I think there is probably some practical realities to that, but regardless, that is quite separate. If the budget for both organisations are brought together and are fixed, decisions will need to be made about how that funding is allocated.

COMMISSIONER FITZGERALD: Sure. Well, let me assure you on the last point, that is not our proposal.

MR DENNER: Right.

COMMISSIONER FITZGERALD: That the Veterans' Services Commission, or DVA if it survives, would in fact be separately funded. We have indicated that part of that funding would come through the premium, and that is a separate issue, but it is related. But we are not merging Defence. I just go back to it, in the budget the Defence portfolio already includes DVA, but it is not Defence Department's. I can clarify that upfront.

MR DENNER: Yes.

COMMISSIONER FITZGERALD: You have raised a whole range of issues in your submissions, but if I just go to one. I understand, and correct me if I am wrong, that you are proposing a slightly different version of the transition arrangements than what we have proposed. I was just wondering if you can give some explanation to that. I think we have got the same objective, but we are coming to it from a different angle.

MR DENNER: Sure, and perhaps if I can just talk about why both Marg and I are up here. I will certainly respond to questions about broader policy. Margaret has long, indeed, experience with supporting veterans and dealing with DVA, so I will just defer to her in this case.

COMMISSIONER FITZGERALD: Sure.

MS JENYNS: Thank you. Would you like me to go through what our submission was?

COMMISSIONER FITZGERALD: Just in very brief terms why your model.

MS JENYNS: In brief terms, yes.

COMMISSIONER FITZGERALD: And why you think that might be preferable to the one we have proposed.

MS JENYNS: The model proposed in relation to rehabilitation for transitioning members is that essentially DVA would take over the process at a specified time before the person was - the date that they were actually identified to transition out. So what I have gleaned, from a long experience in dealing with rehabilitation processed with DVA, is that there is a virtual conflict between what Defence is providing through the Defence Rehab and what DVA is moving into, to then provide once they have transitioned out. So the conflict there is the actual takeover period. DVA doesn't get advised of people who are transitioning out in a very coordinated and specific way. The advice comes in a variety of timeframes and a variety of processes, and often when a person transitions out, they may not be prepared for the whole change in the life of what they are going to be going through. That is because sometimes it is left very late. So our proposal was that 30 days before the date of their transition out, the rehabilitation process is handed completely over to DVA. My proposal is that is already facilitated by the existing legislation, so it doesn't require any particular changes. So section 39 of the MRCA allows that the Chief of Defence Force is the rehabilitation authority whilst they are in service, and then under 39(3)(aa):

> *if the Commission, after considering advice from the Chief of the Defence Force, determines, in writing, that the Commission is to be the rehabilitation authority,*

they can take over.

What that would mean, within the ADFRP, their prime purpose as I understand it is getting the serving members back into the Defence Force. Back into the roles that they were existing - their existing roles. That's what the ADFRP is mainly about. If they can't get back into their existing roles, they are put into a role which is suitable for them within Defence.

So the whole aspect of moving into a civilian vocational rehabilitation process is quite foreign to their main core business, and it is the sort of work that DVA does, and I, in my submission, have said they could do it better. But if they could get engaged early and give a veteran a full understanding of the process and a way forward and a link into a high quality rehabilitation provider, who is expert in not just medical and psychosocial issues but also in vocational rehabilitation, they can then move forward with an existing plan. So at the date that they walk out of Defence, they have a complete plan of what is in the future for them. That is including working with commonwealth superannuation, including working with all aspects of their future. So they will be working in conjunction with the joint transition command, but they will be under DVA. They will have specialised rehabilitation providers who are working to assist them back into - - -

COMMISSIONER FITZGERALD: What we were looking at, we won't go into the detail, we have got plenty of opportunities to do that later. But we were wanting to get to the same outcomes but by a slightly different structure, I suspect.

MS JENYNS: Yes.

COMMISSIONER FITZGERALD: We see the joint transition command as certainly picking up people well before their discharge date.

MS JENYNS: Yes.

COMMISSIONER FITZGERALD: We absolutely see it as a multi-disciplinary and multi-departmental sort of beast which would have DVA and ComSuper and others involved in that. But can I just ask a specific question in relation to the rehabilitation? That has been one of the very big issues, where people have started or should have started rehabilitation prior to discharge, but on discharge it all falls apart. There is a number of factors for that. I was just wondering if you can comment about that particular issue? I know it has been raised in the taskforce, but your view of how it is functioning at the present time.

MS JENYNS: Well, a lot of the reasons it falls apart is because if a person starts their transition into civilian through the DVA process a bit late, they have to lodge a claim for liability, they have to get that process, they then have to apply for incapacity payments and whatever, and then they can be placed on a rehabilitation program. So often there is quite a gap between when they walk out the door of Defence to when DVA picks it up and says we're ready to go. That's the time when any veteran is most vulnerable. They have gone from a very structured, controlled life,

and suddenly they are in this vacuum, not knowing where the next step in their life is going to go. It's during that time, and I can say from experience, where we lose a lot of veterans. Where they get so confused and disorientated by the whole process that they start to take on more of an invalid type mentality as far as their future goes. It's the very important role, I think, of both Defence and DVA to say, get in early, so that when a person leaves they know exactly what the process is that takes them forward.

COMMISSIONER SPENCER: Sure, and we would absolutely support that view. Can I ask a few questions about the future role of ESOs? Because clearly RSL Queensland plays a really significant role with the veteran community, and you described earlier the number of veterans, families you support, the range of services. By way of background, we know that the - Robert Cornell has handed his report to government. It hasn't been made public yet, hopefully it will be soon, we are certainly encouraging that and we can look at that. That will have recommendations about the advocacy issues obviously into the future. But as you described in your opening comments, I mean, the range of services you provide is very widespread. From our point of view, and I think we have signalled this already, but we certainly want to say more in the final report. We see that as part of the bigger system. It's not just a government system, it's a bigger system. And an extremely important part of it, because as I mentioned earlier, there are those that are often the most isolated, the most in need, who will not engage with government services, who will be invisible to government services, but not to your members and your networks. Those kind of soft entry pathways into really finding out who needs help and how to provide it is an extremely important part of the system. I mean, two things that have struck us is, one, obviously the range of ESOs and what's happening, and as Robert said earlier, what ESOs do is up to them. It's part of a civil society, you decide what you are going to do. The role of government is who do we speak to? Who do we sit down and carve and nut out better solutions and answers so that they can do that? And very importantly, who do we fund, and why do we fund them? And we will be encouraging a better sense of planning strategy thinking about what makes a difference, and where is the outcomes from that.

There is a whole range of issues in there. When you look to RSL Queensland, you know, five, ten years from now and you think about what would we be looking for in terms of a government relationship? Money is part of that, but beyond that, what would fit well with where you see RSL Queensland going? Just in that discussion, obviously we are conscious that the notion of hubs is developing, conscious of what's happening up in Townsville. So what are the new models? What are the new ways in

which you, as RSL Queensland, would want to be operating if you look to future of a system like this?

MR DENNER: Sure. Can I perhaps just start with a bit of context. All member based organisations, whether they are ex-service organisations or not, are facing some societal pressures around membership. Of our 35,000 members who are in Queensland, they all have to be current or ex-service personnel. Their average age is 68. They are the ones who provide our volunteer effect. We concentrate in Queensland on running an effective business so that we can employ people increasingly to do the services that we provide. So whilst our member base is aging, the average age of the veterans that we support remains relatively young. Around 75 per cent of the claim support we provide is for DRCA and MRCA, so only about 25 per cent is VEA. So if you use those as a rough approximation of age, the average age of the people that we help is probably somewhere between 35 and 40. The veteran community is definitely looking for assistance, which is quite separate than do they want to be a member of an organisation? Part of the reason for the growth in the ex-service organisation community is failure on the behalf of the RSL to adapt effectively over the last 20 years. I think certainly as an organisation in Queensland, we are trying to respond to that. There is a lot of cultural change that needs to go on to move from being an organisation that contemporary veterans view as relevant to them versus being one that older veterans do.

Practically, one of the actions that RSL Queensland took was establishing another ESO named Mates4Mates in Queensland, and that was done deliberately. It is very targeted on support for the wounded, injured and ill, but it is also very targeted at being an organisation that is attractive to contemporary veterans.

What does the space look like ten years from now? Some of it will depend on government policy, and some of it will depend on how effective large ESOs like Legacy and RSL can be in adapting to the modern environment. We have done a lot of demographic studies here in Queensland. There are some very strong concentrations of ex-servicepeople. We know that in the northern suburbs of Brisbane about 8 per cent of the adult population are current or ex-servicepeople. That percentage is about the same in the west of Brisbane and in Townsville. In many of the other areas in rural and regional Queensland, it might only be 2 or 3 per cent, and they typically are much more aged. We see a hub-based approach developing in those areas that have large concentrations of veterans, and a fundamental shift in the peer to peer activities that veterans perhaps historically have looked to.

I think in many ways, the RSL, one of the adjuncts to the services that it provided was comradery, but effectively the establishment probably of the drinking culture in the 60s, 70s and 80s, and that aligned with society at the time. What we do know from extensive analysis of veterans in Queensland, and we surveyed about 3000 veterans and their families last year, is that they are really looking to move away from that as a means for engaging with each other, to have peer support, and much more towards a health and wellbeing model. So totally unsupported by government, so separate from what needs to happen through DVA for rehabilitation. Contemporary veterans and many older ex-servicepeople as well are looking for organisations to provide that opportunity for comradery to exist in a much more healthy environment, and we believe that hubs are going to be part of that, where physical activity can occur that is accessible by a broad range of the Defence population, but at those hubs services can be provided to assist connecting DVA with other ex-service organisations.

COMMISSIONER SPENCER: Look, it is an interesting trend, and I am sure you are aware of it, but generally across a whole range of human services what you are experiencing is the trend, namely that many organisations began purely as volunteer organisations around a particular issue, but over time, for a whole range of reasons obviously, the need to have a smaller group of professional services, but then how to leverage volunteers and what roles. And you mentioned peer to peer, and once again we'll have more to say in our report about that, but we understand the value of that. That is a very significant entry point for a lot of people in the form of assistance.

Just coming to another issue, we talked a bit earlier this morning about the peak body idea, and that is sort of a bit of a holy grail, I suspect, in terms of how to achieve that. It is not without its challenges for sure. But your thoughts on that? Because once again, government hearing the voice of a constituency in terms of deciding on its policy and its response is very important. How do you think that should emerge in terms of peak body, both input and influence, for government to be able to better attune its policy thinking around what is going to work and what is needed?

MR DENNER: Sure. Again, speaking frankly, the reason that there is a need for a peak body or something analogous to it is because of failure on the part of the RSL over the last 20 or 30 years. Practically speaking, up until the 1960s at the RSL national AGM, the Prime Minister of the day would go to the national AGM. So it reflects poorly on us as an organisation that there is a need for some form of national consistency, but I agree that there is. The form that that takes, I am quite open minded about that. I think as a current and ex-service community, you know, we

will need to be accepting that acting with one voice doesn't mean that everyone will agree with that voice. I think that has probably been part of the reason for the proliferation of ESOs, is as soon as one person disagrees with a line that their ESO is taking, they have gone and created a separate ESO. So I think there is some individual self-regulation that we need to do, but we need it as a - let's call it an industry, or you know, a grouping of peers. We need to be able to give government a single voice.

COMMISSIONER SPENCER: Thanks very much for that, Scott. Can I just raise another issue, which was a bit surprising to us, and we first encountered that when we came to Queensland last year, and that is the role of state governments. We see, both here and in several other states, state governments beginning to enter this space, and there are a range of state-based services. So we have had several veterans say to us, who have moved after discharge to another state, or they have just moved simply for new jobs or whatever, that they have encountered issues around benefits that they got through one state government but not another. Your thoughts about is there an emerging role in this space for state governments, or not? What could that look like? I am not sure what we can say about it, but I would be interested in your thoughts about how that seems to be a newly emerging trend.

MR DENNER: So there is a lot of benefit to state governments in they can deal with this in the right way, but they need to look at is holistically. I'll use Queensland as an example. The LAND 400 project for armoured vehicles has been awarded to a supplier who is going to build an armoured vehicle manufacturing plant to the west of Brisbane. That is an enormous injection of cash into the economy. The ideal employees at that factory, and particularly the people to do the training and introduction in the service of Defence, ideally are ex-servicepeople who have that experience in operating armoured vehicles. You know, we are a garrison state in many ways. There's three really large garrisons in Queensland: in Townsville, to the north of Brisbane, and then out at Ipswich. If state government looked at it in a holistic manner, around employment, around services that are provided to Defence around those garrisons, and also around the families, there would be a very large upside. As a slight adjunct to this, there is a definite impact on the children of service personnel associated with being in service. It is something that we as an organisation are invested in understanding the impact. But you can imagine, if you are a service person and you're getting posted from one geographical location to another every two years, there is issues around the schooling system between states, but there is an impact on the child as well. So there is a lot more that state governments can do to support current serving personnel as they are moved from location to location, but also to assist their transition into civilian life.

COMMISSIONER SPENCER: Thank for that.

COMMISSIONER FITZGERALD: You indicated just then that you are moving to a health and wellbeing framework, which we obviously support, because our whole report is about moving to a wellbeing framework. But I want to just canvas a couple of issues. Right at the moment, it is a system in which outcomes are almost impossible to determine. I know that many ESOs have now come to the support of DVA and want it to remain, and your organisation is also of that view. Yet it is a very unusual phenomenon that nobody can actually determine the outcomes for the veterans at all.

MR DENNER: Yes.

COMMISSIONER FITZGERALD: So we know what people get, we know what payments are received, we know what expenditure is made on health and community services, but no outcomes.

MR DENNER: Yes.

COMMISSIONER FITZGERALD: I am surprised that the veteran community up until now has not been demanding of an outcomes-focused scheme, given we spend $13 billion a year on it. Now, it is not about cost saving. It is just - am I right in saying that the veterans community hasn't been calling for the outcomes, or has it been frustrated by government in not being able to obtain that? And the second part of that, is there a change in culture? Because in the other area of human services that we do enquiries into, everyone demands outcomes.

MR DENNER: Yes.

COMMISSIONER FITZGERALD: This sector talks about benefits, inputs, how you fund things, but not outcomes. At the individual level, they do. I was just wondering, are we moving to a culture which really does want to be outcomes-driven, both in Defence and DVA particularly, or is there a barrier to that in the whole scheme?

MR DENNER: I think the barrier is history. You know, I would contextualise that there has been, you know, a prolonged struggle that has happened between the veteran community and the government really for the best part of 100 years around recognising the impact of service, the impact that that might have on someone's body, rehabilitating them, but doing it in a manner that supports the dignity of the veteran. I think probably what has happened is culturally as a group of people, through the

ESOs and through the veteran community, we have grown so used to having to fight for individual components of recognition that it's then we're perhaps nervous that when people start talking about outcomes we think it's just going to be a fig leaf to take away some hard earned recognition. But fundamentally, yes, this needs to be about making people whole again, if they can be made whole again, and for those who can't supporting them with dignity. We completely agree with that. There is a mountain of data that exists within DVA that has not being effectively utilised as part of this.

We would suggest that there is a massive issue with polypharmacy, particularly for Gold Card users, and there is a lot of work that DVA can do. So there's probably massively suboptimal outcomes to a lot of people receiving support through DVA because of issues such as polypharmacy.

COMMISSIONER FITZGERALD: Okay, and just in relation to that then and either yourself, Scott, or Margaret might want to comment. In 2004 the government ultimately introduced MRCA, which had a very different approach both in terms of trying to take a rehabilitation and return to work sort of approach. I was wondering, looking back on that period of what some 14 or 15 years now, do you believe that approach was fundamentally sound? I'm not talking about the actual Acts which are difficult and confusing but – and I know that people who are VEA protect that Act and we are – we've recommended that it be retained. So it's not argument about VEA.

But that was a huge change. A huge shift. So I was wondering whether there's evidence, anecdotal or otherwise, that that direction, that policy change which was huge has actually delivered. Just from your own experiences and organisation or is there – is the evidence unclear about that.

MS JENYNS: Well, I mean I do believe it has delivered but it's also delivered some complexity. But I mean when MRCA was first mooted, and it was following the Tanzer review, there was a lot of ESO consultation.

COMMISSIONER FITZGERALD: Yes.

MS JENYNS: They went through a lot of – a very long process trying to get – and the ultimate goal was to get from a new legislation the best bits of both the – what was then the SRCA and the VEA. With a specific focus on rehabilitation and wellness, and so the process worked well. I think the outcome with MRCA, with some little flaws and things, is a

good product. It's just that the confusion in relation to the three existing Acts - - -

COMMISSIONER FITZGERALD: Sure.

MS JENYNS: - - - and the various differences there makes it hard to follow. But if you just looked at MRCA by itself it would be not a bad legislation, I don't think. I mean there's some issues there you might (indistinct).

COMMISSIONER FITZGERALD: Sure. There's lots of issues.

MS JENYNS: Yes, yes.

COMMISSIONER FITZGERALD: And we've recounted some of those.

MS JENYNS: Yes, yes.

COMMISSIONER FITZGERALD: But if I (indistinct) that from that point of view then, if we look at the health card system, we're trying to understand how best to deliver health outcomes for veterans and we're looking at the card system and we put alternative thoughts on the table, but not alternative recommendations yet. How – in your mind, how do we – how do we get better outcomes in the health area and the mental health area other than just by everyone keeps saying we'll extend the Gold Card. So putting aside our view that we have concerns about how the Gold Card operates, and we'll look at that more fully, beyond the Gold Card what is – and again you may not have a view of this, what is it in the health area – health service area and mental health service area that needs to change?

I mean we can have as much – the cards are simply a funding mechanism and that's very important, but actually the most important thing is services. Funding is important but services are even more important. So whilst they're completely connected, we're trying to concentrate (indistinct) on what the services need to look like. So I wonder if you have any comments about the general health, mental health space going forward.

MS JENYNS: Yes, I do have quite strong views on that in relation to the fact – exactly as the Commission found that there's no review process. There's no outcomes driven look at how the general provision of treatment is establishing wellness. So when a person is provided with a White Card or a Gold Card they are entitled to get treatment for that condition that's been accepted or for all conditions, and there's no real monitoring of that

and no real effort to ensure that the treatment they're getting is best practice, and I refer back to what Scott said in relation to pharmacy.

COMMISSIONER FITZGERALD: Yes.

MS JENYNS: That's a particularly big one. So, you know, we've got the Gold Card, we've got treatment and that's great. There should be a review process, and at the risk of constantly flogging a sad horse with the permanent impairment where I suggested there be a review process there if a person lodges a claim for permanent impairment early, you assess them at the level of the impairment they've got at that time and then you have a review process. And to me that's the only real ability that DVA has to be able to say is this person getting treatment – because they'll be on rehab programs or whatever – that is effectively reducing the level of their impairment.

If it's not, is there something wrong with it? If it's not – are there things that we can learn from that? Say, maybe there needs to be a better way of approaching these things. So built within that PI process I saw the only real opportunity to review the effectiveness of the medical process.

COMMISSIONER FITZGERALD: There's an absolute logic to what you say. So that I can just understand that, what – why is that not part of the process at the moment? If I can just understand this. Under MRCA and DRCA people are able to take lump sums based on an assessment.

MS JENYNS: Yes.

COMMISSIONER FITZGERALD: And so that makes it complex if there needs to be changes down.

MS JENYNS: Yes.

COMMISSIONER FITZGERALD: So that's a complexity in the system. But putting that aside for one moment, what's the objection to having regular reviews for people that are on impairment payments? Or are you talking about even reviews for people just simply who are receiving services?

MS JENYNS: No, not once they've been paid. So it's in relation to before they're found to be permanent and stable.

COMMISSIONER FITZGERALD: All right. Okay.

MS JENYNS: Okay. So it's when - at the moment what DVA does is giving them an interim payment.

COMMISSIONER FITZGERALD: Yes, that's right.

MS JENYNS: And says you've got an interim payment of, you know, we can see that you're really, really badly hurt but we'll give you an interim payment of 10 per cent - - -

COMMISSIONER FITZGERALD: (Indistinct).

MS JENYNS: - - - because we think you'll get better. Go away and get better, and that's the process. So what I'm suggesting is you say we can see you're really, really hurt, we'll give you an ongoing, you know, periodic payment which reflects the level of your hurt, but we will review it periodically to ensure that you're getting best practice treatment. Cap it at two years or something like that and then say now we'll pay you out your full amount and you can take it as a lump sum or you can continue to take it as an ongoing payment.

COMMISSIONER FITZGERALD: Sure.

MS JENYNS: But what it does – and what I found frequently in a previous life, if you say we'll give you $10,000 to – or 10 per cent to make you feel happy because you're really, really hurting that increases the hurt.

COMMISSIONER FITZGERALD: I see.

MS JENYNS: People feel quite, you know, upset that they're only getting a small amount of assessment when - - -

COMMISSIONER FITZGERALD: Right.

MS JENYNS: - - - anyone can see they're bad.

COMMISSIONER FITZGERALD: So just to understand that fully. It's the period whilst you're assessing the permanent and stable.

MS JENYNS: Yes, exactly right. That's the only thing (indistinct words).

COMMISSIONER FITZGERALD: We've said that should be capped at two years.

MS JENYNS: Yes.

COMMISSIONER FITZGERALD: A determination should be made at that point.

MS JENYNS: Yes, yes.

COMMISSIONER FITZGERALD: It shouldn't linger on.

MS JENYNS: Yes.

COMMISSIONER FITZGERALD: But you're saying that during that period of time the interim payment needs to be assessed at the highest level or a higher level.

MS JENYNS: Yes.

COMMISSIONER FITZGERALD: Rather than what some people might say is a token level.

MS JENYNS: Yes, yes.

COMMISSIONER FITZGERALD: And then you do the reassessment.

MS JENYNS: Yes.

COMMISSIONER FITZGERALD: Okay. Thanks for that. Just a couple of other questions if I can. The issue in relation to MRCA and DRCA coming together, you've been I think supportive of that, subject to a couple of caveats. If I can just deal with that just for one moment. Is the caveat largely – we understand it's complex but once we put that aside for one sec, is it largely around the way in which the Gold Card is treated or do you have other concerns in relation to MRCA and DRCA coming together? We have to work out the payment level, that's a question. But is it largely around the Gold Card?

MS JENYNS: Yes.

COMMISSIONER FITZGERALD: Okay, we get that. And the second thing is subject to that I understand you're broadly supportive of a two scheme approach over time, subject to a whole lot of things being fixed up. Is that right?

MS JENYNS: (Indistinct).

COMMISSIONER FITZGERALD: So we end up with a situation where a person is only in one scheme and eventually thirty years from now there's only scheme anyway.

MS JENYNS: Yes, it's just that we feel that trying to force – do you want to speak to that, Scott?

MR DENNER: (Indistinct).

COMMISSIONER FITZGERALD: Sure, please.

MS JENYNS: Just trying to force it through there's so many complexities involved - - -

COMMISSIONER FITZGERALD: Sure.

MS JENYNS: - - - that you will then – you know, you'll start off with yet another legislation essentially because of the transitional effects of it all.

COMMISSIONER FITZGERALD: But that's a – that's really a timing issue, isn't it?

MS JENYNS: It's a timing issue, yes, but I mean it will mean that, you know, once again we have veterans who are totally confused as to the process.

COMMISSIONER FITZGERALD: Well, we'll try – yes, we're trying to minimise that but we understand the complexity. Those in VEA are least affected but those in the others are affected. I'm just conscious of the time but we've got just a couple of minutes. Is there anything else in your submission that you want to raise with us before we finish? Because I know you've got an extensive – and I must say when I flipped through I'm very pleased by the number of recommendations supported or partly supported. So that does my soul good. But that there are some more you have strongly not supported or objected - so we take that on board as well.

MR DENNER: Sure. So it's not contained in detail in our report but I note the presentation made by Mr Campbell around ComSuper and, you know, it would be our fervent wish as an organisation as RSL Queensland that you would have been given greater scope to look into ComSuper. We deal extensively with DVA and fairly regularly with ComSuper. I've got 50 full time staff that do nothing but – and their feedback to me is that DVA is a model partner compared to ComSuper and we don't believe DVA is a model partner. This is simply comparative.

I – the specific issue that Mr Campbell was talking about, you know, I met with the CEO of ComSuper last week and I made the observation to him that I think, you know, this to me looks like a junior bureaucrat in ComSuper made a decision in about 2004 or 2005 and the organisation has doubled down on something that makes absolutely no sense ever since, and they've – they've fought it hard. So as an organisation we put in a freedom of information request to them to get some data to prove that the payments are renewable – are reviewable and of course they are.

But the organisation said it didn't have any data on what was reviewable and this is a core purpose of ComSuper. So we went to the FOI commissioner who forced them to give us the information, which of course proved that they are reviewable payments, that they do reviews annually and that they do reduce payments. It just seems madness to us that they continue to report to the Family Court on Form 6's that this is a lifetime pension when it clearly is not. It's an issue with an organisation that's been captured by a decision that it's made previously and it's just totally unwilling to unwind it.

COMMISSIONER FITZGERALD: Without going into the technicality of it, because it is a very technical area and you heard my response to Mr Campbell earlier, we are entering it but only in a very limited way. But can I just ask this question. Why do you think ComSuper has taken the approach – you've said that they've locked into a decision and they – you know, they dig down and we've seen that in many agencies. But if there's no logic to it and in fact if there is some evidence – as Mr Campbell has put this morning – that the Federal Court took a different view.

