**Productivity Commission Inquiry into Compensation and Rehabilitation for Veterans**

**RSL NSW Submission**

Key Points:

- The existing three Acts should be maintained rather than merged or replaced, with such efforts instead directed towards more promising areas for improvement.
- All current SoPs and streamlining should be extended to apply to VEA and DRCA claims.
- DVA should set a target of 15% of frontline staff with military backgrounds by 2020.
- DVA should commission an independent investigation and review its current schedules of fees based on a comparison with the AMA schedule and a sample of actual health specialists' fees.
- DVA should pursue a range of tactics to improve its communication and information sharing.
- VRB appeals should be open to DRCA claims but should not have a right to legal representation.
- DVA should commit to funding a peak body of ESO service providers tasked with accrediting ESOs as eligible for DVA funding, taking the international aid sector as a model.
- Consideration should be given to broadening the role of the Defence Force Ombudsman to include identification of systematic and emerging issues in the sector by analysing complaint data from official and informal channels.
- ESOs should improve their capabilities to leverage technology for communication with rural/regional areas.
- Volunteer advocates, claims advisors and support workers should be individually endorsed by an accredited professional ESO.
- ESOs should commit to increasing the number of female claims, advocacy and support workers.
- Access to mental health care under DVA's Non-Liability Health Care programme should be expanded to the immediate families of veterans.
- DVA should investigate a comprehensive peer support programme for families and carers.
- DVA should review and formalise BEST grants to jointly fund professional ESO service provision.
- DVA should implement a comprehensive consumer-directed care and case management trial.
- ABS should include targeted questions in the 2021 Census to identify and locate veterans.



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## Introduction

This submission has been prepared by RSL NSW for the Productivity Commission's Inquiry into Veterans' Affairs' Legislative Framework and Supporting Architecture for Compensation and Rehabilitation for Veterans (Serving and Ex-serving Australian Defence Force Members). Representatives from RSL NSW met with the Commissioners on 20 April 2018, shortly before the release of the Issues Paper, and again on 23 July 2018. This submission seeks to focus on key issues that, in the experience of RSL NSW, have not received adequate attention to date, but will not dwell on areas which will doubtless already be under review by the Commission.

In line with the 8 November 2017 Joint Communique of Federal and State Veterans' Ministers, RSL NSW defines a veteran as any person who has served in the Australian Defence Force, regardless of operational and service history, or service duration or commitment (full- vs part-time). The term should not be limited by the definitions contained in existing legislation. More specific terms are used in this submission only where a distinction between types of service is necessary.

To counter the catch-all use of the term 'advocate', this submission uses the RSL NSW / RSL DefenceCare terminology: an 'advocate' refers strictly to an individual who represents veterans and their families at the VRB, AAT and/or Federal Court without formal legal accreditation (although he or she may be legally trained); while one who assists the veteran to navigate the initial claim process is a 'claims advisor'. The term 'pensions officer' unnecessarily raises expectations of an outcome that cannot be guaranteed and, in any given case, may not be in the best interests the veteran. It is deliberately avoided.

Further, this submission uses the term 'professional' to denote a person who is paid and supported by an ESO providing a range of enablers including governance, supervision, de-briefing, administrative and IT systems, and other resources required to provide claims advice, advocacy, and/or support services to veterans and their families; follows the formal policies and procedures of their organisation; and is therefore legally accountable for their advice and professional behaviour. This is not to suggest that volunteers in the sector do not behave professionally in the broad sense, or that their work cannot be of an equal standard to that of a paid and highly trained professional.

### Role and experience of RSL NSW

The Claims & Advocacy and Community Support teams at RSL NSW comprise paid professionals drawn from a range of industries and sectors, with qualifications spanning Social Work, Community Support, Mediation, Counselling, Training, and Workplace Health and Safety, as well as training in all TIP and ATDP courses, Accidental Counselling, Vicarious Trauma, and Suicide Awareness. Service provision includes welfare, counselling, case management and follow-up support for current and ex-serving Defence personnel and their families, as well as assistance with DVA claims for compensation and rehabilitation, and appeals to the Veterans' Review Board. RSL NSW takes steps to avoid fostering dependence on welfare, aiming to deliver a holistic and professional service to meet both the short- and long-term needs of its clients.