MR DENNER: Yes.

COMMISSIONER FITZGERALD: Why do you think an agency such as ComSuper would hold that line?

MR DENNER: Compensatory payments. So we did a very broad leafed assessment on the negative impact of people who'd been subject to decision based on that and we assess that it totalled about $250 million.

COMMISSIONER FITZGERALD: Is that largely through the Family Court (indistinct).

MR DENNER: Yes.

COMMISSIONER FITZGERALD: So the linkage to the Family Court is in fact the critical issue in that issue you've - - -

MR DENNER: Certainly that's part of it, yes. There is some knock on effects in terms of the impact on the life of the person who's receiving it. So Brad talked about people not being able to get mortgages and certainly there are some ancillary impacts.

COMMISSIONER FITZGERALD: So can I just ask one other question in relation to that. A different issue but the offset in between the impairment payments paid under superannuation and the incapacity payments paid under the DVA. Is the RSL's view that that sort of offsetting – while some people in the sector object to it – is appropriate?

MR DENNER: So effectively with offsetting it needs to be that the payment that has been offset is for the same thing. So if a payment is a compensation payment as opposed to – so it's for injury and suffering as opposed to a payment that is for the continued support of the person because they're not able to work. Those – there shouldn't be offsetting, but if there – if the payment is designed to do the same thing, it is logical that there is.

COMMISSIONER FITZGERALD: Okay. Thanks. Richard, any final comments?

COMMISSIONER SPENCER: That's fine. (Indistinct words).

COMMISSIONER FITZGERALD: Thank you very much. That's been terrific.

MR DENNER: Thank you.

COMMISSIONER SPENCER: Thanks Margaret.

MS JENYNS: Thanks (indistinct).

COMMISSIONER FITZGERALD: And could I have Mark Raison, I think it is. Good. Thanks, Mark. There's some water there if you need it.

MR RAISON: Thank you, sir.

COMMISSIONER FITZGERALD: Mark, and if you can give your full name and if you're representing an organisation the name of that organisation.

MR RAISON: Certainly. My name is Mark Raison. I'm here on behalf of the Brisbane North District RSL, being one of the 10 RSL districts in Queensland, as previously mentioned.

COMMISSIONER FITZGERALD: Good. So if you could just give us your key points in about 10 minutes that'd be terrific.

MR RAISON: Not a problem. I just might start with a little bit of background. I did 19 and a half years in the army. I was discharged medically unfit in 1997. I was the first person in Victoria to be discharged AIRN, so it's come under the new scheme where if you couldn't be a young fit soldier, even if you had experiences in other lines, you were discharged, and you were given a month to go away somewhere, do a job experience and then left and told there's people out there called advocates that will help you.

I informed my boss at the time that I am an advocate. I had been for three years at that stage whilst I was in and I had no training on organising the discharge for service member. So it was a very hard time. At the time I was living in a caravan and I wasn't earning enough money to pay for the rent, for my dog living in a kennel. I told my wife to leave me because I couldn't afford to pay the rent on the caravan. Luckily she didn't. I was eventually retrained as a paralegal and with my advocate background I've been doing that now for 25 years in ESOs.

So I just thought it was important to let you know I've had four veterans commit suicide on me in the last 25 years whilst dealing with the department. I'm not going to say it's the department's fault. Obviously I have no proof of that but I've been through this system myself, dealing with multiple legislations and no one has yet mentioned the other legislation which is Centrelink. The DVA advice to me when I got discharged medically unfit was go on the dole.

If you do that – and I wasn't earning any money, I then have the other payment problems should I bring my claim. My claim took 18 months to settle. Luckily I was in a fortunate situation where I had a good supportive family around me or I may have been the fifth person that – going through this situation because it's very hard when you can't support your own family.

I'd like to go onto the matters at hand now I've given you that bit of a run down. One of the first things is BEST [Building Excellence in Support and Training] funding. Currently BEST funding rewards failure. It's done on a points system and if you take a matter to the AAT you get more points than if it goes to the VRB or if it settled as a primary matter. Now

where we are at my ESO and our district, we pride ourself on trying to solve matters at the first point of call.

It used to be called building a bridge, and we try to provide the doctors' reports, the statements and all requirements so when we put the claim in - I've been told this by people from the department, they look towards the end of the month, when their stats are due, for claims from our sub branch because they turn around and grab them and they don't have to write off to doctors, they don't need to contact veterans, they don't need to do listing questions, smoking statements because that is all there in the claim. So those claims are picked up and they very often ring us and say "thanks, the decision will be in next week" as opposed to, you know, making the doctors' appointments, getting veterans statements and all the other things that are required.

So we are being penalised by doing our job more productively. So funding has reduced over the years by three quarters. So it seems a funny way where if I turn around and tell my advocates don't do a good job because that way we'll get more money. So it's an inherent problem with the best funding model at the moment.

I agree with the first speaker about the ESOs and that and the problem. I think about accreditation for ESOs. I think one of the big problems we have, we don't distinguish between an ESO and a social club. I'm in a transport association ESO, I'm in a parachute association ESO. I'm the advocate for seven ESOs, and many of these organisations really aren't ESOs. They're not representing, they're not – they don't have advocates, they're not making submissions to the government. I'm not here for the transport association or the parachute association, I'm here for my RSL district and my RSL sub branch.

So many of these clubs I'm a member of that we call ESOs, if we had accreditation we would know the difference between and ESO that has advocates, wellbeing officers, provides welfare for our veterans and their dependants as opposed to a social club where we get together a couple of times a year to talk about old times. So that might be a distinction there that you - talking about injuries in training, Dr Rudzki was brought into RMC in the early and mid -1990s to look at why there was so many injuries and days of productivity lost at RMC.

He's a sports specialist. He gives great needles in the spine, by the way. I had that experience, and they found out that the sporting field was the biggest single injuries. They were getting more from there than training in operations, and on operations, which there obviously wasn't many at the time.

The stopped training at RMC. They stopped sport. They still did physical training, but reduced or stopped their sports training dramatically. They found out the sports training was contributing to the fitness level, and by reducing and stopping the sports, and reduced the level of fitness of the cadets, and they brought the training back in for the sports.

So, talking about what the RSL were saying before, it has been recorded. So if you're able to track down those stats from RMC about how the training level was reduced because of the – too scared of the injuries. So that was in the mid-90s.

After the Black Hawk disaster, which I had several clients from, the then chief of the Army set up the hearing and said we were aware there was problems, and I can now assure this Commission that every member of the Defence department knows all their entitlements in relation to the Veteran Affairs, and I spoke to the other two service chiefs, and they've assured me the same thing.

So, a tick of the box, and of course, it's not true. It was never true then. It's not true now. People that are discharged do not know their entitlements.

So one of the recommendations in that, which was accepted, was that each person discharging will be appointed a discharge officer, and that person will be given the job of streaming that person through transition.

Now I'm aware that's not happening still, even though it was an accepted recommendation from the Black Hawk enquiry.

I wasn't going to speak about this, but after the first speaker, one of the recommendations or things that the Commission is looking at, is the reduction of why someone who dies from a non-service related condition, if the person is a special disability rate, EDA, or TPI, their widow becomes a War Widow and gets a Gold Card with its benefits.

What I'd like to say about that is, the reason that the – may receive these benefits from non-service related death is to make up for the actual and potential of many years lost income, because the Veteran who is receiving these benefits are very often out of the workforce prematurely.

In my own case, I had to leave the workforce at 45. I would love to be back doing my full-time job as a paralegal. I loved it. Absolutely thought it was great, but I'm not able to do it.

So, solely due to their accepting the service conditions, these small benefits are given to the Veterans' dependents as a way of saying thank you from a grateful nation, because that person may have been required to be a carer, and the joint income of that couple has been reduced.

So, giving them a Gold Card and calling them a War Widow is a very small payment for what they've done. Because if that Veteran was required to have full-time payment and care while that spouse went out and worked, the government would be a lot worse off than they are.

Can we use that water?

COMMISSIONER FITZGERALD: That's fine. Have you got any other comments, or would like - - -

MR RAISON: I have got a couple more.

COMMISSIONER FITZGERALD: Just a couple more, and then we'll have a chat.

MR RAISON: Thank you so much. In my years as an advocate, I've done claims for people from New Zealand, Canada, UK, and the USA, and I can tell you, their systems are a nightmare, and I'm not saying it's because they have DVA and defence in a way that you are looking at.

But their system is definitely not as beneficial as ours, and you think we have a hard understanding system, I'm still trying to work out the American one, and I've done claims under it.

I have a question for you at the end, please. I do have a – that state governments. That also refers to councils. Different councils provide different benefits to Veterans too. Most of them haven't heard of the SRDP, and I've had to ring up several councils and explain what that is and try to get benefits that a TPI may receive that they don't.

So, I do have one question. It's been mentioned several times in the draft that people currently on benefits will be grandfathered, but I didn't notice on everything.

I'm just trying to clarify. Every Veteran that's currently on a benefit, allowance, et cetera, will all those be – will be grandfathered, or only the ones where he's mentioned where it will be grandfathered?

COMMISSIONER FITZGERALD: So, let me just deal with the question. In relation to impairment, incapacity payments, the healthcare cards and so on, it applies.

The only issue is there is about a dozen or so allowances that we've looked at, and some of those we've indicated should be paid out with a cash sum. Some we think should be incorporated into other payments, and those payments increased, and some we've raised the question as to whether they should exist or not.

So apart from those allowances, which we have got lots of comments back from different ESOs, the basic impairments and incapacity payments and so on, and why we decided to keep the VEA is largely because of recognition of that.

In an ideal world, the VEA would – the VEA, the MRCA and the DRCA would all become one, and it's not possible to get us there without causing enormous disruption.

So we basically acknowledged, in an imperfect area, that in fact we should retain the benefits as they are. For some people, the benefits will increase, and that depends on decisions that we have to make in relation to MRCA and DRCA in the file.

So, the answer to your question is, but for some of those allowances, the answer is yes, they should stay the same.

The problem is, if I can just make it – the difficulty we have is, to get the same outcome doesn't necessarily always mean you need the same sorts of benefits going forward, and so, one of the difficulties is this is a system that is driven by benefits, entitlements, and we are saying it should be driven by outcomes.

And so for the different people, you need a different array of both services and payments to achieve those outcomes, and this system is exceptionally inflexible. It's completely based on everybody getting this benefit, this entitlement.

Now largely, going forward, that remains unchanged. But where we are – my questioning to other people about mental health services, yesterday we spoke about home services, and all those sorts of things, improving rehabilitation, improving transition, is trying to maintain, basically, the benefit structure, but actually to do more with the system that's currently being done.

So that's a very longwinded answer, but the answer is, in relation to impairment, incapacity, healthcare, and so on, they basically stay, for the current, for those currently entitled.

Can I go to your aper, and thank you for your submission. You've raised a number of issues, and I'll only touch on a couple, and Richard may as well.

In relation to the statement of principles, can I just turn to that? We flagged that we think good practice would only have one test. I was wondering if you could just give us your view about that?

MR RAISON: It's purely from a beneficial nature. If we're going to go to one test, I think the reasonable hypothesis would be the obvious choice. I think most ESOs agree with that.

It's very hard. We're in an organisation, a job nature, where to report your injuries can cause the loss of your job. Just to report them. So before MRCA came out, we used to go, as soldiers, to a private GP, use our Medicare Card, and get our medication on the side, to try to hide the injuries from our employer.

Now, we can't even do that. When you apply for, even Veteran Affairs, and to notify them you've had an injury, your CO or OC is informed that you've applied, that you have an injury. So underreporting of injuries is rampant throughout the military because of that fear of their job, which makes the paper trail very hard to find.

So if we do go to a single set of SOPs, I think the obvious choice for us would be the reasonable hypothesis, because it's very hard to track down someone you jumped into a pit with five years ago, and who carried your pack for you, but you didn't want to go and see the medic because you didn't want to let them know you hurt your back.

COMMISSIONER FITZGERALD: Sure. As an advocate, and in trying to have claims dealt with under both of those tests, in practice, do you find the application of those two tests, the beneficial balance of probabilities, and the reasonable hypothesis, in practice, makes a huge difference?

MR RAISON: Very much depends on the injuries. Quite often, the SOPs are virtually identical. The requirements at other times, they are greatly different.

So it very much depends on – orthopaedics are quite often more beneficial and easier to prove through those two. So it is easier to prove on the reasonable hypothesis, where other things, they're nearly identical, and even the proof at law doesn't make a great deal as to the medical evidence.

But with many, yes, I find it is an easier one to meet, and of course, and allowing for now that we don't have the smoking and drinking anywhere near as much as we used to, that those ones used to be a very, very big difference.

COMMISSIONER FITZGERALD: All right. But your position is, if there is to be one, then you're saying to us very clearly it should be the reasonable hypothesis standard.

MR RAISON: Certainly. Yes, please.

COMMISSIONER FITZGERALD: The second one, if I can just deal with this, is in relation to special rates of pension. If I can just deal with that for just one moment.

We were recommending that the SPR, the Special Rate Disability pension, disappear in MRCA. It's a very tiny group of people that have it. We were not talking about getting rid of the Special Rate Disability pension in VEA. Just what's your rationale for keeping this?

MR RAISON: The few people I have, and how long it's been going for now, many years, MRCA, the few people I have receiving that are very rarely physically only. It's usually mental and physical, or mental.

If these people were required to go back to get a specialist's report every 12 months, or a GP report every three months, I've had people not go and get incapacity payments. I've had people say, I can't handle it anymore, storm out of my office, and they're living under bridges because they're not receiving income.

The people that are receiving the SRDP, I'm worried that they may fall into this bracket also. If they were required to continually keep fronting up, and remembering the conditions must be permanent, and it's a much higher set of standards and points than it is for the TPI at the moment, these people have been assessed by these people as being – their doctors and by independent doctors – that it's a permanent condition.

I'm worried that these people will be the next generation of Veterans that will miss out because they will be on incapacity payments, and some people just say it is too hard.

COMMISSIONER FITZGERALD: If we fix up the permanent and stable sort of issue so that people are not left in the never-never, and having to live with that uncertainty for a long period of time, and taking Margaret's comment from the RSL, if we were to look at the payments that were paid during that periodic payment, would that reduce some of your concerns?

Because, as you say, it's often about just establishing that it's permanent and stable.

MR RAISON: Yes.

COMMISSIONER FITZGERALD: But once you've done that, the normal benefits should apply.

MR RAISON: I'm not really worried about what it's called as much as if those people were determined, you know, if it was, you know, two years sounds a great figure, if after two years they've done all the rehabilitation and they've been, you know, exactly what you're recommending, what it's called not a problem.

But if that pressure was taken off them where they wouldn't have to, I don't see a problem with that.

COMMISSIONER FITZGERALD: Because that's basically – well, that last part of what you've just said is our recommendation, which is, we try to get it resolved within two years and then people can live their lives with a little bit of certainty.

And just the other issue, can I raise it? Your own personal experience, can I just ask, when did you transition out of the defence forces?

MR RAISON: The end of 1997.

COMMISSIONER FITZGERALD: And your experience, as you say, was pretty horrific.

MR RAISON: It was. It's definitely not a single case. It's, you know.

COMMISSIONER FITZGERALD: And we've heard, the single most talked about issue to us in our consultations prior to the draft, was transition, understandably, both by current and past serving members.

From your experience of dealing with more recent Veterans, do you think the system has improved, and if so – and if not, what do you think the one or two things that you think are top of the list that we should be looking at?

MR RAISON: I will say it's improved dramatically. It certainly has, but I am still getting Veterans to come see me, saying, they appointed me a discharge officer, I seen him twice since I've left. He gave me a pile of forms and said fill them out, and he gave me a pile of pamphlets and said this is what I'm entitled to.

And we're not dealing with people with legal backgrounds or medical backgrounds. We're dealing with normal people, and giving them a bunch of forms and saying, you'll be right mate, is not adequate, and we are still seeing that.

But it has improved since my time in the military, 20 years ago, without a doubt. But it seems to be base driven. There's certain military bases that have a better handle on it than others, and depending where they come, and I'm pretty sure these jobs might be a regimental job.

It's a job where it's not the person – the discharge officer's primary role, and if they don't have a good working knowledge of it, and they're the discharge officer this year, and next year they're doing another job, as happens in the military, there's not always good handovers, and it takes three years to become an advocate.

So to try to get someone whose core job is to be a platoon commander and maybe give them an extra (indistinct) job as discharge officer for their unit, it's not adequately training, and then it's not being passed onto the Veterans.

COMMISSIONER SPENCER: Mark, thanks for your comments about the best funding, and your observations on that, because that certainly sounds like the worst outcome, if you're achieving better outcomes which are being penalised for that.

So it comes back to this general question of how does government best invest to get outcomes with services, and look, thanks for that helpful distinction. I think it is useful to think of ESOs. Who's providing services for Veterans, and perhaps a broad distinction between what may be more of a social club so that we start to focus in.

But it comes back to something we've talked about several times this morning, and that is government having a clearer role of what services

will best meet the needs of Veterans, and engaging with those people in the Veteran community who have experience and observations and thoughts about front run experience that can help with the design process, and then government can commission organisations to go out and do that, and fund that appropriately.

And we think there's scope there for additional investment. One thing that struck us is that the current level of investment in what ESOs do is pretty modest, when you look at the overall cost of the scheme.

So that is very helpful. Is it Greg - - -

MR RAISON: Dr Rudzki.

COMMISSIONER SPENCER: Rudzki, yes. No, we've certainly engaged with him. So we've got a lot of that background. But look, that's an interesting issue you raise about what happened at RMC, because – and look, just to give a context to this, because this is why we get challenged in this space of what was described to me in another military system of where they have all responsibility, lifetime responsibility as well, and it was described to us as a duty of care, and a duty to prepare.

So, we've heard this morning that people can see that they've just been in a conflict, and there's a view which says, well, they are and you can't do anything about it. Other systems grapple with that conflict.

So it was interesting, the RMC one, because in discussing that with a defence department that does carry those two responsibilities, there was a very interesting and different engagement and discussion around what that means, and how to strike the right balance.

And I think it was summed up in a comment that was made by the Chief Medical Officer, that we are concerned when there are too many injuries, and we have long-term data that tells us what's happening, and we track that. We're very concerned when there are too many injuries.

But then he went on to say, and we're too concerned when there are too few injuries, which summed up for me quite nicely that very difficult challenge that all defence forces have around the world of the duty of care and the duty to prepare.

So, I just park that there as a – I think whichever way we can approach that, whether it is defence having more responsibility, or not, during service, is a moot point, and a highly contested one.

When we come to transition, and I just go back to the conversation we were just having with Robert about this, and your own experience, one of the things that challenges us is we hear very good initiatives to get better cooperation between DVA and defence and CSC about the transition process.

It goes to something you said. When you have people on bases, and this is our experience, we've been to many bases around Australia, and we've seen what I've described as bright spots of transition. More often than not, that's about the person who's running it. The minute they're not there, things change.

So, to us, that brings us back to this structural issue about if we rely on goodwill and good people working across boundaries, that only gets you so far.

So the fundamental question for us is, who is responsible for transition? So, look, our proposed solution to that, but there are different views on that, and we've heard that this morning, is this notion about joint transition command, which says that for a period of time, defence is responsible for that.

So command needs to take on board that responsibility. At a certain point, then DVA – there's the handover to DVA. But that will come after what we describe as the critical period of transition.

Do you think that model's got potential value? Do you think it would be helpful in trying to get through this issue of just not relying on an individual doing a good job, or certain bases doing it well, but not others, and that changes over time.

MR RAISON: Unfortunately, I don't. I think Margaret's idea is probably superior, where the sooner DVA can get hold of those people, because it is DVAs job. They're the ones paying the money, at the end of the day.

I know it is the Department of Defence, but it's the DVA, you know, people see the letterhead with the cheque, and just have DVA take that over as soon as possible, and certainly, if (indistinct) with the defence, with the discharge officer, but because they're going to, no matter where it comes along the stage, they're going to be dealing with DVA at some stage.

So yes, to deal with Defence and ComSuper is great but the sooner we can get DVA in there, because they're the ones going to be organising the retraining, the medical, the examination, so that's not a Defence core job,

where that is DVA's core job. So I think the sooner we could get them involved, the better.

COMMISSIONER SPENCER: So just a question, if it's all right, from that: so if that was the solution, how does that work with, whilst the person is in service and in a command structure and DVA comes in, how does DVA assert its authority at that point as to what should happen and what's in the best interests of the discharging member?

MR RAISON: And I can certainly see why you're saying that, you know, will be, you know, a structural problem. I mean, no government department likes to lose, you know, control of what they've got, no one likes standing a step back. You know, I think that like most government departments, we do as we're told. When I was in the Army I did as I was told and if Defence were told to work it out, they haven't worked out retraining; they haven't worked out the discharge; and this is after they said they would 20 years ago after the Black Hawk disaster, so after 20 years of trying to work it out perhaps it's time that they go back to their core job and DVA take over their core role a bit earlier.

COMMISSIONER SPENCER: All right thank you, Mark.

MR RAISON: Thank you so much.

COMMISSIONER FITZGERALD: But just in relation to that last point, I'm perplexed by this. In any other inquiry they would say to us; that is, the interested parties like the ESOs and veterans, would say, "Make the Department change", in the Veterans you say, "Defence is shocking at doing this, this, and this" and just, we'll let them go. It's an anathema to us. We can't quite understand this. If there is an acknowledgment that the Defence department has a duty of care, which it does, not only a duty to prepare and of course it's not going to be long after discharge, because that is when DVA should absolutely come in, and as you and Margaret and others have said much earlier, at the end of the day why is there not a pressure from the veterans and the serving military to actually get Defence to do what most people would think is a "reasonable" explanation, not lumbering them with veterans' support system, and we never proposed that.

But why is there this reluctance to actually to say, "'And' Defence should get it together". If I read between the tealeaves, well maybe not, you basically say, if they haven't got their act together in the past 20 years, you have no faith they will now. That seems to us an appalling position but it may be an accurate position. So is what you say what I'm just saying?

MR RAISON: Yes, very much so, yes.

COMMISSIONER FITZGERALD: So why is the veteran community not up in arms saying, "Defence should change"?

MR RAISON: Well, we're up in arms saying, "Let DVA do their job". We are up in arms but we're coming at it from a different point of view and the reason we have two different points of view is because we've been through it from two different ways. We've been through it and I've seen it and you're interviewing people so, I'm not saying I'm right, I'm just saying that's my belief and - - -

COMMISSIONER FITZGERALD: No, no, - - -

MR RAISON: And I understand your point too.

COMMISSIONER FITZGERALD: No, I'm not attacking your view about DVA or anything, I'm actually just asking why the veteran community doesn't actually require the Defence department to do a slightly better job in relation to its own personnel which seems to us to be unexceptional?

MR RAISON: Yes, I don't know, I can only talk from my point of view and - - -

COMMISSIONER FITZGERALD: That's what I was asking.

MR RAISON: And you're asking and that's something that I've (indistinct) other people obviously and we seem to be pretty much of a coming from that point of view. If the Commissioner was to come down with his point of view and it worked, I'd be happy. I mean, if it was better and was proven to be that there was a better way than I'm recommending, I'd be ecstatic about it because I don't want to see young veterans going through what I went through. I mean, it's quite horrific.

COMMISSIONER FITZGERALD: So we have an absolutely shared commitment and I think we can collectively come to a way, and ultimately it's government's decision as to the model, and the structure, we think it needs a structural requirement, and I suppose my question was a broader issue about this issue that Richard's raised several times today and it does perplex us, I have to say. It just seems to me that Defence does have a duty of care., I think they acknowledge that, but when push comes to shove there is an acquiescence that says basically, "We don't think Defence can do it and therefore…", you know, "We'll go somewhere else" and we do find that a bit perplexing so that's just my point.

MR RAISON: That's fine.

COMMISSIONER FITZGERALD: No, that's good. Any other final comments, Mark?

MR RAISON: No, that's it, thank you so much.

COMMISSIONER FITZGERALD: Thank you very much for that, that's great. So could we have Andrew Khoo? G'day Andrew. How are you?

MR KHOO: Good, how are you?

COMMISSIONER FITZGERALD: Good, thanks. So, Andrew, just if you can give us your full name and the organisation you represent and then ten minutes of the key issues and then we'll have a conversation about those.

MR KHOO: Okay, so I'm Dr Andrew Khoo. I'm a psychiatrist working in Brisbane but I'm representing today The Royal Australian and New Zealand College of Psychiatrists. So really what I'd like to comment on - I mean, there's lots to say and the report is huge and, you know, first of all the College - and I will speak mostly on behalf of the College. If you ask me for my personal views I'm happy to give you those as well. But certainly the first thing is the College would like to broadly support the overall direction and outcomes of the draft report and certainly commends the Productivity Commission on their detailed work so far.

I suppose I divide up the College feedback in terms of the draft report, into three parts. The first is that things we'd like to say about things that we specifically support in terms of recommendations; then recommendation we feel perhaps could do with some amending; and then finally just a few further comments on things that potentially could be added in. So firstly, the draft report acknowledges critical need for a more effective mental health and suicide prevention strategy and as well as the need to provide seamless support for veterans and these are things that we strongly support.

In supporting specifically recommendation 7.1, we would like to advise that implementation should incorporate a focus on improving awareness of mental issues across command within Defence and this is for a number of reasons which I'm happy to go into specifically later. In supporting recommendation 13.3, the College would advocate for better training for DVA staff particularly on engaging with mentally ill clients and

specifically also with the language used in communications that are written as well as verbal, less bureaucratic, more understanding, and we think that that in itself will deal with quite a number of issues.

We strongly support recommendation 15.3 around suicide prevention and we'd encourage greater support of DVA by clinical experts, particularly psychiatrists in guiding reforms around these areas. Next I'd like to talk about some amendments we felt would be helpful in terms of the report from the College point of view. The first was recommendation 6.3, particularly with regard to the Joint Transition Command that's been suggested and we would like to suggest that psychiatrists perhaps, as well as other clinical experts, be embedded within that and I'm sure that's probably what you had in mind as well. And that, thinking about whether this should be placed under the auspices of the Department of Defence given the historical lack of engagement with veterans and their long term outcomes.

An amendment to recommendation 8.1, and while we very much support adopting a single - first of all, we very much support harmonising the three different legislation pieces and we also very much support adopting a single standard of proof for - because there was a freeze a few years ago put on any incremental increase in - I think it was put on by the Abbott government, there was a freeze and that has lifted and so they've fallen. The remuneration that we get for senior veterans has just fallen further and further behind over the years, so what I would say is that the best - look, if we need people helping us make those kind of recommendations to the government, people like a Productivity Commission we feel, because the more people that are leaning on them and telling them that - we can tell them there are manifest problems but, you know, when they're making the budgets that's, I think, conveniently forgotten.

COMMISSIONER FITZGERALD: So we'll take that point up because we're looking at both whether or not the - what are the differentials across the whole health care system, between what DVA pays and others and sometimes there's not a big gap and others there is.

MR KHOO: Yes.

COMMISSIONER FITZGERALD: The second thing that interests me, more importantly, is how do you get (indistinct) process because pricing is an ongoing issue. You know, funding or fee setting is ongoing so we've looked at that in the area of other parts of human resources so we've got to look at what's the process that makes that not a random but actually a considered ongoing process.

MR KHOO: Well I think you could look at, for example, how WorkCover Queensland works. They just follow - I believe they might just follow what health bodies are saying that you can charge and they will just follow that and follow that directly. The other way would be that the DVA decided that there was going to be a certain percentage gap between them and a bulk billing or MBS pricing would be and then just use that but they would have to considerably increase it so I could get more of my colleagues to see veterans.

COMMISSIONER SPENCER: Andrew, just pulling back and thinking more generally about this. I mean, across a whole range of human services what typically you can see is that - the response to the crisis situation, so governments in areas like homelessness, child protection, out of home care, they're constantly having to address the crisis and the dynamic that's at play here of course is how, if you go back to an earlier period, could you have intervened had early intervention and prevention measures, which mean that the outcomes for the individuals affected and who end up in a crisis, that you would minimise that happening? So that's about the person, that's entirely about the person and their wellbeing and getting earlier into working and addressing the needs of that individual and sometimes that's right at the early stages of their lives in child protection-type issues.

So that's often driven - but then the research comes and the research says, "Actually, this happened here and this is what happened later on 10, 20, 30 years later". So if we can intervene earlier at this point, will change that trajectory, all right, so then people - and it's tough for governments because governments then say, "But we're overwhelmed with the crisis, we want to intervene in early intervention, but we just never quite get to it" so that's a dynamic that plays out all the time. It seems to me one of the ways in which you kind of break that cycle is to show that over time, and this is where money becomes important and whenever money gets raised people think, "Oh it's about saving money" but it's about better use and smarter use of money because once again, and research shows this in other fields, if you do get in early not only does the individual get a better life trajectory and a better outcome, it will actually save dollars and more dollars over time can be put into those efforts to save a much "greater" quantity of money later on when they're truly is a crisis.
So look, that plays out in many other areas so when I look at the mental health issue in relation to the military system - and you're already saying it, there's a lack of research and there's a lack of awareness around this. So what could help to change understanding and attitudes about both the better outcomes for individuals and the better direction of financial resources into earlier interventions that happens at the moment?

MR KHOO: Okay. A massive question and a very good question that we could talk about for a long time. If you - - -

COMMISSIONER SPENCER: And I'll just say that we're looking at what would a really terrific scheme look like over 20/30/40 years so this doesn't happen tomorrow, I appreciate that, but over time how could we move to that sort of approach?

MR KHOO: So the first thing I'll say is that there is research, very solid research, very well accepted research worldwide, for virtually all of the mental problems that resolve from military service, the early - well, all of it, as far as we know, early intervention works so that's the first thing. Even though there is a dearth of research and understanding about a lot of things and a lot of that dearth of research comes from the fact that many defence forces around the world didn't want to shine a lot on problems that they were creating so that has been a hinderance. And also many defence people not wanting to be researched because that would mean they had a problem and how that problem might impact their ongoing employment promotional opportunities, deployment opportunities, et cetera, so lots of barriers to research but certainly not insurmountable.

But the overall answer for that is that the answer is in the research. The answer is in it if we can show, if we can talk to the right people and say that, "If we intervene early, we will change trajectory of - will 'completely' change the trajectory of these currently serving people". I can give you a very - very briefly I'll give you an example that is very personal to me and that is I run courses for post-traumatic stress disorder. A few years ago a proactive brigadier at Enogerra came and said to me, "Can you treat our guys that are currently serving?" Previously before that, we had to wait till people got so sick that they got kicked out or left of their volition and then treat them which was way too late because all their social and psychological deterioration that goes along the way had already happened so it was much harder to treat them. He said to me, "Andrew, if I give you these guys with PTSD, they're currently serving, can you give them back to me and I can still use them?" and I said, "Well, the answer is I don't know" because we'd never that before and there is - you know, we haven't done that really around here, we haven't used the courses for them. So he did that and we ended up seeing quite a number.

Now, we were able to return way higher percentages of people to - so these are people with diagnosed PTSD that could no longer work. We returned 25 per cent to military work; now remember that 50 per cent of those that were still referred to us were already on the discharge path so we couldn't even affect them. So we at least got half of them back to work and many of them have now deployed again so this is just an example of

how powerful early intervention so if things like that happen, us producing the papers, us feeding that back to Defence and saying, "If you send us people that are motivated to stay in that aren't already on the discharge pathway, we can return a high percentage of them to work" but that really depends on Defence taking a transparent rehabilitative approach to people with mental health disorders instead of saying, "As soon as you put up your hand, you're gone" because that just discourages them even letting anyone know that there's anything wrong with them and we don't get access to them early when we could have given them a much better outcome.

COMMISSIONER SPENCER: So you mention the barriers to research and just not here but internationally as well, do you say - I mean, there is a transformation on the way, I think, generally in Australia around mental health and as you know the Productivity Commission is doing a major inquiry into mental health so gradually I think the community's understanding is starting to open up.

MR KHOO: I think so too, yes.

COMMISSIONER SPENCER: So those barriers that you've experienced in the past, do you see an appetite to explore this base further within the military at the moment?

MR KHOO: I see more of an appetite than I ever have now which is great. We've got - I think they're redoing now all their mental health strategy and everything and if we can really get them to start understanding that a psychiatric disorder is just like a physical disorder. If you get in a treat it, they can be rehabilitated and they can be returned. We've got to get rid of the stigma that occurs there. We've got to make sure that when we starting returning people, the other people within the military are saying, "Oh hang on, I saw Joe up his hand and say that he had depression or say that he had some anxiety or stress or post traumatic issues and he went away for two months but now he's back and he's fine" and then, "Oh that means I can put up my hand and they're willing to manage, you know, mental health illness", with a rehabilitative model. So breaking down the stigma that's personal, that's cultural within the military organisation, breaking down that stigma is going to be key in getting that happening but I do see more of an appetite to that happening.

COMMISSIONER SPENCER: So it seems to me there's a double benefit there. There's the return to duty was sensibly done.

MR KHOO: Yes.

COMMISSIONER SPENCER: And there is the life trajectory of that individual post-service.

MR KHOO: Yes, 100 per cent.

COMMISSIONER SPENCER: That's one of the things that we hear, which is the stigmatisation of particularly PSTD in raising awareness of that, some people have said to us, when they go through a deployment, people think all veterans have PTSD.

MR KHOO: Yes.

COMMISSIONER SPENCER: So, you know, it's a very difficult subject but community understanding what you just said, no different from physical injuries and it can be early intervention, can put you back on a very positive life trajectory, should enable that individual both for employment opportunities and have better possibilities.

MR KHOO: Absolutely and I think everybody wins. The services win because they're keeping experienced personnel who have got lots of skills that they've invested in already, so yes.

COMMISSIONER SPENCER: All right thank you, Andrew.

COMMISSIONER FITZGERALD: Just a couple of the more specific recommendations if I can; you've supported our approach in relation to a permanent and stable condition. Can I just ask this question which is basically it resolves within two years and obviously there's a payment and support during that process, the issue we've heard is that mental illness is one of the most difficult areas to actually come to that point of saying it is permanent, or even more that it's stable. So we're trying to deal with that and you've supported that recommendation.

MR KHOO: Yes.

COMMISSIONER FITZGERALD: But I just want to understand this: if a person with a mental health condition, and that's the core of their claim, and we say yes, it's deemed permanent and stable after two years; is it likely that in many cases people would actually move to a situation where mental health is much less of a concern or a problem or for those people where mental health is central to their claim, it's likely to remain a debilitating problem for some considerable time, I'm not aware of the evidence, that's really what I say of that.

MR KHOO: All right, so it's difficult to find specific evidence on that but what I can do is, after treating veterans for 20 years myself, I'll tell you what I think with regards to that and certainly that is reflected by the interest group that supports and advocates for veterans within the College, and that is that it is possible that down the track veterans will improve considerably. It is also possible down the track that veterans will, for whatever reason, deteriorate quickly. So the stable and stationary thing is very hard - it's a compensation thing that is very hard to apply to mental health and, because mental health is impacted by so many things (indistinct) ways you can move forward in life. That's why we thought it was an excellent idea in terms of just saying at that two year point, "Well, you know, regardless you're going to get compensation now. We're not going to draw it out and make you wait."

COMMISSIONER FITZGERALD: Sure.

MR KHOO: I will say that even if, however, down the track if an individual was to move and I'd hope was to move down the track in a positive trajectory point of way, because you've got to remember too, like PSD, for example, it takes a long time to get better. Two years would be an average or maybe below average time before someone would reach maximal improvement anyway because all the changes they have to make in their life and all the things they have to do. So what I'd say is even if they were to improve significantly, because you've got lots of clinicians trying to make that happen, they shouldn't be punished for that because they've still lost two years and had their life trajectory significantly skewed by the damage that's been occurred via their work so it shouldn't make a difference anyway and I'd - yes.

COMMISSIONER FITZGERALD: No, that's fine. Semi-related, is your support of maintaining a non-liability mental health care, we would support that, but can I just ask this question again: you've said in your submissions, it was recommended the Productivity Commission prioritise the maintenance of the mental health treatment. So we agree and we believe the White Card is beneficial.

MR KHOO: Beautiful.

COMMISSIONER FITZGERALD: The question is whether or not that should or not be extended beyond its current recipient group?

MR KHOO: It should.

COMMISSIONER FITZGERALD: But, again it's only a funding mechanism.

MR KHOO: Yes.

COMMISSIONER FITZGERALD: So we come back to this fundamental question, and I know you've been in a round-table with us on this, is the service system itself. So what we understand is that in relation to medical problems of a physical nature, the system works well enough, not perfectly but well enough and the mental health service doesn't work well enough and so the question that still remains, after the draft report, is what is essential to improve the mental health service system? So, we've talked about pricing and we've recommended a revision of the mental health strategy for veterans, and I'm sure that people will agree with that, but I'm still a bit perplexed as to what it is in the servant system that needs to change?

`

MR KHOO: I think the biggest change that could happen involves veterans, or us identifying veterans, that need help and then our ability to "keep" them in effective care. So now, that incorporates again mental health literacy, that incorporates stigma at cultural levels, at individual levels, that incorporates them having a better understanding of what mental health treatment means, a better understanding about what the medication means, a better understanding of what they can expect when; so, "Come and see your psychologist or a psychiatrist or some kind of council but don't expect to be well within a month" You know, "We start a process and this process will build as we go and stick with us and you will get better and if it's not working, it's very easy to find someone else."

This is the other thing too, you know, a lot of service people are used to be just told what to do so they come and they get treatment and they know the fits not there between them and their particular treater but they figure that, like if they were in the Army, that you've just got to do what you're told to do so they just sit there and nothing happens until they get so jack of it that they just leave. Whereas they don't know that this a service industry. You know, you're out of the services now, you are now in this free service industry-type well where if something doesn't work go and see someone else, find someone else and even, in mental health I would advocate for this but it's a terrible thing to say, shop around for doctors and find the one - or psychologists or councillors, find the one that works.

So it's getting them into treatment and keeping them in treatment and I remember one of the doctors that wrote the US Department of Defence Handbook on the treatment of mental health disorders in veterans, said, "The biggest change we can make to our outcomes is keeping veterans in treatment" but I would add to that it's accessing them, finding them, identifying them, getting them in, and keeping them there.

COMMISSIONER FITZGERALD: So you may not have thought but very shortly DVA will have a register of all ex-serving veterans because they're going to get a White Card so by some means this will all be registered, I don't know the process. So they're not necessarily clients of DVA but they will be registered so the notion that we won't know who and where veterans will be less of an issue into the future. But in relation to the mental health aspects of that, I was wondering whether or not any attention or any thought has been given as to whether there should be a proactive dialogue with veterans, that have that card, not to say that you have mental health issues but we actually will have a group that can be contacted on a regular basis.

MR KHOO: Yes.

COMMISSIONER FITZGERALD: And I wonder whether or not preventative sort of educative material is helpful in that space. Given one factor, we know people generally don't listen to anything until they have to; that is, you can talk about an issue for ten years but it won't be until the moment of crisis that they actually say, "We're listening" but it is a new era. Whereas previously the veteran would have to approach DVA. Now, DVA will have access to a vast register going forward.

MR KHOO: And that is a great step forward. I think the other thing to say around that is a really formalised education package for GPs because they're the kind of gate-keeper for the medical system so just making sure - because I think there are things being put in place too for a post-discharge kind of medical that they've got to get and making sure that they lock in with a GP there and the GP says that, you know, "There are all these things that we've got to monitor for, all these physical things, but just as important there's all these psychological things we've got to monitor for and we've got to be proactive in our health across all of those and so if we need to, I'm going to go and get you to have a review by a psychologist or a psychiatrist just to sort of make sure that you're psychologically healthy, not to find where you're psychologically deficient", you know, and so this a proactive way of moving forward there.

COMMISSIONER FITZGERALD: So just two quick questions to final, you've supported the use of a one measure of proof in relation to the SoPS, the statements of principle, but you've chosen the reasonable hypothesis one which is the lowest level. Could you just articulate a couple of your reasons for that, for choosing that particular one again? I know you mentioned it in your opening statement but just a little bit more precisely.

MR KHOO: Well, the College feels that this will take away another barrier that the veterans need to jump in that difficult transition time when finding compensation - you know, when trying to work out their compensation sort of issues. I think that it will also hopefully with time improve the DVA's - or give the DVA something to have PR about in terms of they're going to look less like an insurer and more like the beneficent body that they were painted as when they were first formed and I think - finally, I think if you make the compensation barrier less, I think in some ways it also decreases their barrier to going and finding help for their rehabilitation purposes so I think that there is a cross-over there within the individual that, if you make the compensation easier you don't complicate the rehabilitation in many ways. Because the amount of times I've seen veterans deteriorate spectacularly, purely from a psychological point of view, because of the process that they're navigating, in the compensation, is too many times for me to even count. And then the last thing, too, is if we're focusing on transition and suicide – two of the big issues – then both of them could be significantly enhanced, in terms of outcomes, I am sure, if we lower that bar.

COMMISSIONER FITGERALD: And just a follow up question; we've heard from widows and widowers, but particularly widows, and also partners of living veterans, about their mental health conditions over the last several public hearing days that we've had. And there's a general sense by those advocates that we and the system itself underplays their needs in relation to mental health. And at the moment, put in very simple terms, Open Arms provides the way forward. But it's the only way forward, and so various proposals have been put forward. I was wondering whether you have any comments about how we should approach the issues relating to both widows and dependent family members, including partners of living veterans.

MR KHOO: Are you talking about treatment, or are you talking about compensation?

COMMISSIONER FITGERALD: No, not compensation. I'm talking about mental health commitment.

MR KHOO: Great. Look, I think it's another education package that needs to go out there. I think, too, that a lot of partners feel that they don't deserve treatment, because nothing really happened to them. We've got – and, appropriately, we've got a lot of very good advocates that will rubbish that kind of particular thought, because it is ridiculous, and because partners go through the whole journey with the veterans. Partners as well as children go through the journey with the veterans.

And that's an education piece that we need to roll out, that, "Your problems are no less significant." And in fact, we find in our research, too, that the better the partner is, the better the veteran goes. The better the veteran's relationship with their children, the better they are down the track; less guilt, less remorse, more support, et cetera. So, yes, a very important piece, and again, it's another education thing that needs to go out. Open Arms is very good. That is a non-capped service. And, again, I think more efforts into pushing what they can offer, as well as sort of letting people know about the other – many other good NGOs that provide services in those areas.

COMMISSIONER FITGERALD: That's good. Thank you very much. That's terrific, Andrew.

MR KHOO: Thank you.

COMMISSIONER FITGERALD: Thank you very much for that. That's good. They're very generous. Nobody – in no other public hearing do they clap, only in Brisbane. We'll now break for an hour, precisely one hour, and we'll get back to – we've got quite a number of people, so we'll be back at quarter to two. So it's 12.45 roughly, so at quarter to two.

LUNCHEON ADJOURNMENT **[12.43 pm]**

RESUMED **[1.43 pm]**

COMMISSIONER FITGERALD: Good, thank you very much. So if you could both give your full names, and the organisations you represent, that would be terrific.

MR JEHN: Yes. My name is Thomas Jehn. I'm an advocate at the Veterans Advice & Social Centre in Hervey Bay, which is administered by the VVWA.

COMMISSIONER FITGERALD: Terrific.

MR SPAIN: Daniel Spain. I'm an advocate for the Veterans of Australia Association, and we work at the Veterans Advice & Social Centre in Hervey Bay. So, collectively, we represent the views of the Veterans Advice & Social Centre.

COMMISSIONER FITGERALD: Terrific, thank you very much. So, as you know, you've got about ten minutes to gives us the key points of your submission, and thank you for the detailed submission that you've given to us.

MR JEHN: All right. I'll just start with a bit of background information. First, the Veterans Advice & Social Centre has been running since 2003. Where we are, it's an alcohol-free, gambling-free zone, and all veterans from all conflicts are welcome there. Our main aim is for advocacy work. We have extended that now also to the younger veterans. The background is here, in 2013, Daniel was discharged from the army. At the time he was discharged, he was very, very traumatised, and his wife contacted me and asked me if I can do something for him. At that stage, Daniel was self-harming, plus other things.

With that there, we got him into the Veterans Centre. And with the Veterans Centre, it's completely non-confrontational, where any veteran, or wife of a veteran, family of a veteran come in, and doesn't feel intimidated or anything else at all. Daniel got himself together. With that, I saw he had aptitude, and I mentored Daniel for nearly five years. And with that, Daniel had formed the Veterans of Australia Association, which is an ESO in its own right. And even though it's mainly for the younger veterans, Daniel still does advocacy work for veterans of all conflicts, under all the Acts.

But with that one there, I commend Daniel on what he has done, and what he has achieved, and also with the following, he has got the younger veterans, and the assistance Daniel and his team have given the younger veterans. When they talk to me, it's like talking to a grandfather. Here, Daniel can talk to them, and it's one-to-one basis, on their own level. I would like to pass over to Daniel now, please, if you don't mind.

MR SPAIN: Thanks, Tom. So in 2013, when I first was reached by Tom, I came to the realisation that there was limited support and services for the younger veterans and their families. We have a lot of younger veterans returning to the area, particularly those that are on some form of DVA payment. They're moving from suburbia to a regional area, where their families are, and it's – cost of living and all those things come into it.

So that was in 2013. In 2014, we formalised, by inaugurating the Veterans of Austria Association, VOAA. A need to be autonomous was identified, due to several barriers identified within the veteran community. And we wanted to be perceived by the public as a younger veterans bona fide ex-service organisation. Our association firmly believes that the

veteran community still lacks appropriate advocacy and representation at state and national levels.

I must stress that VOAA is what DVA would consider a bona fide ESO. We provide high-quality and qualified pensions advocacy and welfare services, and advice for the younger veterans community, with assistance from welfare through to primary claims, VRB, and AAT. What was encouraging was the submission – the report which I've heard you speak about, the scoping study with Mr Cornell. I had a lot of in-depth discussions with Mr Cornell, and I'm looking forward to his report, because he was very eager to take on our view.

Our ESO – we're of the thought that – well, until proven otherwise, we are the only younger veteran ESO in the country, providing advocacy, welfare, pensions, and advice service for younger veterans by younger veterans. And on our submission, our contact details are there, so if there's anyone out there doing the same thing, I encourage them to get in contact with us.

All right, moving on to some dot points here. These are, again, on behalf of the Veterans Advice & Social Centre. There's a lot of mixed views on the definition of "veteran", in our understanding where many are coming from in their views of the term "veteran". But we must refer back to 6 December 1972, when the Government first introduced defence service into the VEA, with a revised definition of "veteran" to include defence service in the meaning of the Act.

There is no reason for discrimination in compensation, other than the different standards of proof, which applies to the VEA. However, we support that they be amalgamated into the reasonable hypothesis, for the benefit of the veteran. Veterans legislation is supposed to be beneficial, and it should remain that way. All serving members of the ADF are trained and prepared to deploy, and fight for their country, and, if they're called to do so, should be entitled to be called "veteran" under all Acts. This is regardless if they have war service, operational service, or peacetime service only. You are a veteran. The comments on the military service: we believe this has been explained well in the draft paper, and through the submissions made. I'll pass on to Tom.

MR JEHN: Thank you, Daniel. I'll just go on to a different aspect here. Next one is the studies on the impact of deployment on families. I think this one here is very, very important. I read with interest that there is some evidence from the United States that deployment can benefit families of veterans, and that was in your draft paper, gentlemen. I've been dealing with families of veterans for many years, and I'm dismayed

that this even appears in the draft report, as we're discussing disabled veterans' wellbeing and entitlements.

One thing the US does is look after their veterans. I heard before some of the talks about the Veterans Act. But once again, the US looks after veterans, and they also look after the veterans' family, relating to emotional health issues, by providing free medical and dental to dependents and families of serving and retired veterans, in VA hospitals all over US and on all military bases. My daughter is married to an Iraqi veteran. She lives in America. Herself and her children have full access to VA hospitals' medical and also dental treatments. And that also includes emotional problems as well, and I applaud the Americans for doing that.

As briefly stated in my submission, the veteran's family often suffers months of parental aggression related to deployment issues, and ongoing family distress, that are high-risk factors for child psychological distress. It is normally up to the veteran's family to pick up the pieces and provide support to the veteran, and support to the children. And often, the wife does not obtain support, until she is at breaking point, often resulting in family breakups, and, at times, veteran suicide.

In Australia, I'm surprised and amazed sometimes at the support the wives give to the younger veterans. When they come back from deployment overseas, they haven't come back from a holiday, getting a good suntan, even though they might come back with a suntan. A lot of them are coming back broken people, and there is no support or integration when they come back. I know they have the psychological reviews, but half the time that's a piece of paper, and just a quick tick, "Yes" or "No", "How do you feel?" And as I was saying before, previous speakers, most of the time, veterans always understate. But it's the wife that gives the emotional support.

Unfortunately, in Australia, since all the repatriation hospitals became privatised, many of our younger veterans and their families do not have the luxury of attending a repatriation hospital dedicated to veterans or veterans' issues. And as they have been privatised, once again they are in the queue with the normal civilian population. The aim of a repatriation hospital, when it was set up, was for – repatriation hospital for veterans and returned servicemen.

Now, at the moment, the repatriation hospitals, even though they do have cenotaph put there, where they have Remembrance Day, ANZAC Day services, that is – if a veteran wants to go there, he is put on the same

waiting list as a civilian, even though the veteran's problems a lot of the times is crucial.

With the mental health issue, I have seen younger veterans turned away from the repatriation hospital, because they haven't had the beds for them, and they've had to go to alternative hospitals, such as Buderim, et cetera. Now, that's not good enough, gentlemen. A repatriation hospital should be what it's named. They keep the name "repatriation hospital", but unfortunately, veterans aren't getting the benefit. I'll hand it back to Daniel. Thank you.

MR SPAIN: Wellbeing of recently serving veteran's family: I think Tom spoke on that quite well. We agree that family members play a critical role when defence force members are reintegrating following deployment, and particularly when they're transitioning out of the military service. There's been a focus here on the medical discharge transition. However, it seems to be lacking input regarding the administrative discharge or transition. There's only, I think, I from memory – and correct me if I'm wrong – about 15 to 25 per cent of ADF members that are actually medically discharged. That's a big gap in the ones that aren't medically discharged.

Views on the challenges faced by veterans' families: we agreed with most of the comments provided within the draft report and those within submissions. The Australian Defence Force remuneration: many veterans are being medically discharged, and are forced to rely on ComSuper invalidity payments, based predominantly on their pay grade. The incapacity payments and ComSuper – the incapacity payments under DVA and the ComSuper invalidity payments are offset against each other, as you are aware.