Through its professional support services arm RSL DefenceCare, RSL NSW has a record of both high volume and high quality in its claims and advocacy services and prides itself on being recommended by staff at DVA and the VRB to their own veteran friends and relatives. It is crucial to note, however, that the success rate of claims and appeals is not an appropriate or acceptable measure of the effectiveness of a claims advice and advocacy service for veterans. As a charity, RSL NSW will advise a client it appears their claim has little or no chance of success but will never turn them away if they are operating out of good faith. To achieve a very high success rate by turning away claims with a low chance of success would be an inappropriate measure of performance for a charity.

In 2017, RSL NSW:

- prepared and submitted 1,531 claims to DVA on behalf of veterans and their families (315 VEA, 276 DRCA, 940 MRCA);
- submitted 133 new appeals to the Veterans' Review Board;
- completed 393 appeals at the VRB – 360 through the Alternate Dispute Resolution process and 39 through full hearings;
- provided $599,781 in direct financial assistance to 425 different current and ex-serving Defence personnel and families;
- supported 80 clients experiencing homelessness or at risk of homelessness;
- conducted 69 home visits, 57 nursing home visits, and 42 hospital visits; and
- conducted 91 counselling sessions.

These figures are limited to RSL NSW's professional efforts, however, hundreds of volunteer welfare and pensions officers across its sub-Branch network offer hours of their time every week doing similar work. The majority of RSL NSW clients are in NSW itself, however, veterans and their families from all states and territories of Australia as well as overseas have been assisted. Based on this experience, RSL NSW can testify that the issues facing veterans and families in NSW mirror those in other locations.

## Current situation and the need for change

*Inquiry Questions:*

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

As outlined in the Commission's issues paper, the existing system for veterans' compensation and rehabilitation is a patchwork of inconsistent availability and quality of service, sewn on a base of overly complex legislation. The legislative framework comprises three Acts: VEA, SRCA (DRCA), and MRCA – the parallel authority of which makes the system for veterans' compensation intimidating and stressful for veterans to navigate. Under this complex system, veterans can seem to be effectively rewarded or punished for the timing of their service. As individuals with service covering all three Acts begin to reach their 60s and come out of the shadows, the complexity of claims will continue to increase. At the same time, volunteer advocates and claims advisors are aging and retiring (72% of RSL NSW volunteer pensions officers are older than 65 years, and only 10% are 50 or younger), while the few



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professionals entering the sector are receiving grossly insufficient funding and support. RSL NSW expects these factors will bring the current system of advocacy within the ESO community to breaking point within the next 5 - 10 years.

Advocates and claims advisors, both professional and volunteer, often work in poorly defined roles and deal with confronting, high pressure situations beyond their training. Gaps in the system, and its overall sluggish and byzantine nature, have reinforced strong, negative views of the claims and appeals process within the Defence and ex-Defence communities, and especially of DVA. While gradual improvements to the efficiency of the system and its sensitivity to the unique needs of veterans and their families will hopefully reduce the demand for advocacy and claims advice, it is unlikely that the need for these services will ever disappear, at least not in the foreseeable future. This is due to the intricacies of military service, its impact on veterans, the realities of medical diagnosis, and the need to ensure value for taxpayers.

The overarching focus for both DVA and the Department of Defence should be on coordinating and improving transition and rehabilitation, setting the foundation for veterans to enter and contribute to society after they leave the Australian Defence Force. When dealing with the system at an individual level, younger veterans consistently express their desire for a modern, professional, high-quality service offering independence and choice. In the view of RSL NSW, the most pressing requirements are:

- A professionalised national model to ensure nation-wide access to a consistent, high-quality standard of advocacy and support services for veterans;
- Adequate and accessible training and support for both professionals and volunteers in the sector, including advocates claims advisors, support workers, carers, and families of veterans;
- A shift towards a consumer-directed care model of rehabilitation focused on outcomes; and
- Minimisation of inefficient spending (on everything from one-size-fits-all medical treatments to DVA offering services already provided by ESOs) as a means of maximising both well-being of veterans and their families, and value for taxpayers.