An issue here with them is, often, the spouse of a veteran, or the family cannot access assistance from Centrelink, as these are income-tested before tax. So it's significantly reducing any entitlement the family may have through Centrelink, perhaps for a carer's payment, which, when the veteran needs care and cannot access the dependant's allowance through DVA, they're being crucified in that regard.

There does not seem to be provisions within MRCA or DRCA for those who have been granted compensation to be eligible for the DFISA payment. This has significant effect on young veterans, who I deal with all the time, and their families, as families are often forced to repay childcare rebates, family tax benefits, and other such allowances and benefits from Centrelink.

Often, veterans' families are then deemed by Human Services as ineligible for their childcare rebate, which they have received for the last 12 months, or even longer. And they are sent out a letter, stating they have to repay this money, whereas under the Veterans' Entitlements Act, DFISA is there to offset this against the compensation.

I am intrigued by the comments by the Department of Defence relating to the payments of allowances for posting to remote locations within Australia and tax-free allowances for overseas deployments, and would like to compare these allowances with fly in fly out workers, such as miners, and the monetary expenses paid to the public servants sent to and working in remote areas or overseas locations. It's an ambiguous one there. I'll just pass over to Tom.

MR JEHN: Well done, Daniel. Now, the next thing I refer to is box 2.8, some issues in understanding veteran health studies. Now, I think it's important – when I was listening to what Dr Khoo was saying before, and I completely agree with Andrew, with these comments. Many veterans tend to understate, refuse to admit they have problems, due to the culture of the ADF. Anyone who served knows what culture is, and I'm not going to go into it.

This is commonly called the I Feel Good Syndrome. (Indistinct) the I Feel Good Syndrome due to the fear it may affect future promotion and/or future deployments, and is often demonstrated in medical documents. The amount of times I have gone through the medical documents of many, many veterans – and you'll see they've had a broken tibia or something, and they ask them in there, "How is it?" They say, "It feels good. I've got no problems. All I want to do is get back out again, and not let my mates down." It's part of a culture, and you have to serve in the military to know what that culture is.

So as I was saying, it's often reflected in medical records, where they downplay the extent of their injuries, emotional problems, without further medical investigation. Unfortunately, many of these problems manifest and are diagnosed after discharge of service. Now, this is where we go into the emotional disorders. A lot of these, even though on the statement of principles you have a limitation of time on them, on certain SOPs, many of these emotional problems come years after the service, and sometimes when they get older.

I've had 80-year-old World War II veterans, who have had no problems all their life, all of a sudden have a breakdown, where they start reliving – whether it's because of senility, getting a bit of dementia or what, I don't

know, but there's no time limitation on these. And I think that's something we have to realise and make sure we're aware of it. Back to you, Daniel.

COMMISSIONER FITZGERALD: I just need to – I'm just mindful of the time. Just a couple more comments, and then we'll have a chat.

MR SPAIN: Yes, all right. A focus on wellbeing and rebuilding lives: we agree with most of the comments relating to wellbeing and rebuilding lives. It is particularly disturbing that a veteran must make a lifelong choice of whether to take incapacity payments, along with a lump sum, or take the SRDP. This is under the MRCA. And many are relying on the Commonwealth Super and their access to invalidity class A or B.

It is my opinion that lump sum compensation payments are inappropriate for many veterans, particularly younger veterans. And it is noted, invalidity class A or B pensions are offset against the SRDP, under the MRCA. And I just want to add that there is a difference between the special rate of pension under VEA and the SRDP under MRCA. And I've heard the two terms being crossed a lot today, and there is a big difference here between them.

If a member is medically discharged, the first assessment that is made on discharge, or prior to discharge, is a determination under the ComSuper, which is effectively the insurance claim covering the ADF employment. It is not about liability, but simply the capacity for the individual to work. These payments are made as remuneration for loss of earnings. They are not compensation, so it is definitely not fair that these are offset against permanent impairment payments, that being the SRDP.

It is acceptable that the SRDP be reduced for any permanent impairment already taken by that veteran. However, it is not acceptable that it is offset against the Commonwealth Super invalidity payment. And I also believe that the SRDP payment, if offered, may also be offset against a retirement super payment. So those who have gone on to serve through their DFRDB, and are awarded their pension as more of a defined benefit for life, it is also offset, reduced because of that. And that is their money, that is their right, and they're being crucified with that.

I'm aware that MRCA provides funding for the member to gain financial advice prior to making a decision regarding a lump sum or ongoing payments, as a pension. However, when a young person is faced with the proposition of obtaining a very large sum of money or a small fortnightly compensation, payment, the overriding temptation is to take the lump sum. And often, there is a significant difference between offer of $100,000 or a small payment of $16 a week.

They do not think of the ramifications of when they hit the wall, and are no longer able to work or able to earn a living. In this case, they cannot double dip and revert back to the SRDP. It is offset against any invalidity payment. This is the main reason we are seeing more and more homeless veterans seeking assistance today. They do not receive, or are unable to receive invalidity class A or B. This seems to be taking over the role of supporting disabled veterans financially, with DVA supporting the veteran for accepted conditions and mental health.

COMMISSIONER FITZGERALD: If we can just bring that to a conclusion now, and then have –

MR SPAIN: Yes.

COMMISSIONER FITZGERALD: As I understand it, we've got two submissions from you.

MR SPAIN: Yes.

COMMISSIONER FITZGERALD: One is the one that you've been referring to during that presentation, and that's four pages, and then there's a more detailed one; that's correct?

MR JEHN: That's correct, yes.

COMMISSIONER FITZGERALD: So we've got both. Thank you for that. And we've read those with interest, so thank you. Can I just come back to a couple of points that you've both made. In relation to the advocacy for young veterans – and you've established yourself predominantly for contemporary veterans –

MR SPAIN: Young veterans.

COMMISSIONER FITZGERALD: Young veterans. The difference in what you're hearing from those young veterans to what you might hear from older veterans: has it become clear to that you that, in the work you're doing, they have particular needs –

MR SPAIN: Well, it's absolutely clear, really. These older veterans, I still support a lot of older veterans under VEA entitlements. However, these people, 90 per cent of the time, they're established. They own a home, their kids have moved on, they're grandparents. They're established people. Yes, they may have health concerns and disabilities, but they are established in life. The younger veteran – male, female – has typically a

young family, a wife who is not confident to separate from the husband or wife, because they're that worried about their mental health and wellbeing. And they're forced – the husbands or wives are forced to rely on the partner.

They're on a smaller – on the 75 per cent, regularly, of their incapacity payments or ComSuper, and circumstantially, they're very different. They're trying to provide the best life for their family, with all those pressures, as well as trying to establish themselves, provide the education for the child. A lot of the time, the family environment becomes toxic. The wife or husband is sick of walking on eggshells around the member with the problems, and it's a lot more complex. When dealing with younger veterans, I often – I can see a young veteran for up to 12 months, 18 months, keeping in regular contact with them, before we even put in a primary claim to DVA, because they are simply not ready to do it.

COMMISSIONER FITZGERALD: Can I just ask this question. In relation to the advice you gave to Robert Cornell – and obviously, we are encouraging the Government to release that report, and we will reference it and make some comments in a final report. But what was the principal approach you've recommended in relation to advocacy for young people?

MR SPAIN: Well, it's a very – well, the current situation is very difficult, and it's not sustainable in its current practice. The biggest thing when talking to Robert was mainly about things around the fact that younger veterans are being induced or enticed into certain groups, where they're offering, you know, "Come on this trip, do that." And there is definitely a place for that sort of wellbeing activities. However, a lot of the time, they're one-off events for these people, luck of the draw to get on these things, and they're one-off situations. However, they're not – the ongoing wellbeing care, which we try to provide to all our clients – the younger veterans and their families – is not there. They might shoot off for a surfing trip, all expenses paid, and then gone. You know, that seems to be a focus, and I understand why it's gone that way, most people would love a free trip somewhere and enjoy time with their friends with a wellness focus. However it is not the ongoing welfare support is being provided. In terms of advocacy we've heard it many, many times that with this new ATDP system that is currently in operation that the Department has come out, Veteran Affairs has come out and said that these - it's a registered training organisation where certificates are now awarded.

We are being assured by DVA that if a veteran on incapacity payments obtained that certificate that it will not be used against them as an ability to work. However, then the next paragraph goes on and says this is an individual based circumstances sunset paragraph. So honestly I am

waiting for the time when it is not predominantly run by veterans with entitlements under VEA. I'll wait a few years and I have a strong gut feeling that it will end up being used against veterans who are on incapacity payments as an ability to work.

The current system for instance with this ADTP the administration support officer for Queensland was relocated, no one was told, and then we finally got in contact with someone and the next week that position had changed again, email and phone number and no one was told. It just seems very impractical the way it is at present and there is a strong issue with mentoring at present. I was mentored under the TIP regime, under the old training with Tom when I'd been - we've been working together for five years. I'm now the advocate and Tom is stepping away as more as an advisory role for me and my team, and still, we will still work together as a team down there, but I sat in there every week in all the appointments, I would run the appointments through the proper - originally what was designed as Tom tells me under the TIP as a mentor role.

The current mentor role - a lot of people may wear the badge as a mentor, or the title, but is that person really capable of being a mentor. I went to an ATDP mentor workshop in Maryborough and it was scary to think that some of these people were candidates for being mentors and to pass on their knowledge to other people, because sometimes I see there's a problem within the welfare of veterans, particularly with older veterans of dependency and I see it quite a lot where older veterans are encouraged to - you can get that from DVA, you know, you can get this from DVA with the household services. Then that older veteran who once prided himself in keeping his garden nice, cleaning his windows, is now getting that done for him, the result being he's sitting in his chair all day, you know, downhill quickly. There just needs - the whole framework, the mentality it needs - there needs to be a dramatic shift with a community focus and it needs to be developmental.

COMMISSIONER FITZGERALD: Sorry, we will certainly be looking at Robert Cornell's paper, and some of the submissions he will put in. Both of you have identified the issues of the partners or spouses of veterans and the families of veterans, and I was just wanting to know from both of you, do you have any specific proposals in relation to how they can be better supported at this present time? Daniel, as you've indicated younger veterans are going through that transition and the difficulties and we've heard lots about that, but I was just wondering having regard to your submission are there specific things you think we should be particularly attentive to in our final report?

MR JEHN: Yes, if I can just speak on this one here slightly. What we have got we've got programs running to involve the family of veterans with the every day running of our veteran centre. With that there for example here, and I applaud the younger veterans for doing this, recently we had a fishing competition at Camp Gregory which all the younger veterans, their wife and kids were invited to go. Also there we organised a whale watching trip. We took all the wives and families out on a whale watching trip. We are trying to get the younger families, and when I say this is - to me there's no such creature as an older veteran or a younger veteran, we're veterans, full stop, and the only reason we have the difference, the old or the younger veteran is because of a multi Acts.

The younger veterans come under the MRCA, the older veterans come under the Veterans Entitlement Act. That caused a lot of friction, a lot of jealousy between the different areas. The Black Hawk tragedy has been mentioned is a prime example. I know I've been involved in that one too. But the thing is here virtually it's playing against each other where you get one lot of veteran gets paid X amount and the other veteran serving exactly the same period, but because of his entry date is paid a different level. The same thing goes, Daniel mentioned the gardening. Under one Act you can get the gardening done, the other Act you can't get it done. We have to get consistency, gentlemen, right through. To me I'm very pro the Veterans Entitlement Act. I think it's more beneficial for veterans. The MRCA has got some good points and I know with Margaret I went to the very first MRCA introductory with DVA when it came in in 2004. Okay, I'm fully aware of that. There is good points on both, but common sense has to prevail.

COMMISSIONER FITZGERALD: We are trying to harmonise some of those things and for example the home services and home attendance we think should apply across all the Acts and be improved. But can I just deal with one and then Richard might have some. You've made the comment in relation to the statement of principles that you support a single test, but it's obviously got to be the reasonable hypothesis one from your paper. I just want to go back to that in relation to your statement, Daniel, about a veteran is a veteran, and we have heard various views about that right throughout these public hearings and prior to the draft, but I just want to understand that. In some of the submissions, not many but some, they wanted to distinguish between veterans that are injured in operational service and those that are injured elsewhere. You're fairly firm of the view that they should be treated the same, and the way to achieve that in the statement of principles is just to make it a reasonable hypothesis. Am I interpreting you correctly in relation to that?

MR SPAIN: That's correct, I think it's disgusting that a veteran is discriminated against by way of compensation. For instance lumbar spondylosis is lumbar spondylosis. You should be compensated the same as under the GARP in the VEA for your symptoms and your disability for your rate of impairment. Not because you have war-like or non-like war service or peacetime service. It's just - that's ridiculous, and I've also noticed there's inconsistency of applying these SOPs on DVA' s behalf, where if a veteran under MRCA has four or five war service deployments they're accepting all their disabilities under the less beneficial compensation when most of their injuries have all occurred due to their war-like service or non war-like service, not their peacetime service.

So there is a lot of ambiguity there on DVA's behalf when even through the appeals process I have argued for the reasonable hypothesis through the appeals and the appeal eventually comes back except on a lesser standard of proof for the same factor. It's just bloody ridiculous to be honest, you know. I just can't comprehend why people deserve to be compensated differently whether war service or non war service, and if you look at all those submissions that support that from ex-service organisations and the like they are from a membership base of veterans who have entitlements under the VEA, all their entitlements under the VEA. Not from the membership base of younger veterans with service under - with only SRCA - sorry, DRCA and MRCA service. All the time these submissions, the ones that are predominantly listened to their membership base are predominantly VEA.

MR JEHN: Sorry, if I can just say one more thing here. While we're on about this sort of thing, Daniel did just touch on it, I'm in full agreement, in agreeance with the single stream as far as the statement of principle goes, but also it should be a single stream as well under the Veterans Entitlement Act that because you weren't in an overseas deployment but your incapacity is worse, less than what it was if you were injured overseas. You have two different scales, one for the returned serviceman, one for the Defence service. Now to me that's absolutely ridiculous, because they've both been injured serving their countries whilst in the Defence forces. So therefore we should have a level playing field on that as well as the statement of principles.

MR SPAIN: If I can add on that.

COMMISSIONER FITZGERALD: Sorry?

MR SPAIN: If I can add on that. With the war-like service and operations in today's environment in the Defence Force to get on the deployment most veterans would give their left leg to get on operational

service, to put their employment, their job description into action. You've basically got to be standing in the right spot at the right time to be deployed. That is how it works, and I believe that was still the case years ago. Vietnam, the same thing, there's a lot of people during Vietnam who would have done the same. Perhaps they would have given their right leg to go to Vietnam, but they just simply didn't deploy, and there should be no discrimination, and that's what it is, I use the word discrimination because it is.

COMMISSIONER FITZGERALD: Thanks very much. Just a couple of quick questions. First of all I must say it's terrific to see a younger veteran and an older veteran together talking about shared perspectives on all of these issues. We've heard the voice of the older veteran quite often, but fantastic to hear the voice of the younger veteran, and that goes to some of the contents you've made in your paper about how does that voice get heard in a way that's influential around policy and about current needs, and you've made some suggestions there about that and we're very mindful of that. So I just wanted to acknowledge that.

Just going back to this issue, you both commented on it, and that is the way the different Acts and combination of the Acts play out in terms of benefits and compensation. As you know there are a couple of things we're trying to do, first of all the harmonisation where that's possible. Secondly over time to move to that two scheme approach. True you might have points that you disagree with this on this, but trying to push towards that two scheme approach over the next five to six years is that a direction that you think is a good direction? What are your views on that?

MR SPAIN: My views on that is at present we need to look after our most vulnerable which is those veterans with eligible service only under the DRCA. My personal view is to extend the Defence service under the Veterans Entitlement Act to 30 June 2004 and have all those veterans come under the DRCA. It will give them the same entitlements. They will be subject to the same offsetting provisions against under lump sum payments taken. It's going to provide their family with coverage over the gold card, and if they die for an accepted disability or some other reason with the TPI and the DVA (indistinct). However the biggest thing is then it's going to put them under the one umbrella, everyone has the same entitlements, and then we can start working on the MRCA.

COMMISSIONER FITZGERALD: Okay, so it's a little different - - -

MR JEHN: If I can just go one step further on that one. Sorry, I know we're taking up time here. First of all, okay, reading the draft paper sometimes it's like reading a history lesson, and I congratulate you how

you did put it down, but in 6 December 1972 under the Whitlam Government they brought in uniformity right across all the Defence Force. Okay, the reason they did that really was to try and entice for national servicemen to stay in the Defence and that was a carrot they hung out for them, which is fantastic. But then when they changed after 1994 and brought the SRCA in as an interim period that's when all the trouble started. So between that ten years from 1994 to 2004 all those people who come under multiple Acts. I'm dealing with veterans, I'm sure other advocates here are exactly same. We're dealing with people who come under the Veterans Entitlement Act, the SRCA and the MRCA, and it's a bloody nightmare. Okay. I've got an AAT case going through this very moment based on someone who comes under multiple Acts.

Now virtually once again we go on here again. The veteran is put under so much pressure, trauma and everything else there they're not saying "No", it's not service related, but they're saying that because it happened this one here and it got aggravated on this one here, and then also because of that it also may have come under this one it's ridiculous. We can't get in TPI, we can't get in SRDP. Virtually even if they had apportments you could maybe work something like that, but apportment doesn't come into it like it does in GARP. So on this one here no one has thought it right through, and everything is so fragmented and virtually - it's a nightmare.

COMMISSIONER FITZGERALD: Where we want to end up is, the position I think everyone wants to end up in, that at a point in time you will be under one Act only and very long term there will only be one Act, so we're all heading there. I think what we've got to do is, there's a lot of issues to work through and we've raised some of those, and the timetable for this is also an issue, but one of the things is very clear, we need to get to a situation where at some stage a veteran is only under one Act, and the second thing is that there's relative consistency on a whole lot of issues across all of the Acts in the interim. That's the process we are trying to get to.

MR JEHN: But in the meantime their veteran suicide is rife at the moment.

COMMISSIONER FITZGERALD: Sorry, say that again.

MR JEHN: Veteran suicide at the moment, and that is the big worry here because what we're saying here - look, I'm not being critical if I am - we have had so many enquiries, hearings, everything else over the last five years, I'm sick and tired of hearing it.

COMMISSIONER FITZGERALD: No. So what we've got to do - the problem is there have been lots of enquiries in this (indistinct) but we haven't had much structural or systemic change, and so what we're trying to do is - - -

MR JEHN: There's none at all.

COMMISSIONER FITZGERALD: - - - to actually get to a system where the veterans will be able to be under one Act, one scheme, and the question is how do we get there. That's really the great challenge. We are going to run out of time and your submission is detailed and we are very grateful for it. Can I just deal with one other issue and it comes back to the issue about suicide that you've just referenced. For younger veterans I was wondering whether they are identifying to you, Daniel, or Tom, particular gaps in the health area, mental health area that they want addressed. So I understand there's a big argument about the way we fund it, whether it's gold cards or white cards and other approaches, but putting that aside, and you've made comments on that, in relation to services, access to services is there an emerging set of issues, just in a very brief time if you can, for younger veterans?

MR SPAIN: So the term "wicked problem" was raised by the RSL Queensland and this is one of them. In regional areas particularly, and I would say the same is in urban areas, I can speak mainly on regional areas where we are, the first point of call which we've had over the years until the recent change was the VVCS, now Open Arms. Veterans may not want to approach DVA for the non-liability health care, fear of government type things. There's an issue there, Open Arms providers are overwhelmed. Often the intake and session allocation is based around acute treatment sessions only, periods - episodes of treatment, and the providers in our area actively encourage clients to go out and get - although they get paid a significant amount less go out and get mental health treatment plan and they're happy to accept the patient under that because of the pressure from Open Arms is putting on applicants.

I can speak from the perspective of my wife who is given three sessions and then has to go through the whole history and everything once again to apply and do the intake again to apply for another three sessions. It's just ridiculous, and that puts more pressure on the veteran if the wife isn't getting support. Suicide is - in terms of the white card for suicide, for instance I have a young veteran who did East Timor, Iraq and multiple trips to Afghanistan, he had the white card severe PTSD, in fact he's in the Buderim Hospital at the moment. He had a significant back problem, as well as his PTSD. He fell in the shower. He had been on a – waiting to get prior financial approval for rails to be put in his shower. Because he

has the White Card, the process is you have to get private – prior approval to put them in.

The wife then assisted the Veteran up, and she blew two discs in her back and went – and was sent down to Brisbane to have surgery immediately, and they had – and the surgeon reported back it's the biggest disc bulge he's ever had to remove.

This shouldn't be the case. What a significant stressor, not only on the husband and wife, two children, young family. This only impacts the mental health worse. It's such a complex problem. All these things come into it.

To get treatment, willingness come into it. Is the Veteran willing to get treatment. I can ring up all the time and ask people how they're travelling, go around and see them, but the willingness comes into it. Their illnesses and disabilities exacerbate that willingness and take it away.

But all these little things just compound and compound. I've had two Veterans who I was in Afghanistan with suicide, one in the last month. A friend of mine, and also one client.

Now, this client was a special forces soldier. He was on his entitlements. He had reached, under MRCA, he had reached his entitlements, and I was actually helping him and encouraging him to seek tertiary education.

This Veteran showed no indications whatsoever, and with the other ones, they showed the indication signs. This Veteran showed none at all, particularly being a special forces soldier of – he about eight war service. No signs.

But in terms of getting the service, it is – accessing the service, it is available. I have had many younger Veterans attend the community mental health service provided by the state government, but I think there needs to be more of an understanding between the White Card and also the limitations on prior financial approval.

A Veteran, any Veteran with a White Card, should be able to turn up to the emergency department of a private, funded hospital, and be assessed to be admitted to the mental health ward.

That's what needs to happen. Whether he's taken there by a family member, police, whatever. It needs to be common knowledge that a Veteran can be taken to a private mental health hospital and be assessed for admission.

COMMISSIONER FITZGERALD: And just so, without going on, because we are out of time, that's not possible at the moment, without pre-approval?

MR SPAIN: No, you need prior – as far as I'm aware, and from my own experience in Townsville, when I ended up in the public system, right, and they utterly couldn't – jumped up and down. It was a weekend and they couldn't do anything. You needed the prior financial - - -

MR JEHN: Just to back up what Daniel is saying, we have tried to get people put into the mental health units, and we can't do it. What we have now running is we have our own welfare team. We've identified our high risk Veterans, and we go send our welfare team around once a week to visit these people, and that includes people like Cliff (indistinct).

MR SPAIN: There's a lot of young - - -

MR JEHN: But there's a lot of them like that that we do that there, but we haven't go the resources. We haven't got anyone to back us up. Everything is volunteers, and no one's getting paid for it, and that is one of the problems we're having with the younger Veterans, virtually those, they have to go and work.

COMMISSIONER FITZGERALD: Yes. No, thanks for that.

MR SPAIN: That point was raised this morning by the War Widows' Association, who spoke well. A lot of organisations do have the resources and the income to put on full-time staff and meet any requirements that are put forward.

So this needs to be considered in any recommendations. The best advocates are often the volunteer advocates. The best welfare workers are the volunteer, and that is often the case. The volunteer ones have the experience.

COMMISSIONER FITZGERALD: Thanks very much, Daniel and Tom. We're out of time, and again, thank you very much for the submission and we will consider what you've put in there. It's quite detailed, so thank you.

MR JEHN: I think we'll get the Tilt Train back to Hervey Bay now.

COMMISSIONER FITZGERALD: Good on you. Say hello to Hervey Bay for me. Thank you so much. That was really stirring.

MR JEHN: Thanks very much.

COMMISSIONER FITZGERALD: So, could we have Rob and John, please. Thank you very much. Good to see you again.

If you could, both Rob and John, if you could give your full names and the organisation that you represent, please.

MR SHORTRIDGE: My name's Robert Shortridge. I'm the Executive Vice President, Defence Force Welfare Association, Queensland branch, and just a little bit of background. I spent 36 years in the Air Force. I deployed four times, and I've been out now for about 14 years.

In that time, I've been involved with Ex-Service community, not in the advocate role, but more in a lobbying role, and I'm also a member of the Queensland Veterans Advisory Council.

COMMISSIONER FITZGERALD: Thank you very much.

MR LOWIS: John Lowis, Queensland President, Defence Force Welfare Association. Just a bit of background, like Rob, I entered the Army through National Service. I did about 23 years then. I switched to the British Army in – for the first Gulf War, and I deployed with them as well, and after I left the British Army, I worked as a civilian contractor for the Ministry of Defence over there, and later also had civilian deployments into operational areas as well.

COMMISSIONER FITZGERALD: Good. Thank you very much. And if you could, within 10 minutes or so, just give us some of the key points. Can I just clarify one issue? I have a series of dot points. Do we have a submission from you at this stage?

MR LOWIS: No.

COMMISSIONER FITZGERALD: That's fine.

MR LOWIS: The fuller one is on its way.

COMMISSIONER FITZGERALD: No, that's fine. I just wanted to clarify, so I had the document. So, yes. Over to you.

MR LOWIS: Just a quick one, following on from what was said in the previous thing. One of the things that I have found particularly distressing is when I have got a Veteran who has got substance abuse problems,

namely ice, and we get him through the stage, and he's about to be given a lump sum of $300,000, and there is nothing you can do about it unless you take court orders to do it. There's nothing to (indistinct) it and it's barking mad.

However, there's a lot of stuff in the report that we're quite enthusiastic about it, especially the stuff about the combining the Acts and all the rest of it.

But in the report, you'll also notice a number of reviews that have gone on before, and they've all fallen over through lack of political will, or whatever, around the place.

What you're proposing, in many respects, is a major change management program which requires buy in by a lot of stakeholders to gain any momentum.

I think on some of the stuff, which is quite startling and radical, I think that should be option A, and I think you should have a lesser option B. Otherwise, a lot of the report is just going to be shelf ware.

You're aware of DFWA, our role, and the Defence Force Remuneration Tribunal. You're aware of our role in the vocational educational training setup, where the civilian recognition of military qualifications Australia-wide. We have a bit of experience in those areas as well.

The areas that I'd like to address is the unique nature of military service. I know that's been done to death, and the report is peppered with, yes, military service is unique, but. Or something or other. It's much in common with others. It is not that unique and doesn't justify generous treatment that other workers – over what other workers get.

The concept is often misunderstood and is equating it emergency services and that. However, the big thing is it's subject to military law and giving up certain rights, and that is the particular thing that's unique.

The report does mention emergency services and says, well, you get this and they don't, and brings it up. We will respond to that in our main report.

But in pointing out the differences, I did come across an area that I think is quite relevant when you're looking at the treatment of military members and a whole wellness regime, and preventing stuff from happening.

Emergency services organisations still have meaningful desk jobs that people who are traumatised, that stuff, while they're being rehabilitated or given some respite, they can go to.

Over the last few decades, literally hundreds of uniform jobs have been contracted out and civilianised in the defence forces, and those jobs were there, or were able to provide respite, periods of rehabilitation, periods of normalisation both for the Veteran and for the family. But they were gone.

And the reason they went was because the – I think we referred to it as the bean counters or the gnomes from finance – put the pressure on and said, military, that's your job. Go out there, kill, and if (indistinct) uniform, that job can be corporatized and put away.

So there's a whole range of – and arguments to say, hey, they're needed for this, were thrown out because, hey, the aim of the ADF is to go out there and kill people, not to look after people and provide (indistinct) for them back in Australia.

And there was another aspect of this, too. The training that has been done over the years used to be done all in – we used to have – people used to get trade recognition. A lot of the training has been pruned, and it's been pruned because, oh, that bit of that module is not required for the military. It's only civilian stuff.

So there has been a focus on efficiency, effectiveness, and getting rid of staff. Now we're in the situation where we're saying, gee, transition is a darn good idea and we need to get trade recognition. Why isn't there?

Well, the reason there is because, again, the gnomes from the finance and the efficiency experts and that have got rid of it, and now we're at the stage where, without being insulting, you seem to be coming at this from a cost-cutting measure that we've experienced before, and put us in this position.

There's a lot of elements in the report that refer to affordability and that, and over-generosity, which makes me feel, here we go again. It's cost-cutting, and that's a perception that we have, and that's what comes through.

The terms of reference, just speaking on the use of the term "generous" in the report. Terms of reference require a look at the best practice of workers' compensation, and we're fully supportive of adopting best practice as far as delivery of services is concerned.

But somehow it seems to have morphed into comparing what the financial package that the military get compared with what other workers get, and I think it's a bit of a – things are being a bit skew-whiff. It's not the comparison of delivering services, it starts to focus on affordability.

But if judgments on generosity are to be made, they should compare like with like, as far as possible. I point out that there are many ex-ADF members working as contractors in the Middle East right now, close protection, logistics, and a whole range of stuff. They're doing the same sort of task that they would have done in the military.

Now, I don't know what the current paying conditions or provisions for medical or compensation are at the moment, but 11 years ago, my job as a civilian involved my being on standby for about 18 months, on about eight to 24, or a week's notice to move, and I did deploy a couple of times a bit before that, and it was going into the operational areas that the UK were on.

If I suffered medically from deployments, my package included continuing on current pay for up to two years in the current employment, private health cover, including rehab, carers' allowances, nursing for however long it took.

If after two years of not being able to work, or an assessment of permanent impairment, I could be pensioned on 80 per cent pay until retirement age, and a continued private health cover for life, plus a lump sum based on extent of incapacity. I had the option for those payments to go into a trust, and effectively (indistinct) it from a potential divorce I was facing.

It didn't apply to me, but some had provision for their children to continue on with private boarding school education. The package of compensation, I think, compares very favourably with – well, it gives a more accurate basis of compensation, of accurate basis of comparison than the one that's being used throughout the report.

Another area that we're particularly interested in is CSC and DVA. Now, I'm glad the matter has been addressed in the report. It looks at the invalidity benefit payments by CSC, and we've been very closely involved in that, and I think Brad Campbell's raised a few things this morning, and we've been working very closely with him and quite a few other young Veterans at the Administrative Appeals Tribunal.

There's test case litigation funding being provided for a whole raft of areas there, and we're intimately involved in that.

But there seems to be a reluctance to embrace this by the affected organisations. On DVA point of view, the Veteran Centric Reform shortcoming is really it is DVA centric, which is a narrower subset of a Veteran Centric report – a Veteran Centric Reform, an organisational reluctance to embrace issues or adjust responsibilities beyond the historic legislation to extend into looking at the invalidity benefits.

But that area is an area of a lot of complexity, and especially when you consider that CSC invalidity benefit payments are very much rehab and money – it is very much – not rehab, the exact opposite. There's no rehabilitation element in there at all.

It is just money there for pensioning, and the main aim when a person's got a class A is to stay on class A, and if you're on class B, to stay on class B, and don't let them know that you're going to be work or capable, because you'll lose everything, and that's a bit of a cynical attitude, but it's what the legislation encourages.

I think, looking into the future, there'd be arguments by CSC not to hand over the insurance element, and that DVA wouldn't be capable of doing it. But if you start looking at the future, and the likely actual management of super issues by the CSC when the thing is largely accumulation funding – there'll be accumulation funds and the ability for people to move their funds around, they won't be that – there won't be that much requirement for them to be actually fund managers. We'll go into that in more detail in our actual submission.

COMMISSIONER FITZGERALD: So we've only got a couple of minutes, and then we'll have a chat. So just a couple of key points.

MR LOWIS: Yes. I'll pass over to Rob.

MR SHORTRIDGE: One of the problems I have with, when we're talking about the workers' compensation and the sustainability and affordability, the affordability aspects.

If the government can afford to have a military, they can afford to send them overseas, they can afford to look after them, and I don't think it's the affordability in that aspect when comparing workers' compensation. It is applicable with what's happening.

The problem is, you know, what are you going to do with the people? People who do get injured in their job, fine, but again, it's the government. They're sending people out. They need to do it.

The other thing is the future of DVA. Your recommendation was that it be split by – into four, between defence, or two ministers. I don't think that'll work, and I prepared questions to go to that in the further detail.

COMMISSIONER FITZGERALD: Sure.

MR SHORTRIDGE: Furthermore, we've got – there's a discussion paper that's been raised. Unless you want to go into it now.

COMMISSIONER FITZGERALD: Your (indistinct). Are you going to mention that?

MR SHORTRIDGE: Yes. Well, if you want me to continue on, I'll - - -

COMMISSIONER FITZGERALD: Well, maybe we'll just ask some questions. But do have any other points you want to make, and I'll come back to a couple of questions.

MR SHORTRIDGE: Other than that, the concern is the report says that the – specifically states that none of the benefits have been quantified, which makes it really difficult to find out if it's – is that going to be any benefit to anyone, either financially or for the Veteran, and that's a real worry.

With the ESOs, I do note that you were waiting to – wait to see what happened with the Veterans Scoping Study. Could I suggest maybe you look at little bit higher and say how does the government get ESO input, because right now, I'd suggest most of the people in this room are all volunteers. They're not getting paid.

They got a 900 page, or 700 page report lobbed in on them just before Christmas to provide meaningful comment, and maybe there is a argument to have a Veterans Centre of Excellence, which is duly funded by some of the more affluent ESOs, and government, to be able to provide a professional level of support to the government's considerations.

And the other concern I have is when you're talking a lot of times in the report, apples aren't compared with apples. Under the Gold Card considerations, you've got four different amounts of money that a Gold Card is meant to cost, no one mentioned a comparison – everything seems to be compared to the average Australian, when most Gold Card holders

do, in fact, do have disabilities, they may be able to get current help under NDIS and other disability schemes. So if we're looking at things like that, apples need to be compared with apples and I'd suspect that if you were to do that – and that's not going to be easy because of the complexities of invalidity support, both, within the military and outside – I would suggest things like a Gold Card, there's not going to be a lot of difference between what's available, you know, particularly when you're looking at other people.

COMMISSIONER FITZGERALD: Look, thanks very much for that and, I must say, thanks to Robert and John. Robert, when we came up here to Queensland earlier last year, you raised a whole range of very significant issues, including setting us down the pathway of the superannuation. So I was hoping to escape and you stopped us from doing that. So I'll come back to that in a moment. Can I just go to one point?

I understand – two things you've raised which I just wanted to talk about. The veterans' scheme, including impairment incapacity payments and payments for healthcare, just those three things; we've had to look at the cost of that scheme and to try and make some evaluation of whether or not it's an effective and an efficient scheme.

We came to a conclusion that it is generous. But we didn't come to the conclusion that that was a bad thing, and every time we've used the word "generous", veterans have said, "Oh, you're making a judgment." What we actually said is, "Relative to the five eyes, taking apart USA's health system, it's a reasonably generous scheme." But we've actually supported that because we haven't actually reduced any of the benefits at all, in terms of impairment or incapacity payments and we've kept the structure of VEA and MRCA/DRCA.

So I only make this point to you, when you see us use the word "generous" that's trying to make an assessment, it's not a value judgment. I do agree that there are parts in the report that talks about "unique, but that's true", but I think in the general side and I suppose my point there is this. We got a sense in the veteran's community that, by and large, the incapacity impairment payments generally, were reasonable. They wouldn't have used the words "generous", we might say that, but were reasonable and in all the evidence to us, today, is that's not where the arguments have been or the issues are. So are we reading that correctly? Just trying to give some context of where we came from on that.

But our understanding is most veterans are saying to us that the quantum of benefits, either, impairment or incapacity are, in their terms "reasonable". Would that be correct?

MR SHORTRIDGE: I, you know, can only agree.

COMMISSIONER FITZGERALD: Yes. So the second thing is, just in relation to the workers' comp, we are not trying to turn the military compensation scheme into a worker's comp scheme. But one of the things we have been trying to do, and we are required to do this, is to look at whether there's any learnings from those schemes.

So what we've tried to do is to say, "Well, there's a large number of workers' compensation, accident compensation schemes around Australia in the nine jurisdictions," and what we are trying to say is, "Are there learnings from those?" and there are; there is significant learning and Richard's made that point several times, today. Certainly much more outcomes focused, much more pro-active in terms of early intervention, trying to get people back to work where that's appropriate; so there are learnings.

So I just wanted to just clarify with you. Is it correct? You wouldn't have any objections to those learnings? Am I right that what you're fearful of is trying to turn this into a normal worker's compensation scheme?

MR SHORTRIDGE: Yes.

COMMISSIONER FITZGERALD: Which we don't think you can do and should do.

MR SHORTRIDGE: Right, we're concerned about – well, I've had a long history with dealing with the efficiency and effectiveness people from the Department of Finance which I – you know, I had this approach to it and a lot of this rang bells with me.

COMMISSIONER FITZGERALD: Yes.

MR SHORTRIDGE: "You've got to keep politics out of it," is one of the principles in the Insurance Council, I think, yes.

COMMISSIONER FITZGERALD: Yes.

MR SHORTRIDGE: But we're here because of politics and this thing wouldn't have risen if it hadn't been the political will. Affordability; that's like efficiency and effectiveness with a value judgment and a

political decision over the top of it. There's a lot of good points and the wellness points and that in those principles and we fully support those.

COMMISSIONER FITZGERALD: Sure. So my third general point just relates to that. I hear what you're saying about affordability. Our proposals will actually cost governments more. There'll be more money in the hands of veterans, not less after these proposals. You're right, we haven't been able to cost all those yet and there's a dearth of information that's not available to us, but we'll try that.

So if you take our proposals in relation to transition, improved rehabilitation, any increase role for ESOs in things like veterans hubs, if you actually take the MRCA/DRCA merger where there's likely to be an increase in payments for a whole range of people and so on, it's actually going to cost more.

So I understand the use of the word "affordability" has raised that alarm bell and I don't – you know, I'm not critical of that. I would just simply say, and I have to say this in sincerity, we didn't come from a cost-cutting point of view, nor did the government ask us to. But what we are about is the efficient use of funds and, of course, that's going to raise alarm bells from the finance perspective.

But I do want to ask this question. Where do you think, going forward, greater attention or greater resourcing needs to take place in the scheme generally? I mean, we can talk about the details, but where do you think the scheme – the veteran support schemes we're talking about – is actually lacking – resourcing or lacking – yes, attention at the moment? Because you've got a good broad view of this scheme.

MR SHORTRIDGE: Could I suggest – and you've raised this it number of times in your reports – "statistics"; there aren't any.

COMMISSIONER FITZGERALD: Yes, we know.

MR SHORTRIDGE: And until you have good statistics, you won't be able to identify where the resources need to be put for maximum effect and how do you do this. You mentioned particularly within DVA. They need to try and, you know, sort of take away the compartments and take away the cylinders of excellence. But I think the elephant in the room is also the amount of veterans that are out there that aren't DVA clients, never have been DVA clients and, whilst there was a recommendation by myself and some others to have those people in a census, and that was sort of discounted for costs and a whole stack of other reasons, I think that there are other ways of getting the information.

Now, from the Queensland Veterans' Advisory Council, we've been trying to get the Queensland state government to ask questions on the forms, for those agencies that provided services of veterans; homeless, health, incarceration, training, to say, "Have you served in the ADF?" and if they have, "Are you an Aboriginal or Torres Strait Islander?" "Have you served in the ADF?" – tick.

COMMISSIONER FITZGERALD: Sure.

MR SHORTRIDGE: Now, on top of that, through the Veterans' Ministers' Round Table, because it's not a DVA issue, this is a whole government issue, get all states to do that and then collect the statistics which may help to be able to identify where the problems are.

COMMISSIONER FITZGERALD: So do you think that the fact that people that are leaving the military or the ADF will be entitled to a White Card, will that give us, do you think, a much improved base of information, certainly the details that we registered with the DVA in some way, shape or form? So do you think that, whilst you could do the census approach as you've indicated – and it has merit, by the way – there's another way to enter this?

MR SHORTRIDGE: Yes, but only from two years ago.

COMMISSIONER FITZGERALD: Yes, correct.

MR SHORTRIDGE: Now, what we're trying to do is trying to catch the World War II, the Korean, the Vietnam people who served their time and left.

COMMISSIONER FITZGERALD: Yes.

MR SHORTRIDGE: And they're, "Okay, I'm fine." Now, right, now, they could be going into hospital and no one – they would not have a clue that they might be entitled to a whole stack of DVA entitlements, the hospital wouldn't know, I don't understand why the state doesn't want to know, so then they can transfer the costs to the Commonwealth because it becomes a DVA issue, and I don't know how many people are there. But I'd suspect whatever number people think they are, they're significantly more.

COMMISSIONER FITZGERALD: So Liz Cosson, the Secretary of the Department, gave figures in evidence to the public hearing in Canberra.

MR SHORTRIDGE: Canberra.

COMMISSIONER FITZGERALD: Her estimates were that there were 640,000 living veterans and there's about 180,000 – and I apologise if that's the wrong figure – who are actually formal clients, claim clients, of the service. So that proves the point that you're making and that's 640,000. Of course, its' impossible to verify.

MR SHORTRIDGE: People have tried by going and looking at superannuation data.

COMMISSIONER SPENCER: Yes.

COMMISSIONER FITZGERALD: Yes.

MR SHORTRIDGE: And with MSBS, you know, everyone who has served gets a reserved benefit, so they'll probably know those. But when it came to that for ADB, you didn't serve 20 years, you just got your money back and that was it and there's some – yeah.

COMMISSIONER FITZGERALD: Yes, can I just go to your MudMap, if I can, just very briefly?

MR SHORTRIDGE: Yes, of course.

COMMISSIONER FITZGERALD: Obviously we put forward a proposal to move policy into the Defence Department and Administration to a new statutory authority and, as you would be well aware and maybe it will be in your submission as well, very few people have supported the approach of putting policy into the Defence Department and there has been a great deal of misunderstanding. We never intended to put the administration of the scheme into the Defence Department, but that's an issue.

Can I just ask, without going into that, what's the key few feature of this particular proposal that you're putting forward to us?

MR SHORTRIDGE: Okay, a key feature; you recommended four organisations supporting veterans. You had your Veterans' Service Commission, Veterans' Advisory Council within the Defence portfolio, Veterans' Policy Group and a transmission command and - - -

COMMISSIONER FITZGERALD: Well, within Defence.

MR SHORTRIDGE: Within Defence. Now, that's within the Department, the first two are in the Defence portfolio.

COMMISSIONER FITZGERALD: Yes.

MR SHORTRIDGE: First instance, I think transition command is using – to develop a transition command, it's using a sledge hammer to crack a nut. Now, 80 per cent of people tend to leave, you know, quite successfully and I think there are other ways of doing it.

Right, now, I am giving presentation on post-ADF support to transition seminars out at Amberley and it's really interesting because, when you talk to them and you say – 60 or 70 people in the room say, "Well, if you've heard of DVA's on-base advisory service, put your hand up;" one person puts their hand up.

So I think Defence needs to be more aware of the issues at transition command and particularly when, for complex medical transitions, people are assigned case officers. So I think, you know, that sort of thing with better relationships between DVA and Defence is not necessary.

To have one organisation supporting veterans I think is beneficial; I think it'll be efficient and effective. To have a policy area within Department of Defence; they do the policy and then someone else in another department or under another administerer who's responsible for implementing it is a disaster waiting for place to happen because you can make a policy without taking account of any of the resources required to implement that policy.

So we believe, or I believe, that Veterans' – well (indistinct) that a veteran support group, for want of a better word and sort of structured in what was the DMO and is, now, the Capability, Acquisition and Support Group which has a ministered, it's a group sitting there, have a central office and then, rather than having offices in CBD in four or five states, they can put their people out on the bases, like DMO have their people – or CASG have their people out on the bases supporting the weapons systems – and then there'll be the ability for Defence and the veterans' support group or DVA – we didn't want to use that word 'DVA" so it gets confused of what we want and what's there later.

COMMISSIONER FITZGERALD: Sure.

MR SHORTRIDGE: They'll be there; they'll be together; they'll understand and, quite frankly, my time in Defence, didn't understand anything about what happened and even when I did some Reserve work

back in 2012, people didn't understand, they didn't understand what was out there, what was available for them – to them. So that's why we have the veterans' support group.

COMMISSIONER FITZGERALD: Okay.

MR SHORTRIDGE: A new one is the Superannuation Board and Insurance Board to try and interface with CSE and get some formal - - -

COMMISSIONER FITZGERALD: So if I can just deal with that and then hand it over to Richard. We're aware of your previous concerns in relation to the superannuation generally, but we've been hearing more and more about the invalidity payments within super.

MR SHORTRIDGE: Yes.

COMMISSIONER FITZGERALD: So when, in this MudMap, you put Superannuation Insurance Board, is that largely targeted at that or are you trying to deal with the whole of the superannuation as it effects ADF members or veterans?

MR SHORTRIDGE: Initially, the invalidity side and we believe something can be done, now, you know, by putting advisors out there. In the longer term, the whole box and dice could go there as well because there's elements of superannuation – I'll detail it in the actual report – which are most appropriate.

When a person is getting out and they require advice, they have got to consider their superannuation, they've got to consider if there's invalidity stuff and there's a whole range of things where that advice is terribly, terribly complex and, at the moment, it is only available to them in silos. Within the VEA side of the house and MRCA, you can get a – especially when, you know, "Do I take a lump sum or do I take" – you can get access to an allowance for professional financial advice.

COMMISSIONER FITZGERALD: Sure.

MR SHORTRIDGE: That was not available to consider the superannuation impacts and, as you're aware, there's a lot of complex superannuation impacts in that area. When people were given the option to change from MSBS to ADF Super, they had no access to any superannuation advice and, yet, in the civilian role, there would be provision made or advice to be made, either, through an advance or something or other from the – yes.

COMMISSIONER FITZGERALD: Some one of things that are common in a number of the proposals, even though we've got a particular approach, as you say, the joint transition command, others have got different models. The one thing that we all seem to be agreed on is we need to have Defence, DVA and CSC present, together, you know, in a consolidated sort of range, so that a person can receive that sort of advice that you're referring to.

MR SHORTRIDGE: Exactly right, and it needs to be done formally and not rely on goodwill, which will fade away.

COMMISSIONER FITZGERALD: No, no, we don't want goodwill, as you know. Goodwill's important, but as Richard's often said, "It's not enough," and one of the issues we've had, and just in a serious nature in relation to this, this set seems to rely heavily on goodwill; individual's matter, individual secretaries, individual ministers.

MR SHORTRIDGE: Yes.

COMMISSIONER FITZGERALD: History has taught the Productivity Commission and ourselves and only lasts for a very short period of time and, unless the structures and the systems are solid that can actually withstand, both, good and poor individuals, you end up in difficulty and that's a difficult issue because you've actually got to step outside of the current personnel and say, "Let's think about this ten years from now."

MR SHORTRIDGE: Yes. The other reason why I was saying superannuation comes in, military superannuation is far more complex than the civilian superannuation. Yet, they are governed by the Act and the CIS Regulation which is designed for civilian superannuation industry and it's been said a lot of times, trying to get the military thing to fit into that or interpreted legally to that, is like trying to put a square peg in the round hole, and that is a common thing, duly because the special things associated with that due to the military.

There's a common understanding. If we can get that common understanding of the military, it aides in the interpretation of acts and, you know, possibly easy administrative load and get rid of a lot of the complexity.

COMMISSIONER SPENCER: I can't resist one more word on transition and, look, just so you know where we're coming from, we hear two scenarios. One, is, "I'm fine. I've got my job lined up and I'm out of here." Terrific. Sometimes that doesn't end so well after three or six months. The other one, is somebody who quite clearly is identifiable for

transition but clearly – and obviously medical discharges falls into that category – who is going to need a great deal of assistance through that.

So what we have been grappling with, as we've been discussing, is we see lots of good things happening here and there. It often depends on the base, it often depends on individuals, but the key question for us is, so who is responsible for that whole process through transition? And, look, it comes back to something we've been talking a lot about today.

A lot of the issues – not all of them – but a lot of the issues which are identifiable at that point or are not identifiable, it manifests later in life, what happens before transition, during service and then particularly, during transition, can play a key role in that? It's a lot of things we observe in other systems that respond and are pro-active about that better than we see in the current system and one of the failings we see is that issue of responsibility. Who is responsible?

So that's why we've put the Joint Transition Command on the table. There may be other ways of coming at that, but that was to our thinking. Rob, you mentioned something that I was just a bit intrigued by and you did get a chance to expand on it. But this was in the context of "this is pretty rushed". We put out 700 pages and say, "What do you think?" and, "By the way, tell us in six weeks' time," and we know that's difficult and, you know, this will be an ongoing discussion, no doubt, and we also – I think Robert explained at the beginning of the day – when we hand in our report, government has 25 sitting days to make it public. No doubt, there will be a vigorous and continuing debate about so what will government do about the sorts of recommendations we made.

But you mentioned something of the notion of a veterans' centre of excellence. So I was just wondering where you were going with that. Is that about - - -

MR SHORTRIDGE: Okay, if you have a look, ANAO report efficiency at DVA; you know, your inquiry, you know, the Defence report where they come to ESOs and want a response; the VAS are the centre inquiry into the use of the quinolone, the anti-malarial drugs; AAT cases; the Royal Commission of Banking and Superannuation, which we tried very hard to get CSC into; development of the Australian Military Covenant; DVA's transition taskforce; input to critic to DVAs veterans' centric; perform Australian War Memorial coming in and inviting ESOs. Now, they're people coming to these volunteer organisations and that's all over the last 12 to 18 months, thank you very much, and quite frankly, I think a lot of people, probably in this room, are getting a little bit jaded and it would be nice - - -

COMMISSIONER FITZGERALD: Sure.

MR SHORTRIDGE: Now, my understanding of, for example, some of the White Ribbon people, I've seen a lot in the Indigenous people – do get significant government funding to be able to have people that are sitting there on a full-time basis, to be able to provide this.

Now, I know the RSL suggested that DVA fund this. Well, it's really interesting because it came for RSL NSW who's probably one of the most affluent organisations we have – well, that the RSL has. But the point is, you know, for you guys to – or for government to get good advice, you know, you're relying on volunteers, you know, relying on people giving up their time with no payment, their resources with no payment and sometimes you might get good stuff, sometimes you might not. So if you was – one was to implement a centre for veteran excellence, for want of a better word.

COMMISSIONER SPENCER: Yes, yes.

MR SHORTRIDGE: Funded and maybe located in Canberra because that's where the action is, for want of a better word. And then as these reports come up they can drag people in who understand - generally probably I'd suggest ex-service people, understand, do the job, get paid to do the job so there's responsibility and accountability, and then they'll leave and the government, I think, would get a far better product and a far more concise product because part of their job would be to liaise with the other ESOs.

I wouldn't suggest it'd be under command or under the auspices of one ESO. Get people in. Get them – do the report. I think that would be – give a much better product to government.

COMMISSIONER SPENCER: No, thanks, Rob, and look let me just repeat a few things I've said earlier because I think it goes to this issue. We've commented that clearly there's a changing role for ESOs and that's largely for ESOs to determine. But government comes in in terms of who does it engage with in order to, for want of a better expression, co-design what's needed. And I mentioned earlier about people who have front line experience of what's happening. Now in Human Services, and I've had a lot of experience in that space, as has Robert, it's demonstrably different.