## Streamlining the Legislative Framework

*Inquiry Questions:*

- *Is it possible to consolidate the entitlements into one Act? If so, how would it be done? What transitional arrangements would be required? How might these be managed?*
- *Are there approaches, other than grandfathering entitlements, that can preserve outcomes for veterans receiving benefits or who may lodge a claim in the future?*
- *Are differences in support and ways of accessing support based on different types of service (such as operational, peacetime and Reserve service) justified?*
- *Is there scope to better align the compensation received under the VEA, MRCA and DRCA? In particular, could the provisions for permanent impairment compensation and incapacity payments in the MRCA and DRCA be made consistent?*
- *What is the rationale for different levels of compensation to veterans with different types of service in the MRCA? Should these differences continue?*
- *Are there diverging areas of the claims and appeals process under the different Acts that could be harmonised?*

MRCA was conceived with the intention of giving future veterans the best and most generous of both former Acts. Unfortunately, VEA and DRCA retained some advantages for those veterans covered under them not available under the new MRCA, and their continued applicability for service prior to 2004 ensured an overly complex system long into the future. A veteran of the peacekeeping operation in Somalia in early 1993, for example, could be covered under VEA until the 2060s, and DRCA could be relevant for another decade beyond that.

The current legislative environment offers a wildly inconsistent range of compensation to veterans depending on when and how they served. The complexity of the existing framework itself takes an unnecessary toll on the mental health of vulnerable veterans, while also generating inefficient legal and advocacy expenses. RSL NSW stands behind the principle that every veteran, no matter when or how they served, should be treated equally; that it is unfair for three equal conditions, sustained in different serving contexts, to receive different levels of compensation. There are clear, strong arguments for some level of legislative simplification. Merging the three Acts would be ideal and would greatly improve the well-being of veterans as well as claims advisors and advocates. However, RSL NSW believes there are significantly higher priorities for reform than legislative merging, especially considering the gargantuan task this may present.

An important yet relatively minor change to make compensation fairer and more consistent for all veterans within the existing legislative framework is the provision of a Gold Card for DRCA claimants. The lack of entitlement to a Gold Card for DRCA clients represents a significant discrimination against a cohort of veterans, but one that is relatively simple. The Gold Card should be made available to DRCA clients on equivalent impairment points to VEA and MRCA clients.

Concurrently, however, RSL NSW recommends renaming the DVA health entitlement cards. The existing card hierarchy of Gold ('All Conditions' or 'Totally & Permanently Incapacitated'), White

(specific conditions) and Orange (pharmaceuticals only) cards encourages a view of the system as a contest to be won, with the Gold Card as the prize. This view is already deeply held by a large number of volunteer advocates and claims advisors immersed for decades in VEA claims, which emphasise financial payments to veterans at the expense of thoughtful and well-planned rehabilitation. The outcome sought for veterans should be rehabilitation, not monetary settlement. The "gold card" nomenclature utilised by DVA reinforces a negative entitlement culture where success for veterans is the extraction of cash from the government, not their rehabilitation and return to being a productive member of civilian society. Changing the three cards to 'Full', 'Partial' and 'Pharmaceuticals' respectively, without garish colouring, would represent an important symbolic step towards changing this culture in the veterans' space.

Despite the recommendation against legislative merging, RSL NSW notes that if and when a new Act were introduced to replace the existing legislation, it should be guided by the following core principles:

- Cover all veterans, and provide equal compensation and rehabilitation for equal conditions, regardless of type, location, duration or timing of service/incident;
- Carry over existing Statements of Principles, Streamlined Conditions, and Straight-Through Processing provisions;
- Open the full appeals process to all veterans, including access to the Veterans' Review Board;
- Focus on both compensation and rehabilitation;
- Shift to an outcomes-focused, Consumer-Directed Care model, possibly rooted in clinical standards (see Recommendations 39-42); and
- Be sufficiently open and flexible such that it can be periodically amended to adapt to changing global circumstances and changing experience of veterans in future conflicts and operations.

Recommendations:

1. The existing three Acts should be maintained rather than merged or replaced, with such efforts instead directed towards simpler and more effective areas of improvement in order to achieve more immediate results.

2. DRCA clients should be entitled to a DVA Gold Card on equivalent impairment points to VEA and MRCA clients.

3. The existing Gold, White and Orange DVA health entitlement cards should be renamed to 'Full', 'Partial' and 'Pharmaceuticals' respectively, without garish colouring, to remove their connotation as prizes to be won.