That voice is brought increasingly to the table before even working out what to do about the issue. It's to identify issues, hear from those organisations and individuals on the front lines of these issues and what

can we do about that. It's up then to government to design what does it want to do and commission by way of services, and who will it go to. And we've heard comments earlier today about governments being smart and thoughtful about that. Not just spreading money around but actually working out what will make a difference, what does the evidence tell us, who are the good performing organisations who can do this work?

So I think you'll find in our final report we have much more to say about that both in the earlier design process but also in the implementation process (indistinct). And I commented on this earlier, it's been very surprising to me to see the relatively modest – I'm just using diplomatic language here, funding that goes out to the NGO and ESO communities around these issues and we'll probably have more to say about that because in Human Services it's shown time and time again that the sort of work that you and other organisations do on the front lines of services is extremely valuable and cannot be done by government.

And it's what I describe often as the soft entry points. Those people who are most isolated, most in need, who won't engage with government but you have the opportunity to find them and connect with them. It goes back to an earlier comment, you could use some assistance in actually trying to find out who they are and how to, you know, go about connecting with them. But you have the capacity to do that through peer to peer type programs, through hub programs, through drop in centres, as we've talked about before.

That has to be part of a bigger system. Not just a government system, a bigger system. Where government can assist with that is they can leverage that value and we'll have something to say about that.

MR SHORTRIDGE: And I'd probably argue that the ex-service communities or the Australian defence communities is a little bit naïve because they don't really know how to access government because I'd guarantee if we had the expertise of some of these other more radical organisations they would know how to access and we'd have the money – we – (indistinct) – it's just we're used to getting on and getting the job done and I think that's part of the military ethos.

MR LOWIS: I think the other thing too is we're not just a reactive organisation but being proactive and identifying the issues and formulating something, rather than just sort of responding to a request for information or views.

COMMISSIONER FITZGERALD: Yes, and one of the issues for us is how does policy wherever it sits get better informed from a range of

views, not only ESOs but also for more – there's more and more professional players in this field as well at organisations. So one of the things we're looking at is how do we actually get good quality advice informing policy? And that's at different levels, ministerial, departmental and other sorts of issues and we've have some discussions with that today.

MR SHORTRIDGE: You didn't mention the Veterans' Ministers' Round Table which has only been in existence for two years where all the state veterans' ministers' (indistinct) - - -

COMMISSIONER FITZGERALD: Yes.

MR SHORTRIDGE: - - - with the federal one and I think that's probably – it's a start, it's never happened before and I think it's a very positive one and then you've got the committees that feed into that.

COMMISSIONER FITZGERALD: Yes.

MR SHORTRIDGE: So that's a basis I think too, and that's why in our description in the (indistinct) diagram there we have the Veterans' Advisory Council which I'd imagine would also have some ESO input going direct to the minister because they would probably provide the secretariat for the VMRT.

COMMISSIONER FITZGERALD: We would certainly – yes, we believe the Minister should be directly advised in relation to policies in relation to the veterans support scheme and that has to be not only veterans and ESOs but it has to be a body of experts and expertise, which is currently not around the table. Otherwise all we're doing is we're talking about bits of the scheme. We need to be able to talk about the whole scheme and that now involves private operators in the health and mental health scene as well. So – yes.

All right. Thank you very much for that. We'll break for just five minutes and then come back, so if you want to grab a tea or coffee bring that in and then we'll start in five minutes.

SHORT ADJOURNMENT **[3.15 pm]**

RESUMED **[3.21 pm]**

COMMISSIONER FITZGERALD: We might start. Only so that we can get away at a reasonable time, not from our point of view but from yours. Could we have GO2 Health, Jenny and Kieran, I think. Good. Thanks. So if you just want to grab those two microphones that would be terrific. Thanks very much.

MR McCARTHY: How long have we got, three hours?

COMMISSIONER SPENCER: Good luck.

COMMISSIONER FITZGERALD: Wishful thinking. So Jenny and Kieran if you can give us your full name and the organisation you represent please.

MR McCARTHY: My name is Dr Kieran McCarthy. I'm a veterans' health GP. This is Jenny Strike who is my senior practice nurse and business manager from GO2 Health.

COMMISSIONER FITZGERALD: Good, and the arrangement is if you can give us 10 minutes' worth of, you know, the main – the key points, then we'll have a brief chat after that.

MR McCARTHY: Okay. So my background, quickly, I've been told I've got to tell what I do. I was an army doctor for six years and deployed five times. So now I basically look after veterans. We – I've come from sort of the special operations world and I got involved with the rehabilitation of wounded soldiers back then. I manage, and the practice manages - the best way to put it, some immensely broken humans. We get ones that are very, very complicated and often they see little future for themselves and their family following their services.

We're a coal face provider, so we – we're at Everton Park. We're a large allied health and medical clinic and we look after the contemporary veterans. So the 25 to 55 year olds. We have – we're lucky to have very good relationships with a lot of the feeding organisations, ESOs, RSL, advocates, so we do a lot of the DVA claims and support them that way. We provided a submission to this to help sort of shine the light on some of the issues that we face in the health space.

And I know Andrew Khoo was here earlier. We work closely together. The complexities of accessing care with (indistinct) DVA patients. On the surface it looks quite straight forward. There's the White and the Gold Card system and they are supported in that way, which most of the general public don't get and that's important to understand. But in many ways

because of what DVA is, it's often quite complicated and their lives are very complicated and as I said these are very broken people.

And they often struggle to see a way forward. So one of the problems in the community, as an example, is DVA have very nicely provided everyone with a White Card for any mental health when you get out. So psychologists compared to market rate get paid 60 per cent below market rate, and so we struggle to actually get people in to see psychologists and psychiatrists because of purely funding. So there's funding issues around that.

A lot of the DVA paperwork is very confusing. A lot of GPs don't understand DVA for various reasons or don't have the time, and I suppose the reason we work is we provide that time for them, to take them through a journey. We're essentially a sports clinic. So we do the physical, nutrition and a lot of the psychological support for them. And the system works, it's not rocket science. You take the time with someone, you look at them and you provide support for them and their life improves and that's pretty much what we do.

MS STRIKE: But it's managed care.

MR McCARTHY: It's managed care.

MS STRIKE: So it's not just siloed practice where you have one - - -

COMMISSIONER FITZGERALD: Sure.

MS STRIKE: One practitioner not speaking to the other. Our team all collaborate so we get much better outcomes.

MR McCARTHY: The end point is essentially trying to create a functional member of society with a vocational goal so he can reintegrate back into the community and also support for their family as well, because often the families as we all know are ones that are left out of this. We try and link with all the various ESOs as well to provide some support for them as needed because it's one big team effort. It's a big – it's a pie which we need to have addressed.

We have – we look after about 400 veterans a week in the clinic. We've got well over a 1,000 on my books, 80 or 90 per cent of my patients are veterans. There's 10,000 in the clinic all up – patients. So we're a busy place and we're also quite involved with the Gold Card Coordinated Veterans' Care Program and we advise DVA on that because we have a system which seems to be the one that is the most effective. Look and as

I said before it's – the process is there, it's a good system but parts of it are just too unmanageable, too unwieldy.

The financial aspect is a drama because you're going to have a problem now where you're actually not going to be able to get care because the remuneration is not enough for market rate and the paperwork requirements around that, and that's one of the reasons we wanted to raise this as well. So all of our providers lose income whereas they want to treat DVA but the paperwork requirements around it are going up. The concerns (indistinct words), you know, WorkCover pays better. If we move to a WorkCover model, which I know it's been talked about what does that mean for the actual back end with – you see someone and then you've got to have more paperwork around that which reduce the amount of care you can give.

Anything to add? (Indistinct words) because I'll just keep talking.

MS STRIKE: So in regards to maintaining practitioner care, we struggle to (1) attract psychologists especially, but even physiotherapists because they are paid so much under the market rate and therefore we also struggle to keep them because we have such a high percentage of patients through DVA. So therefore their income drops in relation to the number of DVA clients that they see. The other thing to remember is that there are whole companies that don't see DVA.

So even though everybody is issued with a White Card or a Gold Card and non-liability mental health care, we have numerous psychiatrists, psychologists that do not accept DVA patients. So therefore when they come into a clinic like ours and we see them, there's a higher demand on our psychology because there isn't the availability and not only that, when we have somebody in an acute crisis, which happens quite regularly, we call around to the private hospitals to admit them and there's up to a four week wait to get in for an acute mental health disorder.

And then we end up calling an ambulance and they get sent to the public hospital and they're discharged that afternoon.

MR McCARTHY: Because they're a veteran and they're supported by DVA. And that's unfortunately what happens and then we're left to pick up the pieces and trying to find somewhere for them.

MS STRIKE: But we can't provide an acute care mental health facility. So we need to address the issue of paying psychologists the appropriate market rate, together with physio and (indistinct) because they are also under - - -

COMMISSIONER FITZGERALD: Sure.

MS STRIKE: So veterans may be entitled to these services but if there's not the – if they're not – if the practitioners are not being paid accordingly, there's not the services available for them.

MR McCARTHY: So we've banged on about it. I mean we choose to do this. I'm one of the owners. So, you know it's something that the clinic has - converted in the last 12 months. We've now become - 60 per cent of our patients on a weekly basis are DVA from about 30 per cent and that's in the last 12 months. I'm seeing five new patients a day. It's fantastic. We transition people from Enoggera Barracks. That's one of our big things. We've got very, very strong connections with the barracks. I do all of – I now do all of their DVA paperwork. All their paperwork, their pen and paperwork and we – our main thing we're trying to do is have a very – a very clear transition process. When the (indistinct) shut, they don't notice because everything is picked up so we've got connection with the barracks and they come to us and we can move them on from there if they're in our area and that's been very successful. And why is that, because we just take time and sort of help them with what they need and then connect them with various other organisations which you've spoken to today.

COMMISSIONER FITZGERALD: Can I just ask you a few questions where - I mean it sounds like a terrific integrated care model. As you'd be aware, you know, with the Health Care Home model that the Department of Health is trialling, somewhat unsuccessfully so far, and once again not surprisingly I think money is one of the issues, it's that's been (indistinct).

MR McCARTHY: (Indistinct) evidence, yes.

COMMISSIONER FITZGERALD: Yes. My understanding is that DVA has been trialling something like that, does that connect with you or are you part of that, or?

MR McCARTHY: I'd love to be part of it. We were invited to Health Care Home. We, without banging our own trumpets, we were told we were the model. And unfortunately, and we are very keen on the model, it's what we do, but when you look at its unfortunate financing behind it and the fact that it's a new government, nobody really knows what's going to happen with it, it was too much of a business risk for us to move forward with it.

MS STRIKE: Not only that, the risk stratification tool that they were using does not fit the contemporary veteran yet they are extremely broken people but because they're not chronically ill, but they are chronically broken, the risk was that they would not fit into the high end of the spectrum that there needed to be care. And when I spoke to the Department about this, they could not give me an answer before the time that we had to sign up so - and they still don't have that answer for how people in this category will fit in.

COMMISSIONER FITZGERALD: So this is the Department of Health?

MS STRIKE: Yes.

COMMISSIONER FITZGERALD: Right. So when you speak to DVA and you say, "Well, here's a model that...", and you would know far better than I do, there's terrific examples around the world of how that can work and there's good evidence to show the outcomes from that. So is DVA interested in this? Have you spoken to them about it? Is there any thinking around how could you actually have a veteran specific veteran appropriate model around this notation of an integrated Health Care model?

MR McCARTHY: We're are too busy seeing patients. It would be a stunning thing to do and my aim has always been to have something like our model outside every barracks in Australia, which transitions people supported by DVA and realistically has to be funded by somebody else. I'll run it but I'm not funding it because it's too hard from (indistinct) but it's the perfect Health Care (indistinct). You know, all the guys if we had've said 25 to 55 year olds, varying levels in capacity, some of them horribly broken, some aren't, then we'll punch them into the system and then help them move forward and they plug in everything else (indistinct).

COMMISSIONER FITZGERALD: So some of the arguments you get around this are that, "Yes, that's terrific but it's a bit of a Rolls Royce model"; you would say, "Not on the funding we get, thanks very much"; but the other model that people about sometimes is, "Well, we just need to go to all GPs, give them some specific training in terms of veteran-specific issues, that kind of thing, and that's been suggested by some people; what do you think - I mean, you look at model like that, how do you think that's going to work?

MR McCARTHY: The problem - look, I was invited to go sit on Channel 7's - one of the news programs with (indistinct) medical research for (indistinct) on PTSD last year I think it was, to talk about GP

education for PTSD. The problem with most GPs is time, especially the larger clinics and bulk-billing clinics, ten minute appointments, this is our time - - -

COMMISSIONER FITZGERALD: Yes, can you just pull your microphone closer.

MR McCARTHY: Sorry, yes. So the problem is that most GPs don't have time. They're running a 15 minute, I run a minimum of 20 minutes, another doctor runs 30 minutes and so that is going to be the issues. They don't understand DVA and DVA's not hard to understand at our level, they're just out of time and that's scary for them; (indistinct) training issue could do it. I mean, the reason our place works, I suppose, is it's a one-stop shop, so you're under one roof. It's the GP superclinic model that are actually worse because they didn't work, because there was still solo care under one roof. At least we talk to each other. If you come in to see me, everyone's notes are on the computer. I can see what's going on immediately and make changes on the fly. So that process I think needs to happen because otherwise we're not going to make progress; but how do you get the GPs to want to spend time with people who are just too complicated, so?

COMMISSIONER SPENCER: Have you had the opportunity, you may have had the thought but it's not possible, but have you had the opportunity to link with any research possibilities around, you know, longer term outcomes demonstrating that the integrated manage care model will achieve the result?

MR McCARTHY: We're launching down that path though. It's a bit - I mean, it's an alternative but we've just been approved to do a study with Defence Health with acupuncture and veterans.

MS STRIKE: Acupuncture, massage, naturopathy, in conjunction with their regular care and then the studies looking at whether the outcomes are better.

MR McCARTHY: And then also the Coordinated Veterans' Care. There's a process starting now for mental health care for guys who are on White Cards, to get almost like the Gold Card that was - - -

MS STRIKE: There's a CVC Pilot, we're engaged in that as well.

COMMISSIONER SPENCER: So if somebody said to you, "This is terrific. We want to run a pilot for a certain, you know, period of time. We want to work out how do you fund that appropriately? We want to put

in place some longitudinal research and evaluation around that?" What would you think of that?

MR McCARTHY: I'd hand them to my two PhD researches from UTAS that are running the program coming up.

COMMISSIONER SPENCER: Right. Okay, so you have (indistinct)?

MR McCARTHY: Yes, yes. So the project we've got coming up is a fully funded research appraisal for 12 months. There's a reason we've gone down that pathway, is because the future is finding out what actually works because a lot of stuff I want to look at is outside the box. If you've got PTSD, sometimes medication is not the answer. There might be a floatation tank? What are the Americans doing? They've got way more than us. It might just be some acupuncture, it might just be something else, which is not necessarily funded by Medicare; but it might work? Who cares how, it's just as long as it does because you might get a functional human out of the end of it so some of these projects, absolutely. We've recently just set it up to start going down that process.

COMMISSIONER FITZGERALD: Sorry, what's the Gold Card program that you're involved in?

MS STRIKE: So we have a Coordinated Veteran Care program which is the DVA funded.

COMMISSIONER FITZGERALD: Yes.

MS STRIKE: That program was actually designed for "older" veterans and it's usually designed for the chronically ill. We have adapted that to deal with the contemporary veterans so we're dealing with PTSD, musculoskeletal issues. We're looking at their diet, their exercise, their mental health, so it's actually a very inclusive "total" package and the whole aim of the program is one to develop a relationship with the veterans so that when things turn bad, they pick up the phone to us straight away rather than go down that dark path.

COMMISSIONER FITZGERALD: Yes.

MS STRIKE: The other aim is for preventative medicine. So as we know, the older veteran traditionally has multiple chronic illness.

COMMISSIONER FITZGERALD: Sure.

MS STRIKE: And unless something is done with this cohort of veterans, they're going to end up in that same category in being chronically ill as well as chronically broken. So the large number of them that are coming through is going to blow out the health system as they age if we don't spend time and money on them to actually prevent them - - -

COMMISSIONER FITZGERALD: But can I just ask this question? Given that you've got a team based approach or a coordinated or an integrated tier model, the funding for that, however, DVA doesn't actually fund you for that or does?

MS STRIKE: CBC - - -

COMMISSIONER FITZGERALD: As a model?

MS STRIKE: No, no, no, (indistinct).

COMMISSIONER FITZGERALD: So you get a fee for service?

MR McCARTHY: A fee for service, yes.

COMMISSIONER FITZGERALD: So it's all fee for service.

MS STRIKE: Yes.

COMMISSIONER FITZGERALD: So you've taken the fee for service model and turned it into an integrated care model to use, Richard's expression, "effectively".

MS STRIKE: Yes

COMMISSIONER FITZGERALD: In relation to the Gold care one, is that the same or is that a different issue?

MS STRIKE: No, the Gold card, a CVC program, is funded differently again. So that is a quarterly payment in order to manage their care, ongoing, and there's certain criteria that you need to fulfil in order to be able to do that.

COMMISSIONER FITZGERALD: And your practise deals with that?

MS STRIKE: Yes, so we have a practise nurse that's full time just on the CVC program and we also have another practise nurse that deals with our regular - - -

COMMISSIONER FITZGERALD: So without going into the detail of the funding, is that a mixture of - do you get a funding just for that or do you have to - it's also a fee for service "and" that?

MS STRIKE: It's also a fee for - - -

COMMISSIONER FITZGERALD: Plus.

MS STRIKE: No, it's - - -

COMMISSIONER FITZGERALD: So it comes together.

MS STRIKE: Just a fee for service but both of those.

COMMISSIONER FITZGERALD: All right, yes we'll have a look. We'll have a look at that.

MR McCARTHY: It is a good system, it just has to be done properly and that's the thing. They're like GP managed plans, all practises do those, this is just the next level and what we call it is, it's a "touchpoint" and so there's multiple touchpoints with our patients and so they feel like they're supported and they're not left in the dark and we're with them.

COMMISSIONER FITZGERALD: So if I just take it, and we're going to run out of time, but just a couple of the - the two key points you're saying is, (1) is the DVA needs to set the right price, pay the right fee for the various medical and Allied Health Services; and the second one is they move to a different model in relation to almost this integrated care model?

MR McCARTHY: Yes.

COMMISSIONER FITZGERALD: And that's the two things you think are essential?

MR McCARTHY: Yes, I think so. We've got some crib notes I can give you.

COMMISSIONER FITZGERALD: No, we're assuming (indistinct) to us.

MR McCARTHY: Yes, yes. So look, I think, there's a number of things I want to talk about, but in the absence of time, but they're the big things is the future of care, so yes, funding and ensuring that the right care is provided with accountability so it's not just rorting the system with getting X for this five times a week.

COMMISSIONER FITZGERALD: Just one question, the Health Care Home, as you know, it's coming to light in various other countries as well and very successful with one of them, are you aware of any veteran specific programs in other countries that are built around this sort of model?

MR McCARTHY: Not what I'm aware of but I haven't really had a chance to look and that 's probably our next step, is to really - yes, we'd like to on the forefront, it's what we do, as we build our and continue to develop our particular care plan model, then that's what we need to look at is, as part of this, "Well, the Americans are doing this, why can't we do this as well? because there's evidence behind it. Even though it's a bit out there there's evidence, let's try that because it might work.

MS STRIKE: I suppose one other thing that we would like in regards to - because we are such a specialised veteran clinic we would like to be involved in consultation when changes are made because what we think is going to happen and what actually happens are two separate things. So I think would be very useful to be involves in the consultation process when rolling out new changes.

COMMISSIONER FITZGERALD: This is in relation to DVA (indistinct) health - this is in relation to DVA basically and you're not consulted at the moment?

MS STRIKE: No.

COMMISSIONER FITZGERALD: No.

MR McCARTHY: No. And part of that is - I mean, we know we're around because we have the largest number of (indistinct) program in Brisbane that I know of so - but it's what we do, so we're trying to build a model which helps more veterans basically.

COMMISSIONER FITZGERALD: And just my final question; in relation to your relationship with Enoggera, the defence forces, that is simply a referral basis? They refer to you and you do your magic or is there a payment structure or is there some sort of formal arrangement in - - -

MR McCARTHY: So we have two pathways, so we look after - as an external provider to Garrison Health for serving ADF members for physiotherapy, psychology, so there's a "large" number of people that do use that. And then essentially I transition them, so when they get taken

over by DVA, the day after the get out more than six weeks before, they come and see me, we start the process, I make sure we're not missing things, that's a DVA funder so that's not funded by Garrison. I'd like them to do it but it's a DVA process and it's just a handover and so the rehab coordinators all know me or know us, so they're all involved as well so it's quite a smooth process which is exactly what we're trying to do, is just make it easy for guys and girls getting out, with those connections.

COMMISSIONER FITZGERALD: Right, good.

MR McCARTHY: And they're large because I was a doctor there, so, and my first RSM's sitting right there, so that's why that connection in many ways has happened.

COMMISSIONER FITZGERALD: All right, thank you very much for that and we look forward to receiving your submission.

MR McCARTHY: Thank you.

COMMISSIONER FITZGERALD: So we now have four participants, individuals, and they're going to present for a slightly shorter period of time. We need to make sure we have those organisations and individuals, so if I can just call Neil Robson please.

MR ROBSON: Yes, it's Neil.

COMMISSIONER FITZGERALD: So, Neil, if you can just give us your full name and if you are representing an organisation, please let us know and if you can make a brief opening statement and then we'll have a couple of questions.

MR ROBSON: All right, thank you. My name is Neil Robson. Ex-service with Airforce, did 16 years. Not representing any - - -

COMMISSIONER FITZGERALD: That's fine.

MR ROBSON: All right. I just did want to make a quick mention about advocacy groups, is that when I started to put my claims in, I was amazed at how many advocacy groups there were and 30 years down the track I can understand why there's so many advocacy groups because the complexity of DVA claims process, anything to do with DVA, is a bureaucracy and it's just a mess.

And I read your report, the draft report, I've read every submission that was submitted, a whole of lot of different perspectives there that I never

even knew about - understood a whole lot of different things, and I welcome the draft report because to me it's a bit of fresh air and it's a draft and I saw a lot of openings there with the hearings for, you know, talking about further things so to me this is a positive move, it's not a panacea, you can't fix everything, it's not a band-aid. It's been ongoing for years, the DVA process. My father, ex-Army, he said, "Don't let the bastards get away with it", he died prematurely from injuries. And I have understood what he was going through and I vow to continue on to make sure that myself and other veterans get what they're entitled to. Not anything more but not anything less either.

I submitted three dot points to the Commissioners and the first one was about the reviews. I have indicated a whole lot of references that I found in the draft report. In principle I agree with it but my concern for DVA is relating to governments and my question I put to the Commission was, "What governance change mechanisms and monetary measures will the Department be applying to any changes and who will monitor this and how will this be continually monitored so the Department is not drawn back into previous habits?" As I mentioned before, it's bureaucracy that gets in the way of everything.

My second dot point was on compensation. I outlined a whole lot of references from the draft before with regards to that for the Commission to look at. And predominantly, my areas about external medical providers, the assessment process for claims, and the manner in which these specialists actually disclaim and have this preference to be able to say no to veterans' issues saying that the injuries don't exist yet they're still being treated for these injuries, they still have these conditions when they go for assessment, that these specialists are saying either they don't exist or they're childhood onset. Nearly every one of my claims has been involved with having to go to a medical assessor and every one of those claims bar one has had to go four, five or six different process of medical assessment to get a recognition and I'm still fighting.

One claim was in regards to industrial asthma and allergic rhinitis and I'm having trouble with my voice, this is a particularly bad day, from isocyanate poisoning and working in the reseal/deseal where I'd lose my voice continually, suffer with breathing issues, had lots of surgery; 30 years down the track I still can't get a Ventolin puffer, I still can't get medication or treatment for my accepted condition that was accepted in 1990 despite going through two separate Ministers and having to put three additional claims in for the same process. The Ministers assured me that I have the conditions accepted and I should be able to get medical treatment. Allied Health Services continually ring me up and tell me I have to put a claim in.

The third dot point that I brought up was in regards to the deseal/reseal, it wasn't mentioned in the draft report whatever and this is an example of DVA bureaucracy. The deseal/reseal participants went through a whole lot of mess where DVA, in charge of the deseal, decided that only particular musterings or categories of trades would be the recipients of compensation and the rest of the trades were locked out. A parliamentary inquiry into the matter, it was well known, Rudd did a turnaround. They did a tier system of assessment for - it's not even compensation, it's what, you know, putting up with bad stuff - that was pretty bad, and it's still not sorted out.

There's still people that are entitled to claim the ex gratia payments that are still being knocked back. I've applied three times. They don't even contact your referees and they just say no. My question to the Commissioners are: It's twofold, has the Commissioner considered this detail by veterans covered off in the draft report, measures or controls to never allow this to occur again, the same thing that happened during the deseal because that was badly managed by DVA. Also, is the Commissioner likely to make a recommendation to DVA to reassess these claims as you have done in draft Recommendation 9.3 and draft Recommendation 13.5? Then I also made reference to a (indistinct) trigger on page 375 of the draft report.

COMMISSIONER FITZGERALD: Good. Thank you very much, Neil. Can I just go back to a couple of points so that I understand. You indicated your claim for asthma and allergic rhinitis, was that?

MR ROBSON: Yes.

COMMISSIONER FITZGERALD: Were approved?

MR ROBSON: Yes under Comcare in 1990.

COMMISSIONER FITZGERALD: Under Comcare?

MR ROBSON: Yes.

COMMISSIONER FITZGERALD: But were they ever approved under DVA?

MR ROBSON: No, DVA said that they can't understand the conditions and what's associated with them so that's why I get the blinkered no. I've applied twice underneath - the current DVA I did get the claims reaccepted, allergic rhinitis has been accepted twice, the Veterans' Review

Board also acknowledge that it's been accepted; can I get medication or Treatment? No.

COMMISSIONER FITZGERALD: So can I just be absolutely clear, your understanding there was that the DVA, through the processes you've just identified, have accepted that claim.

MR ROBSON: Yes.

COMMISSIONER FITZGERALD: Have you ever received any payment for that claim as an impairment (indistinct)?

MR ROBSON: I did in 1991.

COMMISSIONER FITZGERALD: From DVA or from Comcare?

MR ROBSON: From Comcare.

COMMISSIONER FITZGERALD: From Comcare but not DVA?

MR ROBSON: No.

COMMISSIONER FITZGERALD: So if you - - -

MR ROBSON: I get a small pension as well from that - I offered to take a lump sum and - - -

COMMISSIONER FITZGERALD: From Comcare?

MR ROBSON: (Indistinct) lump sum and get a pension of something like $18.

COMMISSIONER FITZGERALD: We haven't got time to go into the detail but I just need to understand, are you receiving or have you received a payment from DVA, not Comcare but DVA?

MR ROBSON: No, Comcare.

COMMISSIONER FITZGERALD: Never. And so if you went to DVA today, if an advocate went to DVA and said, "Has there been an accepted claim for me, Robson, in relation to these conditions?"; what would DVA say to that advocate today?

MR ROBSON: I have no idea but a claim has gone in to DVA for asthma and it's been rejected.

COMMISSIONER FITZGERALD: Okay. Can I just do a second one, you're the second person in the last few days that has raised this issue of deseal and reseal and I understand that there were serious issues around that particular issue. You're saying to us that a particular group of trades, or people involved in trades, were "excluded" at a particular time; is that correct?

MR ROBSON: Yes, that's right.

COMMISSIONER FITZGERALD: And you were part of those trades that have been excluded; is that right?

MR ROBSON: Yes, yes.

COMMISSIONER FITZGERALD: And what was the nature of your trade if I could ask?

MR ROBSON: I was a surface finisher. We actually look after the surface substrates, paint coatings, conversion control coatings, and the resurfacing of inside the fuel tanks.

COMMISSIONER FITZGERALD: Yes. And so, just again very briefly, how have you taken your case to the Government in relation to your trade being accepted as a group within that particular - - -

MR ROBSON: I never did anything. I was watching what was happening with the deseal issues because at the time I was going through a separation.

COMMISSIONER FITZGERALD: Right.

MR ROBSON: And going through a separation and trying to embark on another issue of significance is not a very good idea so I was watching the outcomes of what was happening with the deseal through the media and through DVA websites and saw what was going on and then when the parliamentary inquiry came on, after that decision I firstly lodged my claim for the ex gratia system then.

COMMISSIONER FITZGERALD: And you were denied it?

MR ROBSON: Three times.

COMMISSIONER FITZGERALD: Right. Have you used an advocate for any or all of those claims?

MR ROBSON: I am a member of an advocacy. Trying to get an appointment with them is impossible so I've just decided to do it best on your own and leave the services available to those who really need it and I'll just keep trying.

COMMISSIONER FITZGERALD: And just my final question is in relation to your health care at the moment, how do you deal with that at the present time give, I presume, you're not entitled to any cards or as just indicated before, you have to - - -

MR ROBSON: I have a White Card.

COMMISSIONER FITZGERALD: You've got a White Card?

MR ROBSON: Yes.

COMMISSIONER FITZGERALD: You've applied for that?

MR ROBSON: Well, that was given to me after the Comcare.

COMMISSIONER FITZGERALD: Right, okay.

MR ROBSON: That was given to me at that time.

COMMISSIONER FITZGERALD: Right.

MR ROBSON: So I've had that since 1991 and I've had to fight very hard, but mainly I've funded my own treatment and my own surgeries and medication, to no avail from DVA. I'm still slowly winning little bit by little bit.

COMMISSIONER SPENCER: Yes. And thank you for your submission. Just a quick follow to this now: you've referenced some of our recommendations about trying to - the confusion, the lack of transparency, the determinations that are made at the outset that end up with the VRB that don't need to go to the VRB and I'm conscious of the fact that you've had no success with the VRB but you've referenced some of the recommendations we are making and you try and bring that back into the early decision making so are you broadly supportive of - - -

MR ROBSON: Yes, definitely. And my experience with the VRB has been good and bad. With the AAT, completely - I just don't regard the AAT as being a viable solution for any type of review because they kept

telling me, "If you don't have a solicitor working for you, we're not going to work with you" and they were - - -

COMMISSIONER SPENCER: Sorry, who is "they" when you said - - -

MR ROBSON: That was the Administration Appeals Tribunal when an appointment was made, a phone conference was done. They kept saying everything, ruling everything, until I had a solicitor working for me and I told them that they can learn to work with me and dumb it down, so to speak, so that I don't incur the costs and I refused to incur a cost where I put some of their children through university.

COMMISSIONER SPENCER: Was that part of the alternative dispute resolution process at the AAT where you have that conversation, or?

MR ROBSON: Yes, yes.

COMMISSIONER SPENCER: So you decided not to pursue the AAT; is that right?

MR ROBSON: Well, I wanted to but they said unless I had another medical opinion to prove that what this doctor had made up, that it was a childhood onset, then I couldn't go anywhere and that's where it was terminated.

COMMISSIONER FITZGERALD: You've raised this issue in relation to, and I'll use your words, "doctor shopping" by DVA, it's come a lot in the consultations and the public hearing and we've heard again earlier this morning. It's very hard to very to the extent that that occurs but your experience from your perspective is that a number of the doctors have not supported the diagnosis that you think was appropriate. What do you think would improve the scheme? I mean, it's - at the end of the day DVA is going to require a medical assessment.

MR ROBSON: Yes.

COMMISSIONER FITZGERALD: And so at the end of the day is it simply about the ethical conduct of doctors, is it about - do you believe that DVA applies undue pressure on particular doctors to come up with particular findings? I was just wondering from your experience, given it's been over the last 20 years or so, what's the solution to the problem that has confronted you?

MR ROBSON: Well, that's going to be your biggest conundrum because two of the specialists they sent me to, the first words that were said to me

were in the vogue of, "We don't believe that suing the Government and the Crown is the answer" and that was their comment so I see their opinion as safeguarding the Crown, the Government, as having to paying compensation for an injury at work as being a disservice to the rest of the taxpayers.

COMMISSIONER FITZGERALD: Right.

MR ROBSON: So I don't know how you'll fix that but medical and ethically these conditions still exist and I'm still being treated for them but the doctors have said they were childhood onsets so let DVA just take it from there and some of those childhood onsets have been disproved and so they then go to the next level and then try and go through a process of acknowledge - "Yes, you have the condition. You won't get compensation but you will be covered by DVA."

COMMISSIONER FITZGERALD: And just a final question, you said you've got the White Card and the White Card in your case specifies certain conditions; is that correct?

MR ROBSON: Yes.

COMMISSIONER FITZGERALD: Just for clarification, what conditions does it actually cover?

MR ROBSON: There's something like eight conditions I have.

COMMISSIONER FITZGERALD: Right. And in relation to each of those issues, I presume, but I might be wrong, but you would have had to have a claim successfully accepted by Comcare, or now DVA?

MR ROBSON: Yes, which some of those have been three or four (indistinct) down to get accepted.

COMMISSIONER FITZGERALD: Right. So notwithstanding the fact that you've had a number of conditions recognised by DVA, you continue to struggle with DVA in relation to additional issues?

MR ROBSON: Yes.

COMMISSIONER FITZGERALD: All right, thank you very much for that. That adds some clarity some the submission. Good, thank you very much.

MR ROBSON: Thank you.

COMMISSIONER FITZGERALD: Can I have Fiona Brandis please. Hi Fiona.

MS BRANDIS: Hello. So I'm very nervous so please be kind.

COMMISSIONER FITZGERALD: Well I mightn't be but Richard will be so it's all right. Now, Fiona, take your time but if you can give us your name and that would be terrific, just for the record.

MS BRANDIS: Sure. So I'm going by my maiden name today which is Fiona Carol Brandis, I won't reveal my married name to protect my partner's privacy to some degree.

COMMISSIONER FITZGERALD: No, that's perfectly fine. So, Fiona, if you can just give us the key points you'd like us to hear.

MS BRANDIS: Sure. So ever since I was selected to this hearing a week or so ago, I've been up backing and forthing about whether I should actually attend because I'm not a veteran myself, I'm the wife of a critically ill veteran. I pressed my husband to make his own submission but he's far too checked out to actually contribute to that level of administration. So given that in the past, and ongoing, I've had no agency and nobody has engaged with me at any point during my husband's deployment, pre-deployment, when he was returned early to Australia from deployment for medical reasons. At no point did anyone from Defence engage with me. I didn't even know that he had landed back in the country.

I got this critically ill man back in my life and at no point have I had any support. He's had multiple hospitalisations for both treatment and suicidality and at no point has anyone engaged with me. So I feel like, in this space when you're living with an injured veteran it's very claustrophobic and it can be very confronting but it feels like I'm in the bubble and there's just this silence. Everyone's just giving me silence so I wrote to DVA and I wrote to Defence. I don't get answers. I get shoved around, you know, I'm just in this vacuum of silence so I want to fill this void of silence with my voice.

So anyway, I thought I would, you know, just to give you a little bit of context about my experiences. You may have already read my submission. That gave a lot of detail about our family hardship but I'll read an email that I wrote to my family last year, "Dear Family. I write these words with love. Please do not take this as harsh criticism. I suppose I'm writing to you so that if something catastrophic were to

occur you would not be completely shocked or unprepared for that event. Yesterday was "R U OK? Day" and I'm a little disappointed that none of you checked in on (redacted). It's likely that he hasn't been particularly forthcoming with you however you must be peripherally aware that he's going through a tough time and has been ever since he was medically returned to Australia from deployment in 2015."

"So far he has spent seven weeks of this year in hospital; four for a mental health crisis and three weeks for specialist treatment. He'll have another three week hospitalisation before the end of this year. Ten weeks in psychiatric hospital total in one year. In short, he's not okay. To respect his boundaries, I won't share any specific stories but you can read my public submission to the Productivity Commission's..." et cetera, et cetera, "For some heavily edited information and he approved this content. As you will see from this document I also am not okay. I'm not expecting any of you to be experts on his situation specifically or mental health issues generally, however I do ask you to educate yourselves a little on veterans' issues."

"For starters, you may wish to visit the At Ease website, the Australian Veterans' Suicide Register on Facebook is another useful resource. Please note that I'm advocating heavily for (redacted). So far I've convinced the Commonwealth Ombudsman to recommend changes to the way Defence supports families of deployed members and I've also had Defence turn aside a $5000 payroll debt at a time when we were handed by lawyers during the period when he wasn't earning and we were about to lose our house. I also have a number of actions I am presently undertaking with Defence, FOI, and the Ministers of Defence and DVA. As much as I'm trying to accomplish myself, (redacted) could really use some more advocates, also nobody is advocating for me. Love Fiona."

So I sent that to six immediate family members and I had one reply. So I can't even punch through the silence in my own family about what we are going through and I should point out that I'm also mentally unwell as a result of his extensive illnesses, so. Any questions?

COMMISSIONER FITZGERALD: Thank you very much, Fiona. Can I ask just a couple of questions. Is your husband currently discharged or is he still in the service?

MS BRANDIS: Yes, he was medically discharged.

COMMISSIONER FITZGERALD: And when was that roughly?

MS BRANDIS: 2017 and that was after a very lengthy period without pay.

COMMISSIONER FITZGERALD: And he was discharged on medical grounds?

MS BRANDIS: Yes, yes.

COMMISSIONER FITZGERALD: During the transition period, given that he was on a medical discharge how long it would have been before his discharge had you become aware that he's likely to transition out of the service?

MS BRANDIS: I think ever since he was medically returned from deployment, he had a complete mental breakdown in the least. There was issues building from an earlier deployment, he was basically re-traumatised, had a complete mental breakdown and they sent him home and they didn't even inform me that he was coming home.

COMMISSIONER FITZGERALD: And when he was sent home, he was still in the Defence Force at that stage?

MS BRANDIS: Yeah, that's right. He was the adjutant.

COMMISSIONER FITZGERALD: And how long was it between that time and he was actually discharged?

MS BRANDIS: So he was returned home in 2015 and he was medically discharged in 2017.

COMMISSIONER FITZGERALD: So during that period of time, can I ask just two related questions. One is, what was the level of support for him, particularly on discharge? And what was the level of support for you during that time?

MS BRANDIS: The support for him - well, first of all 2016 when he was meant to march out and actually be discharged, he sent his CO an email with a bunch of references to killing himself and I had a Chaplain and an officer on my doorstep. Then about two weeks later he had a full breakdown and ended up in hospital, wouldn't speak to me. The Chaplain that I contacted for urgent care and a social worker engaged with me for about two weeks but then when he got out of hospital and was going through a period of leave without pay, for about 18 months, no engagement for me at all.

I believe that he had the occasional psychological appointment but, to be honest, when they're very ill they don't share - necessarily share a lot with their immediate household.

COMMISSIONER FITZGERALD: Sure. And in relation to the support whilst he was still in the Defence Forces, we understood that there were supports for family members through what is now called "Open Arms", was that your experience? Did anybody offer to you any support either through - it was called something then - - -

MS BRANDIS: Yes, VVCS. No, VVCS, can I just say have just been absolutely wonderful. I have called them a couple of times for urgent advice during times of crisis with my husband and they've been very supportive. But I never heard anything from Defence at any time. When he deployed, I was in a vulnerable position. I had just moved house and I was a first time mother of 16 weeks old twins. I had been told that I would get some kind of information or package. I never received - I've received one paragraph note from his commanding officer in (indistinct) during the seven months he was away and that was it. That was it. Nothing.

COMMISSIONER FITZGERALD: And just in relation to Open Arms. Did you start to use Open Arm services whilst he was still in the defence force, or has that only been since he's discharged?

MS BRANDIS: No, it was - well I mean it was while he was on leave without pay, so I guess technically he was still in Defence.

COMMISSIONER FITZGERALD: So, given that you've had this contact with Open Arms, what's the sort of support you need - you need it and you need, that's not being delivered at the moment? And I'm sure there's a whole range of those sorts of issues. But for you, given that you've got contact with Open Arms, are they able to give you advice, counselling, referrals, or is that just not happening, even though you've said they're very good?

MS BRANDIS: I mean I've only ever reached out to them in a crisis situation. I've tried to engage my husband in coming to couple's counselling or family counselling. Our young children are at a point now where they're starting to ask questions, "Why is Daddy always angry at you? How come Daddy never comes to Nana's house?" They need support. I'm very concerned. I know that Vietnam veterans' children have a much higher suicide rate and very concerned longer term for my children that my husband won't engage. And in some cases because I've been so excluded, I don't feel I have licence to chat, so I have to sort out

my own counselling and I am currently on anti-anxiety and antidepressant medication and that's what I followed through for myself and that's what I fund myself, and I don't think that's right. My illnesses, I had a - I basically struggled on for years until last February I had to literally scrape him off the floor and take him to a hospital. Couldn't get him into Greenslopes, a former repatriation hospital, they were full. Had to take him all the way to Strathpine, while managing my very small children. So there's been nobody - ten weeks in hospital, ten weeks in hospital when I worked full-time and I have young, confused children, and no phone call, nothing from anybody.

COMMISSIONER FITZGERALD: And when you've approached DVA, what have you been seeking from them and what's been their reaction?

MS BRANDIS: Well, I really get shut down. When I write to these Ministers of Defence or DVA I just get passed around to each department of defence personnel, "Your husband's no longer serving so these people are going to deal with you. This is not our responsibility". I get very curt answers. I get - it takes months to get any answers. The only way that I find out any information is you get the - you write a letter, get the response and then get the real answer when you apply through FOI. So they basically lied to me through omission. It's very disrespectful.

COMMISSIONER SPENCER: Your husband's experience with DVA. I mean have claims gone in, have they been accepted, is he getting the help he needs?

MS BRANDIS: Well I mean in some ways DVA is good. I mean it was someone from DVA that put us on to The Bravery Trust, who were able to give - which is an ESO - was able to give us some urgent financial support so that we didn't become homeless. So that was really - that was really good. We had - we wouldn't have known otherwise, he wouldn't have known. Like many situations, it takes a long time to process. I think a lot of people are very familiar with lost documentation. Luckily he had had - "You've never had this treatment, you've never had this injury", well here's this stack of paperwork from 2009 that I'd retained, so you know he's had the normal general trials and tribulations, just not the huge ask that some people go through. But when he's trying to engage in his own administration he's very reluctant to do so and he's very reluctant to engage with advocates because of his massive distrust of Defence and that puts a lot of pressure on me. And I don't have a military background or a legal or health background so I'm just trying to navigate this very unfamiliar industry or trying to keep my family and household and myself together.

COMMISSIONER SPENCER: So he's not had an advocate through that whole process?

MS BRANDIS: No.

COMMISSIONER SPENCER: You have been doing most of it.

MS BRANDIS: I've been doing bits and pieces here. He's like "I can't handle this here, talk to Fiona" and hand over the phone. It's like, "Hello DVA" and then, you know, try to understand all the jargon. It's not familiar.

COMMISSIONER SPENCER: So at various times somebody just picking up the phone and talking to you would have been helpful, rather than waiting for - - -

MS BRANDIS: Well, I just think that if you're wanting to treat the whole better and you can't leave the family out of the equation because it feels like he's got access to - you know, of course, he's been in the military, he's been injured, but vicariously I have suffered as well and it feels like I have just no agency to say, "Hey look, I'm suffering. I need support". I can't get support for my own family, I get blocked by government. It's just really frustrating. You know I think it would have been particularly useful when you send this mentally ill man back from halfway through a year-long deployment and plonk him in my lap and, sure, you're giving him all this support and a return to work plan. I had no idea. I had no idea what I was dealing with. It very slowly escalated and became a lot more confrontational and confronting and confusing. I never knew there was such a thing as mental health first aid until I read somebody else's submission for this inquiry.

COMMISSIONER SPENCER: Have you reached out to the ESO community for assistance, for help?

MS BRANDIS: I've reached out to The Bravery Trust. In some ways, I don't know you have chats - you sit and have chats with people and you get snide comments around the edges and it makes you back away a little bit and be a little bit hesitant. It's like, "Your husband was an officer. How can an officer have PTSD? He's - he would've been sitting behind a desk". You know, this is from sort of a digger's partner, and it's like, you know, when he was first brutalised he was an unarmed peacekeeper in (indistinct), so it can happen to everybody. Somebody it feels like there's a disconnect in that sense.

COMMISSIONER SPENCER: Fiona, your key message is about the partner and the impact on the partner and the family, and we've heard that several times today and through the public hearings we've heard that a number of times. And I think there's - you have brought home in a very clear way that the system needs to absolutely respond to your needs and we have to think about how that's best done. It's very important to hear that story, to understand the full effect.

MS BRANDIS: It has really resonated with me when Dr Khoo was mentioned earlier that veterans do better when their partners are well.

COMMISSIONER SPENCER: Yes.

MS BRANDIS: And, you know, I'm so scared that, you know, I am going - my psychological symptoms are going to move into physical symptoms, like an adrenal crash, I get cold sores when I'm stressed. What if I pick up shingles or something like that? I'm the primary breadwinner. I do all the housework and I do the majority of the child care. I'm on my feet from 5.30 in the morning until 8 o'clock at night. You know, I feel like I'm going to crash at some point and then who cares for my children, who cares for me, who cares for my husband?

COMMISSIONER FITZGERALD: We've had representation from one of the bodies of ESOs, the partners of veterans. Have you had any association with that organisation?

MS BRANDIS: No.

COMMISSIONER FITZGERALD: Are you aware of that organisation?

MS BRANDIS: Again only peripherally from reading the submissions. You don't know where to start asking.

COMMISSIONER FITZGERALD: It might be helpful if we can give you some contact details for them.

MS BRANDIS: Sure.

COMMISSIONER FITZGERALD: They have presented in a couple of the cities we've been at and they're exclusively to try and support partners of living veterans and that may be a helpful contact point that we might be able to give you. But can I just go back to it. Given the pressure that you're currently under, is the next step going back into, say, Open Arms to actually say to them, you know, "What are the supports out there, what are

the contacts?" I know you've accessed Open Arms in times of crisis but is it a service that you'd have some confidence in being able to help you navigate the here and now?

MS BRANDIS: I guess what I'm really after is some support in trying to engage my husband to get support. And he's very anti-engagement with anything military.

COMMISSIONER FITZGERALD: Sure.

MS BRANDIS: So I'm really willing to explore any avenue for my family.

COMMISSIONER FITZGERALD: Okay. Thank you very much for that. Your point is really a very powerful point and as Richard has indicated we've heard in different ways from different people throughout this whole inquiry and it will become a greater focus for us going forward. But we will try and give you some contact details in relation to that partners' group. But thank you very much.

MS BRANDIS: Thank you.

COMMISSIONER FITZGERALD: Could we have Terence Fogarty please.

MR FOGARTY: Can you hear me?

COMMISSIONER FITZGERALD: Yes, absolutely, so that's fine. Terence, can you give me your full name and any organisation that you represent.

MR FOGARTY: Yeah, Terence Fogarty. I don't represent any organisation.

COMMISSIONER FITZGERALD: That's fine.

MR FOGARTY: I put a big submission into the Suicide Inquiry and I've mentioned in the submission I put to you.

COMMISSIONER FITZGERALD: Thank you.

MR FOGARTY: They do any - they just sent it back without any correspondence about 12 months later. I didn't get an acknowledgement from you people so I didn't know whether it was accepted or not, so I put the submission I put to you to the Scoping Inquiry with Rob Cornell and

another lady barrister with him, and I made some notes for him, so I might perhaps read them out.

I'm not a lawyer. It took me four years to obtain my TPI, I had four different advocates. I sense the first three advocates had an inadequate knowledge of the relevant laws. My fourth advocate's worked very hard for me because I helped him by researching some of the topics. After I gained my TPI they asked me to research their too hard cases. That was in 2005 and since then I have researched 45 cases for them and six foreign orders, i.e. where people have approached me directly. My basic process was to scan their files into my computer, return the files to them, then research the file in relation to the legislation and case law. This allowed me to build and annex the relevant material. The High Court decisions, in my view, provide excellent tutorials on critical matters. Peter Healy's Federal Court decision concerning the Deledio case was also in this class; remarkably a Federal Court decision with High Court precedence. DVA's law article was contained in their CLIK CD which was widely available. So, I don't know if you want me to go through the submission.

COMMISSIONER FITZGERALD: Not in detail. We have that. So the first thing I should say to you is, yes, we have got your submission and I want to acknowledge that. But I do want to just try to understand the key issues, so if you can just help me with this. You've identified to us a number of cases where you believe there's been errors in law by DVA.

MR FOGARTY: Yes.

COMMISSIONER FITZGERALD: And your interest in those particular cases, what's that - why have you become interested in - - -

MR FOGARTY: Well the two I've quoted here, the widow Montfort, was an AAT case so it's publically available, and the other, the suicide of Jesse Bird, there was a submission to the Suicide Inquiry by I think his girlfriend or whatever, and so they're the ones I've quoted. My view is that most DVA claims assessments have errors of law, the generic ones, and rather than - I know a lot of people say the law's complex, but probably most laws are, and I think the training's inadequate, both the DVA decision makers and for the advocates and very few of them will cite the case law. And the very powerful one that I quoted here was the decision in Burns and the critical point was this soldier had dived into a pool in Townsville and hurt his back. Now none of the doctors gave a diagnosis that said that was the cause but one of them said there's a one in 20 chance and the judges said, well, under VEA section 120(1) that's more than enough to justify it. And so they don't - in a lot of cases that's not what they do.

COMMISSIONER FITZGERALD: Could I just take that case for a moment if I can. The particular soldier or Defence Force personnel, his injury, when you say it wasn't diagnosed as that, what do you mean by that?

MR FOGARTY: Well the doctors didn't give a diagnosis in their medical reports, but when it got to - this was a High Court decision, when it got there they went back and examined it. So they didn't have to rely on the diagnosis, they relied on the application of VEA section 120(1), which basically is the government's got to prove that it didn't happen, rather than the other way round.

COMMISSIONER FITZGERALD: And why do you think, in that particular case, why do you think the original medical assessments didn't adequately acknowledge the cause of the injury and the injury itself?

MR FOGARTY: Well probably from the doctors' point of view, they don't think there's anything wrong. It's how it's assessed. You know, there legal requirement is to satisfy section 120(1).

COMMISSIONER FITZGERALD: So if you come within the VEA and you have that lower test, the lowest burden of proof test, reasonable hypothesis test, that's that 20:1 that you're referring to, that the High Court ultimately applied?

MR FOGARTY: Yeah - well that's part of it, yeah.