**Ongoing initiatives to streamline claims and appeals processing**

*Inquiry Questions:*

- *Will the Veteran Centric Reform programme address the problems with the administration of the veterans' support system?*
- *Have the Statements of Principles helped to create a more equitable, efficient and consistent system of support for veterans? Are there ways to improve their use?*
- *What is the rationale for having two different standards of proof for veterans with different types of service? Are there alternatives to recognise different groups of veterans? What would be the costs*



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*and benefits of moving to one standard of proof for all veterans (for example, would it make the claims process easier)?*

RSL NSW stands firmly behind the Statements of Principles (SoPs) as an efficient means of simplifying the claims process, and consequently reducing both DVA expenses and stress on their clients. Perceived imperfections in the SoPs are generally attributable to imperfections in the medical evidence itself and are thus best addressed by allowing the Repatriation Medical Authority to continue its work. RSL NSW is keen to work with the RMA to continue to improve and expand the SoPs. Importantly, RSL NSW supports the application of SoPs to DRCA claims. The current situation whereby veterans covered under DRCA are subjected to a higher evidentiary burden than other veterans for the same condition is unfair and could be straightforwardly corrected by applying SoPs to all claims, regardless of applicable legislation. While the application of different standards of proof for operational, peacekeeping, hazardous and British nuclear test service, versus other eligible service under the Statements of Principles goes against the spirit of equal treatment for all veterans, RSL NSW believe there are more pressing priorities for DVA resources than the application of a 'Reasonable Hypothesis' standard to all types of service.

We would note that SoPs are, by their nature, a heavily clinical and research-based instrument. DVA has tended to strongly favour such clinical approaches in both compensation and rehabilitation, as will be detailed in a subsequent section of this submission. While this approach is wholly appropriate for the diagnosis and acceptance of service-related conditions (and, as stated above, RSL NSW strongly supports the use of SoPs), it is important that DVA can shift to a focus on non-clinical treatments once the condition has been accepted as service-related. SoPs should not contribute to an over-emphasis on clinical options at the expense of client choice.

Some specific conditions covered by SoPs have been further 'streamlined', with claims requiring only a diagnosis before automatically being accepted as service-related. This greatly reduces the paperwork and processing time required for each case, with requisite reductions in DVA workload and client stress. Currently, 31 conditions have been streamlined under MRCA, however, only eight of these have also been streamlined under VEA, and no streamlined conditions have been applied to DRCA. The effect of this inconsistency, as with that relating to the application of SoPs, is that claims under DRCA, and in this case those under VEA, incur a greater burden of proof for the same condition than those under MRCA. This situation is both unfair and relatively easily corrected. As with SoPs, to extend streamlining to all three Acts would significantly alleviate both the workload on DVA and the stress on their clients.

Recommendations:

4. All current Statements of Principles should be extended to apply to claims under DRCA, and future SoPs should be applied to all three Acts simultaneously.

5. All 31 Streamlined Conditions under MRCA should also be applied to DRCA claims.

6. Where they do not apply already (23 of the total 31), all Streamlined Conditions under MRCA should also be applied to VEA claims, and future streamlining should be applied to all three Acts simultaneously.

## Changing DVA

*Inquiry Questions*

- *Will the Veteran Centric Reform programme address the problems with the administration of the veterans' support system?*

The Australian National Audit Office (ANAO) tabled its performance audit of DVA, *Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs*, on 27 June 2018, highlighting a series of significant deficiencies in the Department's claims handling processes.[1] A significant minority of veterans' claims currently experience long delays, most of which are either due to slow responses from medical specialists or could not be explained by the Department ('inactivity').[2] The report notes correctly that "even a small number of very high TTTP [time taken to process] claims can have significant impacts for veterans and DVA's reputation".[3] Processing times for the receipt of advice from medical experts are, on average, 10 times longer than for DVA enquiries to the Department of Defence, which can itself be a slow process.[4] DVA currently lacks a formal system to manage and monitor these requests for information.[5] Other unexplained delays in processing come from claims being lost in the system or delegates simply taking no immediate action upon receiving the necessary information to progress claims.[6] The report notes this is "indicative of a lack of transparency over workflow within the system".[7] While the majority of claims are processed within the internal DVA targets for time taken, these targets appear to have been set arbitrarily.[8]

The ANAO report noted the lack of effective workflow management over claims impacts significantly on the overall efficiency of claims processing, and specifically that there is currently no effective mechanism for alerting management to those claims at risk of taking excessive time to process.[9] The report made six recommendations covering claims processing targets (TTTP) and workflow management, information and records management, as well as standards for information reporting from independent medical specialists.[10] While DVA accepted the recommendations, the Minister for Veterans' Affairs and Secretary of the Department of Veterans' Affairs issues a joint statement on 27 June 2018 which dedicated the majority of space to describing the work the Department had already done, with little specific detail on plans to address the ANAO findings.[11] DVA should commit to regular reporting on is progress in actioning the ANAO recommendations and meeting service standards.

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1 *Australian National Audit Office*, "ANAO Report No.52 2017–18: Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs", 27 June 2018, accessed 31 August 2018, https://www.anao.gov.au/sites/g/files/net4981/f/ANAO_Report_2017-2018_52.pdf.

2 Ibid., 9.

3 Ibid., 24.

4 Ibid., 43.

5 Ibid., 43.

6 Ibid., 43.

7 Ibid., 43.

8 Ibid., 24.

9 Ibid., 24, 43.

10 Ibid., 10-11.

11 *Minister for Veterans' Affairs*, "Joint statement — Response to ANAO Audit Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs", 27 June 2018, accessed 31 August 2018, http://minister.dva.gov.au/media_releases/2018/jun/va047.htm.

Despite working within a byzantine, sluggish and at-times adversarial system, it is worth noting that in the experience of RSL NSW, DVA staff have been a well-meaning and responsive. Contact between RSL NSW and the Department is frequent (multiple times every day) and the professional advocates and claims advisors of RSL NSW feel they are able to work with DVA delegates to overcome any issues that arise in order to achieve a fair outcome. There are several notable positive trends in the administration and operation of DVA that evidence a genuine effort to shift its culture, service quality, and public perception. The Veteran Centric Reform programme is evidencing slow but real change in departmental culture, particularly by increasing adaptability and flexibility to the needs of modern veterans.

While staff are generally cooperative and well-intentioned, there is a general deficiency of two key capabilities: knowledge of how to interact and communicate with vulnerable people; and a broad awareness of the realities of Defence service life and the range of physical and mental injuries that can result.

The Department would benefit from additional training and support for staff dealing with vulnerable clients, including awareness training for the initial identification of vulnerable and at-risk clients. Care should always be taken to maintain appropriate sensitivity in all staff-client interactions, and to communicate through an advocate when the veteran is suffering severe mental ill-health. To this end, there is a need for a departmental policy that vulnerable or excessively combative clients, for whom dealing directly with DVA may be triggering or exacerbating their condition, be referred to an accredited professional ESO claims and advocacy service (as defined in Recommendation 25) or, if appropriate, an internal DVA case manager. Additional training in this area could help to improve staff retention rates, while allowing DVA staff to develop stronger, long-term relationships with the client base and a more intuitive feel for the claims process.

A positive development worth noting a DVA is the Department's Client Care Coordination programme, which involves a coordinator being assigned to holistically manage the claim of a vulnerable veteran, acting as a single point of contact for the entire Department. This can significantly speed up the process while reducing the associated stress on vulnerable veterans. RSL NSW is optimistic the Veteran Centric Reform programme will continue improving this situation further.

The second area where staff capability is generally lacking is in the appreciation of the breadth of day-to-day realities of life in Defence. Importantly, the immensely diverse range of Defence experiences demand that staff have the ability to consider a veteran's specific experience with an open mind. Gradual efforts at improvement are visible and should continue, however, additional training in this area may be needed. An ongoing project RSL NSW is aware of, which sees DVA staff offered open day tours of counterterrorism training at Holsworthy Barracks, is one example of this in practice. Increasing employment of ex-Defence members at DVA is helping to change the culture further, however, Defence backgrounds remain relatively rare amongst frontline staff, and RSL NSW recommends, in addition to the above, that DVA sets a target of 15% of frontline staff drawn from suitable candidates with Defence backgrounds by 2020.

Efforts to increase awareness of Defence experiences should encompass a focus on improving staff awareness of the additional and distinct challenges faced by female veterans, which are at present

poorly understood and catered for in the sector. As recommended in the DVA-commissioned report, *The Health and Wellbeing of Female Vietnam and Contemporary Veterans*, DVA should commit to improving frontline staff training in the specific challenges faced by women in Defence.[12]

In sum, there is a pressing need for DVA to conduct an internal staff capability review to evaluate the competency of staff in these two key areas – dealing with vulnerable clients and understanding Defence experiences. Based on the findings of this review, DVA should explore options to improve frontline staff training in the specific areas outlined above.

Recommendations:

7. DVA should commit to regular reporting on is progress in actioning the recommendations of the Australian National Audit Office's 2018 report, *Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs*, and in meeting key service standards.