COMMISSIONER FITZGERALD: You've cited the other one, the Jesse Bird case and we are very familiar with that matter. What was the point that you were raising in relation to that particular case?

MR FOGARTY: Well obviously I haven't seen the file, I just went from what was in the submission for the Suicide Inquiry and it seems to me that that medical condition doesn't satisfy VEA section 120(1), although it's a different one under the MRCA, I think it's section 354, but it's the same wording.

COMMISSIONER FITZGERALD: Yes.

MR FOGARTY: They seem to, in the MRCA, have that phraseology but I - it's probably never been challenged. I think that would clash with the equivalent of VEA section 120(1).

COMMISSIONER FITZGERALD: And in that particular case you've raised a number of issues, including this issue of permanent and stable. Is that correct?

MR FOGARTY: Yeah.

COMMISSIONER FITZGERALD: So just, can I ask you, you may or may not have an opinion. We've made some recommendations in relation to the fact that a condition should be determined after two years.

MR FOGARTY: Yeah, I read that.

COMMISSIONER FITZGERALD: Rather than allowing this ongoing and uncertainty about what is permanent and stable. And of course as you know, now the government is able to make a - or the DVA is able to make a payment during that period of time, periodic payments. Do you think that that's a worthwhile shift and change?

MR FOGARTY: I don't know. DVA have a habit of putting their own interpretations rather than the court's ones on. They've copped a hiding whenever they've got up to the High Court and they've had leave to appeal denied to the High Court. I think really one of the solutions is to have the training for DVA claims assessors and advocates independent of the DVA, say by a university or law school.

COMMISSIONER FITZGERALD: You're talking about just the general administration of claims, the assessment of the claims themselves?

MR FOGARTY: Yeah.

COMMISSIONER FITZGERALD: You have no confidence in the current delegates being able to make correct decisions, is that the case?

MR FOGARTY: Well my understanding is they don't have any legal qualifications.

COMMISSIONER FITZGERALD: Sure.

MR FOGARTY: And in most cases they don't even show them the case law. And I had one case I researched and a delegate actually cited a reason for going a particular way as Deledio, but it was the opposite of the Deledio decision, so that person hadn't read it.

COMMISSIONER FITZGERALD: Have you had personal experience in claims in relation to AAT?

MR FOGARTY: Myself?

COMMISSIONER FITZGERALD: Or on behalf of anybody else?

MR FOGARTY: Well, I got my TPI through AAT but it was resolved without a hearing. I had two VRB hearings and whilst I think there's a lot of flaws with VRB, I won them both. So, yeah, I have researched in these papers VRB hearings and AAT.

COMMISSIONER FITZGERALD: And do you have any comment in relation to, firstly, the VRB and then, secondly, the AAT?

MR FOGARTY: Well, one of the things with the VRB, some of their members aren't legal people, they're doctors or - - -

COMMISSIONER FITZGERALD: Sure.

MR FOGARTY: And they have a service member which I don't think they've very well legally trained. So - and they - their decision is just signed by the - I think it might end up being signed by all three, but it's written by the principal member. Whereas say in the courts, each judge gives his or her own decision or says he or she agrees with somebody else. The AAT, it varies and it seems that appointments are doctors. George Brandis, when their turn came up just refused to appoint some others because the ALP will appoint them but he'll appoint his own ones. But there's good and bad in the actual individual people in the AAT. There was a very good one by, I think she was the deputy president of New South Wales and it was just good of the judges' decision but others are pretty ordinary.

COMMISSIONER FITZGERALD: Have you got any suggestions as to any changes in either of those two? Just from what you've said, in your own personal case they both acted - ultimately determined matters in your favour and do you think there's any changes that need to be made in either of those - the VRB or the AAT?

MR FOGARTY: Well, I think the biggest change I could see is that everyone that handle DVA cases should have to have that, you know, tertiary qualification. I know in the AAT they try and pick somebody a lot of times with DVA experience but they don't always uphold the High Court decisions and that.

COMMISSIONER SPENCER: Terence, just a quick question about the delegates because I think it is quite a challenge for DVA because, as you

say, if you don't have legal qualifications or training - and even if you do, as we all know, we're dealing with very complex legislation. I suppose you've raised a couple of issues there. One is we are trying to put forward a number of suggestions as to how there can be a reconsideration of an initial determination within DVA before the VRB process is accessed; once again trying to get better decision making upfront, which I think is your aim as well, better informed decision making. So that might be part of it. But I wonder if - one of the things that has struck us is the legal capability within DVA. From your experience do you see - I'm not talking about delegates now, I'm talking about lawyers within DVA - do you see any evidence of a group of lawyers or a number of lawyers who can be informing, training, looking at decisions, reconsidering them where necessary in order to minimise the issue you've identified?

MR FOGARTY: Well, the ones I've sort of come across in researching and that, I don't think they've got a good grasp of the essentials of law. And the other matter is because at the VRB veterans are denied using a qualified legal practitioner, there's not much knowledge in the legal profession about it and no incentive, like no monetary incentive for them to learn it.

COMMISSIONER SPENCER: Do you think there should be legal representation at the VRB?

MR FOGARTY: I think there should because the veterans fight and die for the protection of a democracy, which includes the rule of law, and they're - then they're denied the right to use it - to use lawyers, and DVA can spend what they like on it, on their legal fees.

COMMISSIONER SPENCER: All right, thank you.

COMMISSIONER FITZGERALD: And in relation to - when you put these submissions in, you put these into the - correct me if I'm wrong - the Senate inquiry into suicide?

MR FOGARTY: Yep.

COMMISSIONER FITZGERALD: And what was the purpose of you putting that into that particular inquiry, what was the connection?

MR FOGARTY: Well I wanted to respond to the inquiry because it was started and probably uniquely so. I actually copied that to Jacqui Lambie this time, who started it, and she's got a heart of gold, she's not a tremendous lawyer but it was a good effort and I think once she got it going I think the smarties in the Parliament pretty much shut it down.

COMMISSIONER FITZGERALD: And you believe that these issues of poor decision making by delegates, who are poorly informed by the law as you see it, has an adverse effect on veterans in that whole claim process.

MR FOGARTY: I think so. It took me four years and four advocates and at that stage I didn't know anything about the law, like the veterans' law, and I had to research it. You know, you've got to make a decision. I just sensed the first three advocates didn't know enough and you're taking a punt then.

I was just going to make a point about - I forget what it was - one of the comments you made, I've forgotten. If I think of it I'll - - -

COMMISSIONER FITZGERALD: Just grab me at the door, that's fine, at the end. Is there any other comment you'd like to make? And again thank you for your submission.

MR FOGARTY: No, that's basically the thrust of what I had, you know. There's not - I haven't come across many that argue that way and you talk to, say, RSL people and that, and of course the RSL doesn't take claims past the VRB, they don't go even to the AAT as a general rule, you know, so - so no, that's mainly what I had.

COMMISSIONER FITZGERALD: That's fine. Thank you very much for that, Terence.

MR FOGARTY: Thank you.

COMMISSIONER FITZGERALD: Can we have Kathy and Steve Barton. Good, you're all set. So Kathy and Steve, could you please give us your full names for the record and any organisation you represent, if you do.

MRS BARTON: Kathy Barton. I don't represent any organisation but I am here supporting my husband, Steve.

COMMISSIONER FITZGERALD: Good. Steve.

MR BARTON: Steven Barton. I don't represent anyone.

COMMISSIONER FITZGERALD: Good, thanks. So if you could just make some of the questions that you'd like us to consider please.

MRS BARTON: Sorry, we're nervous.

COMMISSIONER FITZGERALD: Take your time.

MRS BARTON: I guess I just want to start by giving a little bit of personal history for myself. I was in the Royal Australian Navy for 11 years. I lost my first husband whilst he was in service and while I was still in the Royal Australian Navy over an exercise for (indistinct) in 1992. My second husband, Steve, is also - has also been in the navy and now we currently have our son serving in the Royal Australian Navy.

I'd like to say thank you for the report. It's fairly detailed and I agree with most of it. Some of the things that I'd just like to make note of, and I'll refer to Steve as well. I would really like to see the lifestyle rating ditched. Basically I feel that most people who have served in the military will underestimate their - on the lifestyle rating. We basically - most people join the military at quite a young age and indoctrinated into the military where, as other people have stated before, you're always okay even when you're not. I know that my husband is currently going through that and doing a DVA claim. The doctor actually stated, you know, if your lifestyle rating is like, you know, similar to this, then why are you making a claim? When I had a look at it, it was nowhere near accurate, so I just feel that it's not useful at all.

I'd also like to see DVA claims simplified. I really like the idea of having one Act, and I know that that will take quite a long time to implement, but I feel that - DVA is under a lot of pressure to do the best that they can, and I understand that, but I don't feel that they are doing that, and having multiple Acts is causing, I feel, would cause a lot of confusion. It causes a lot of frustration and I think even fragmenting people who have served in the military and some people feel discriminated against because they come under different Acts.

I also think there should be a more simplified process with making your claim. I'll pass over to Steve about what his experiences have been recently in relation to medical records and GPs.

MR BARTON: Thanks. With my current - I've got two current claims going through at the moment, and with my very first claim I had to go through three GPs and it was only because the issue with time blocks, 15 minutes, the moment you mention anything about GP that just - a lot of the medical centres put up a brick wall because you're taking up the doctor's time, and a lot of the GPs are under pressure too, I guess, not have DVA patients, because they take up so much time and then they're under pressure from their clinical services about how many customers they see.

The other issue is that when I did that first claim when I initially went to see the GP about it he obviously was annoyed because I only had a short timeframe that he could start looking at it. In the end we decided I'd go and get an X-ray, but from the time I went to see him initially to the second time after I got X-rays his opinion had changed, only because Kathy gave him a serving on the telephone for not giving due process, and I find there's a lot of bias against veterans.

MS BARTON: One of the other issues that Steve really struggled with was actually getting access to his medical records. Now, Steve has been out of the navy since 1995 - sorry, 1996, and the I'm okay attitude has caused Steve to deal with his medical issues on his own, not wanting to go to the doctor regularly. That's also caused a lot of problems with making any claims, because there's no history there, so that history in his service medical records. An example would be Steve broke his arm on board HMAS Jervis Bay. We went to a doctor in the evening because it was quite sore and I took him there because he just couldn't sleep, so this was outside of the navy.

That was frowned upon when he went into work the following day and spoke to the medical team at Garden Island. They did an X-ray - pretty much gave him Panadol and sent him back to the ship where they were doing a complete engine rebuild. Now, I had to drive him in, he was in so much pain. I was pregnant at the time, and Steve rang to say, you know, they're not saying that it's anything, but the doctor that we'd seen in the evening had told us that it was broken or that he suspected it was broken. Later that afternoon Steve was still in so much pain that he had to go back to the medics. They then did an X-ray. Two days later they advised him that it was broken, and they said, look, it seems to be in the right position so we're not going to do anything about it. He never had any time off at all. That's the sort of mindset that military people in the past, and I can say even now have to face. So it's taken a lot to get Steve to go and do a claim through DVA, and getting his medical records from Defence was painstaking to say the least. It took months to actually get them on a disc, which we couldn't open, and then he had to go through the whole process again.

One of the things I'd like to suggest is that servicemen and women, and I'm not sure if this happens because my son is still serving, but I would like to see the medical records being given to service men and women on discharge. I guess I'd like to see a little bit more than the tick and flick that they do for your medical history, that they did when we were leaving.

So going on to another point I'm very concerned about the mental health of not only our current service men and women but also our past service men and women, and the processes that they have to go through with DVA, and sometimes even the Department of Defence to get information exacerbates the issue and I'm concerned about the suicide rate.

MR BARTON: One thing on the veterans before they leave the military is that - it was sort of touched briefly on earlier was that there should be an advocate service at DVA supplies or a representative that gives them an exit package. So in that package is a letter stating from DVA that this person's been counselled and has been given this information being services and everything like that. So when I left the military I was given nothing, it was sort of two bob, see you later. My service in Somalia wasn't recognised until 15 years later, and at the time I was, I guess I was okay and had no real I guess need to go to DVA for anything, but because you don't know what services are available to you as a veteran.

When I left I was underqualified, so coming back to the training scenario. Six months out I had a breakdown and found it hard to integrate. So I just had to, I guess, suck it up and move on and - so if the people leaving the Defence Force have that information before they leave at least that way whether they've had any service, operational service recognised or not they are still entitled to some services.

The other thing I want to touch on was about the advocates which was spoken before. I've been through a few myself and the advocates typically - most of the veterans go to the RSL because that's what we've been told and brought up on, and the advocates there they're only there for a day because they're either on TPI themselves and they're just there in a voluntary capacity. So most of them don't really have a full breadth of it, so they just deal with it, the simple issues to go through. So other things like you weren't sure of that, or these other issues, is their own predetermined assumption of what your service is without really delving it too much. So I guess in that regard if DVA could address the advocacy side of things as well as far as whether we need to provide them with more capable people.

COMMISSIONER FITZGERALD: We've got your points here and thank you both for doing that. Could I just ask Steve at the moment you've got a couple of claims going through. When was the first time you put in a claim, was it long after you discharged, several years?

MR BARTON: Yes.

COMMISSIONER FITZGERALD: You waited a long time.

MR BARTON: In 2015 I got recognised for my service, and it was probably another 18 months after that that I actually had applied to be qualified for anything. So probably about - say maybe 2015/16.

COMMISSIONER FITZGERALD: When you left the service in around '96 did you leave voluntarily?

MR BARTON: Yes.

COMMISSIONER FITZGERALD: At that stage did you think you had physical or mental health conditions at that time? I know you had broken the arm, but at that time when you left did you identify, at least to yourself, that you had some difficulties, or is that only much later than that the condition came?

MR BARTON: Unless you were physically impaired the rule of thumb was you're okay. So you had a broken back or, you know, where you physically are not capable walking down the road or doing marching or something. Yes, it was deemed that you were fit enough to leave the service.

COMMISSIONER FITZGERALD: Later on when you started to realise that you were actually not so well, you had other conditions, I gather from what you were saying, Kathy, that you basically became the support person for Steve.

MS BARTON: Yes.

COMMISSIONER FITZGERALD: Did you explore whether there were any other services out there, ESOs or ex-service organisations or other community service organisations that might be able to assist you at that time?

MS BARTON: Probably about two years after I got out I had put my first claim in to DVA and basically they - I didn't have my medical records at that time, and they advised me that there was nothing on my medical records that would allow me to do a claim. I think that that may have caused Steve not to be interested in putting a claim in. He had some, in my opinion, mental health PTSD issues around the time that he was leaving. Yes, he says he was okay, he was a lot better than he is now, but I think that was part of the reason why he didn't pursue anything, and honestly when we left there wasn't anything, we weren't advised of anything.

COMMISSIONER FITZGERALD: So if I could just ask this; Steve, you've indicated that what would have helped you on leaving is an information pack or an exit pack. At the time that you left, and perhaps Kathy as well, did you do a medical assessment, did they require you to do a discharge medical assessment or not at that stage?

MR BARTON: They did a discharge medical assessment. They ask you how you are feeling and they rate it on a scale of 1 to 5 and, yes, I'm okay scenario, so you're sort the generalised run of the mill people and, yes, okay you're good to go.

COMMISSIONER FITZGERALD: Good to go. What about for you, Kathy?

MS BARTON: Pretty much the same. The medic that did my discharge I had had a number of issues after the death of my husband. I managed to stay in the military just over 12 months after the death of my first husband. After my husband died I was having heart palpitations once when I got stressed or anxious, which I'd never experienced before; heart rate went up, body went down on the ground. I still have that today. The navy didn't give me any support at all for my husband dying. No, I will change that. I was - the time when I abused the hell out of the fleet admiral because I was sick to death of what they were doing to me, including trying to post me out of Sydney to Darwin because they felt that that would be the best way to go, when my family lived in Sydney and I explained that to my boss, my senior sailors and officer who were in charge of me, and then their attitude was, well maybe a change of scenery is still the best and if you don't want to go to Darwin then we'll post you to Canberra. That's only four hours away.

That actually wound up causing me to discharge. As I said my issues with my heart. The tick and flick was pretty much they went through what they felt was wrong with me or what may have been caused by service, during my service. There was nothing included about my heart issue, and, yes, it was are you okay with this, and a tick and flick, it was I think a three or four page document and you signed it and it really wasn't explained to you.

COMMISSIONER FITZGERALD: Currently both of you - sorry, I should just ask Kathy. Have you got a claim going through DVA at the moment or have they been settled?

MS BARTON: My claim's been settled.

COMMISSIONER FITZGERALD: And, Steve, you've got those two going through at the moment.

MR BARTON: Yes.

COMMISSIONER FITZGERALD: So what sort of supports do you get at the moment to help you at the present time?

MS BARTON: In what way?

COMMISSIONER FITZGERALD: Whilst you're dealing with these particular issues are you getting support from the ESOs, are you getting support from Open Arms, are you just accessing the general medical and health service system? So just in general what sort of supports are surrounding both you and Steve?

MS BARTON: In general for myself I'm accessing the general medical services. I also see a psychiatrist and I've been to Open Arms twice.

COMMISSIONER FITZGERALD: Have you received - you have the white card?

MS BARTON: Gold.

COMMISSIONER FITZGERALD: You've got the gold card. Given that you've got the gold card do you find that you're able to access the services as and when you need it?

MS BARTON: Mental health services, sometimes that is a bit of an issue. Most other services, yes. I will put the disclaimer in there that I'm also indigenous, so I go through my local indigenous health centre, and they're quite good.

COMMISSIONER FITZGERALD: Steve, for you are you able to access the necessary health and mental health services that you require?

MR BARTON: Up until two weeks ago I didn't know what a care plan was.

COMMISSIONER FITZGERALD: Do you have a white card or a gold card?

MR BARTON: A white card, yes.

COMMISSIONER FITZGERALD: So you didn't know about a care plan?

MR BARTON: No.

COMMISSIONER FITZGERALD: Had you been seeking medical treatment from GPs and that during the last few years?

MR BARTON: Yes. It only really started after I got my claim approved that they were a bit more willing to direct me, but in saying that I had to do a lot of my own sort of research and I ended up going through Allied Health and they've helped me with a couple of the services, but there's still a lot of gaps.

COMMISSIONER FITZGERALD: When you say Allied Health who is that?

MR BARTON: Northside Allied Health. It's just I guess a health services - - -

COMMISSIONER FITZGERALD: Thanks.

COMMISSIONER SPENCER: No questions, but just a comment because - and thank you for sharing your stories with us, because I think it underscores some of the recommendations we are making and you were kind enough to say at the beginning you have looked at the draft report and think that some of the things we're recommending are in the right direction, and there have been changes obviously since you both discharged and there are some positive steps in the right direction through straight through processing and MyService.

It's not without some issues, but I think people getting their records as they discharge and some of the things that would have been helpful to you, so hopefully that's becoming more the norm now. But as you know we're recommending quite a series of issues around transition, some processing, some even more profound than that about really helping people to prepare for what the next stage of their life is going to look like. So hopefully your son will benefit from some of the things that didn't work well for you, but hopefully will be part of the system in the future. But thank you again for telling us about your own experience.

COMMISSIONER FITZGERALD: You have indicated in your submission that your son is currently, and you have mentioned it earlier in the Royal Australian Navy?

MS BARTON: That's right.

COMMISSIONER FITZGERALD: Without going into the actual issues you've indicated he has certain medical issues as well?

MS BARTON: Yes, but once again very fearful for promotion and posting opportunities, to bring those forward. We have mentioned to him about the Open Arms organisation. Just to give you some information. When my son - as our son has been on a ship for three and a half years out of his five years with each deployment the commanding officer has sent information to us about what's going on and who we can contact, and they've provided the VVCS - the Open Arms - sort of like a little fridge magnet thing. So that has been very useful for the family. I'll say that that is a big change compared to when I was a spouse of two service members, and we have provided that to him, but at this point in time he hasn't taken that opportunity. Unfortunately there's still that same culture. I don't know how it's ever going to be shifted, but it needs to be shifted because service men and women will continue to have issues with suicide and homelessness and many, many other issues with their health if we can't shift that, but I think the steps that are happening and have happened are very positive. I'd just like to see them continue.

COMMISSIONER FITZGERALD: So my last question is from what you've said so far it doesn't appear that you, Kathy and Steve, have accessed many of the traditional ESOs for support at all.

MS BARTON: No.

COMMISSIONER FITZGERALD: Can I just ask is there a reason for that? You may not have a reason for that, but Brisbane has quite a lot of ESOs.

MR BARTON: Most of them more in towards town. We live further north - - -

COMMISSIONER FITZGERALD: It's not convenient.

MR BARTON: - - - so a cut lunch and a cup of tea to get there, you know.

MS BARTON: I think for myself part of my issues are how I was treated both as a widow of a service member, how I was treated as a Defence member, and how I've seen my husband be treated, my second husband Steve. I do have some issues and concerns. Yes. It's something I have to work through for myself.

COMMISSIONER FITZGERALD: Good, thank you. Is there any final comments you would like to make before we conclude?

MR BARTON: No, the biggest one was the exit, (indistinct) thing for me that resonated because whether - they claim whether you serve a day or, you know, ten years you're still a veteran. So why can't you be given the information to assist. You may not need it straight away, but at the end of the day I don't have to wait 20 years to use it. That's all.

COMMISSIONER FITZGERALD: Good. Thank you very much, Kathy and Steven.

MS BARTON: Sorry, I do have one more thing.

COMMISSIONER FITZGERALD: Sure.

MS BARTON: I agree with what a lot of people have said and basically the family support for our Defence service personnel and then our veterans is crucial. Without that our veterans are in a whole lot of a worse - a whole lot worse place. So I would really like to see supports put in, more supports put in for families.

COMMISSIONER FITZGERALD: Thank you very much. Thanks very much for that. That concludes the list of those that we have. Is there anybody else who would now like to make a very brief statement before we conclude today, otherwise - yes, please. You have come down and give your name. I did start off the day by saying it's informal, but it's not really. So if you could give your full name and any organisation that you represent.

MR CLANCY: My name's Neil Clancy. I don't represent any organisation, but I have in the past. What I'd like to say is with - I don't know if it's changed now, but when I was going through my claims with DVA the biggest trauma that I went through, and it put me right into a big black hole, was the VRB. Everything I said was treated as if I was a bloody liar - you know, that never happened, and that was with the three of them sitting opposite me and it just made me feel insignificant and just unwanted, and they broke me. They actually broke me that day and I - after that day I said I'd never go through another - put anything else. I wasn't going to chase it up again until I saw a psychiatrist and he forced me to go and see an advocate who sorted it out, thank goodness, and - yes, but I wasn't going to go through it. But that was a big thing, the way the VRB was treating me, and that was back in about 2000 I think it was, I think, I can't remember exact time and that, but, yes, it was - it was

traumatic, and I would never wish anyone, any ex-serviceman or serviceman to go through that again. So I just hope that they have lifted their game and treat a person that's on the opposite side of the table with a little bit of dignity. That's about - yes.

COMMISSIONER FITZGERALD: Neil, you may be aware that the VRB has introduced a whole lot of what they call alternative dispute resolution processes to try and ease that, but I presume in the time you're talking about did you almost go straight to a board hearing, did you?

MR CLANCY: My claim went through and then - well, I was informed as I - well, going back into the 80s, late 80s and 90s I did a pension course and I knew back then, and people have been saying about it, there was a way if you go through if your first claim wasn't put through you could apply for a section 31. I don't know whether that's still going today. I went through that, but, yes, they just - that went through and then the next thing, well we'll go to the VRB.

COMMISSIONER FITZGERALD: Am I right, Neil, that you've put in subsequent claims through DVA?

MR CLANCY: Yes.

COMMISSIONER FITZGERALD: And you've used an advocate for that?

MR CLANCY: To finally get my claim accepted, the one that went to VRB, yes.

COMMISSIONER FITZGERALD: And was that successful?

MR CLANCY: Yes. With the advocate he just turned to me - because when I went to see him I walked in to see him and the first thing he said, "Well, where's your wife", because I walked in there by myself. He said, "You've got to make an appointment, come back with your wife." So that was the push. So I went back there with my wife and she laid it down to him and said, "He's not going through any more VRB or AAT", and because of what it's done, it had done to me, and he said, "Don't worry about it." I gave him all the info and he put it through, and, what, about five months later I think it was I got this big envelope. When I got the thick envelope I thought, yes, it's another one of those envelopes. Yes, you've been rejected. I opened it up and there it was, he got it through for me without any further to do, which I was very thankful for.

COMMISSIONER SPENCER: Neil, thanks for that, and also we have heard from others that a real sense of not being believed and how they have felt insulted by that feeling, that perception that they're not being believed which is what you have said today. So I think there have been some efforts to really address communication. There's always more that can be done, and the notion of a veteran centric reform that should be the veteran at the centre of this and how the veteran is dealt with, how they are communicated with, with respect and dignity continues to be an important issue. So it wasn't your experience initially, but it's good that subsequently obviously that the claim did go through and was accepted.

MR CLANCY: Yes. Thanks to one good advocate I might say. Yes.

COMMISSIONER FITZGERALD: Good. Thank you very much. Thanks, Neil, thank you for that.

MR CLANCY: Thank you.

COMMISSIONER FITZGERALD: Any other person who would like to make a short presentation. If not that concludes today's hearing and we will resume tomorrow here for the second day of public hearings in Brisbane. Thank you very much.

MATTER ADJOURNED AT 5.10 pm
UNTIL THURSDAY 28 FEBRUARY 2019