8. The implementation of DVA's Veteran Centric Reform programme should continue, and opportunities should be explored to hasten the process.

9. DVA should explore options to implement a policy that vulnerable or excessively combative clients, for whom dealing directly with DVA may be triggering or exacerbating their condition, be referred to an accredited professional ESO claims and advocacy service (as defined in Recommendation 25) or, if appropriate, an internal DVA case manager.

10. DVA should conduct an internal capability review and investigate the need for comprehensive frontline staff training in dealing with vulnerable clients and frequent verbal abuse, including successfully identifying vulnerable and at-risk clients; and appreciation of the breadth of day-to-day realities of life in Defence, including on the specific challenges faced by women in Defence.

11. In line with its Veteran Centric Reform programme, DVA should set a target of 15% of frontline staff drawn from suitable candidates with Defence backgrounds by 2020.

**DVA payments for specialist treatment**

Directly comparing schedule items, DVA fees exceed the Medicare schedule of fees for every item by between 14% and 164% (and an average of 43%). However, the Australian Medical Association fees list gives significantly higher values due to indexation. RSL NSW has come across significant anecdotal evidence that DVA payments to specialists, particularly in the mental health area, fall significantly short of the AMA fees list. This forces medical specialists to either accept a significantly lower rate of remuneration for working with veterans, or to decline to accept DVA payments altogether, narrowing the choice for veterans seeking a specialist to suit their individual needs. For veterans already engaging a specialist before being approved for DVA payments, they may be required to change specialists in order to make use of this entitlement, potentially disrupting their treatment. This will be especially problematic in country areas, where fewer specialists are based.

[12] Samantha Crompvoets, "The health and wellbeing of female Vietnam and Contemporary Veterans", *ANU Enterprise*, June 2012, accessed 17 August 2018, https://www.dva.gov.au/sites/default/files/files/consultation%20and%20grants/healthstudies/servicewomen/viet_fem_con_report.pdf, 36.

DVA should therefore commission a thorough, independent investigation of its current schedules of fees, comparing its payments for services against the AMA schedule of fees and an appropriately sized sample of actual health specialists' fees across the country to determine an adequate and reasonable payment for each listed item. Upon the completion of this investigation, DVA should explore the need for a compliance programme to ensure specialists do not charge DVA clients more than non-DVA clients for the same services.

Recommendations:

12. DVA should commission a thorough, independent investigation of its current schedules of fees, comparing its payments for services against the AMA schedule of fees and an appropriately sized sample of actual health specialists' fees across the country, and commit to providing adequate and reasonable payments for each listed item based on the findings.

13. Upon the completion of this investigation, DVA should explore the need for a compliance programme to ensure specialists do not charge DVA clients more than non-DVA clients for the same services.

**Improving communication from DVA**

DVA could improve communications on the following issues: DVA provider locations; distribution of Department-funded research; a straightforward and effective online presence; direct assistance to advocates and claims advisors; efforts to inform veterans of their entitlements; and challenging negative perceptions of the DVA claims process.

DVA cannot currently provide veterans with information regarding DVA health care providers in their geographic area. Instead, veterans are expected to search for one themselves, effectively negating the range of choice they might otherwise enjoy. Informal RSL NSW communication with DVA delegates has suggested a list of DVA providers cannot be provided. However, the Department necessarily must maintain a register of health care providers who have advised they will accept the DVA fee as full payment for health care services, and therefore an externally distributable list or database should be relatively simple to produce. DVA should make a list of registered providers publicly accessible on their website. In the longer term, the ESO community and/or other interested parties can use this information to create a searchable database or map of DVA providers which veterans and their families could search by area.

DVA funding for research should be made conditional upon the inclusion of 'clinical applications' as a research outcome. This research should then be distributed to major ESO service providers (for forwarding on to advocates, etc.) and made easily available online. Research is only as beneficial as its ability to affect real world situations, as claims advisors, advocates, support workers, carers, families and veterans themselves need to have easy access to a summary of the practical applications of DVA research to their fields – see, for example, the 2016 article "Short-term Suicide Risk After Psychiatric Hospital Discharge" by Mark Olfson, et al.[13] In essence, there is little point funding research that

[13] Mark Olfson, Melanie Wall, Shuai Wang, Stephen Crystal, Shang-Min Liu, Tobias Gerhard & Carlos Blanco, "Short-term Suicide Risk After Psychiatric Hospital Discharge", *JAMA Psychiatry*, 73(11) (2016).



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cannot reach and inform the outcomes of non-expert practitioners. More thought needs to be given to the way DVA-funded expert research is communicated to non-expert audiences. This should be a shared responsibility between the ESO community and DVA.

The preceding two points should be facilitated by a redesigned DVA website, prioritising the presentation of thorough information in a simple, clean and intuitive format. Currently, information can be difficult to find, seemingly hidden in obscure corners of the site. Veterans increasingly expect a modern service they can confidently navigate independently as available in other sectors, both government and private sector. An effective, modern online presence fits well with the overall Veteran Centric Reform programme. It should be supplemented with a direct-line help desk for professional advocates, claims advisors and support workers to have direct access to DVA delegates who can answer technical questions.

A further key area for improvement in communication lies in the relationship between DVA and its clients during the claims process itself. The department should work more closely and cooperatively with individual veterans, via an advocate or claims advisor when appropriate, to fill gaps in the evidence attached in support of a claim. When a claim is unsuccessful despite this communication, the veteran and/or their family should be informed openly, sensitively and promptly. Importantly, efforts to help veterans to supply sufficient evidence with their claim will help to minimise appeals to the VRB, where the deciding factor in most successful appeals is the presentation of additional evidence not included in the original claim.

Finally, RSL NSW recommends that DVA and the Department of Defence jointly make efforts to better inform veterans of both their status as a veteran and their consequent entitlements. This will help to address a key barrier veterans face in accessing proper compensation and rehabilitation services. Efforts are currently underway in the public sphere and ESO space to broaden the popular understanding of the term veteran. In the meantime, however, key categories of veterans (including contemporary, still-serving, and Reservists) do not identify as such, and therefore never explore the care and benefits they have earned through their service. In reality, the range of benefits available mean that even amongst those aware of their veteran status, few are fully aware of their entitlements, such as free mental health treatment without acceptance as service related under the Non-Liability Health Care programme. Much of the negative perception of DVA across the veteran community is attributable to poor understandings of Departmental programmes and processes, and could therefore be combated with a joint DVA-Defence campaign highlighting the breadth of veteran status, specific entitlement programmes and the progress of Veteran Centric Reform. The participation of Defence in this project would help to reach current-serving members, including Reservists, before they discharge and begin transition.

Recommendations:

14. DVA should make a list of registered health care providers publicly accessible on their website, based on the Department’s internal register of health care providers which have advised they will accept the DVA fee as full payment for health care services.



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15. DVA funding for research should be made conditional upon the inclusion of 'clinical applications' as a research outcome. This research should then be distributed to major ESO service providers (for forwarding on to advocates, etc.) and made easily available online.

16. The preceding two recommendations should be facilitated by a redesigned DVA website, prioritising the presentation of thorough information in a simple, clean and intuitive format.

17. DVA should set up a direct-line help desk for professional advocates, claims advisors and support workers to have direct access to DVA delegates who can answer technical questions.

18. DVA should work more closely and cooperatively with individual clients, via an advocate or claims advisor when appropriate, to fill gaps in the evidence attached in support of a claim. When a claim is unsuccessful despite this communication, the veteran and/or their family should be informed openly, sensitively and promptly of the specific reasons for the outcome.

19. DVA and the Department of Defence should implement a joint campaign highlighting the breadth of veteran status, specific entitlement programmes and the progress of Veteran Centric Reform. The participation of Defence in this project would help to reach current-serving members, including Reservists, before they discharge and begin transition. This aligns with Recommendation 20 of the August 2017 Senate report, *The Constant Battle: Suicide by Veterans*.[14]

**Veterans' Review Board**

*Inquiry Questions:*

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

The Alternative Dispute Resolution programme has been highly effective in boosting the efficiency of appeals before the Veterans' Review Board, leveraging its non-adversarial nature to maximum advantage. The informal, conversational setting significantly lessens the stress on veterans and their families, while empowering them by restoring a measure of agency. The rollout of ADR should continue, namely its expansion to Queensland. Future opportunities to further increase the efficiency of the appeals process should be explored.

Crucially, RSL NSW recommends that appeals to the Veterans' Review Board should be immediately opened to DRCA claims. The VRB is currently only included in the appeal process for claims under VEA and MRCA, with DRCA appeals proceeding directly from an internal DVA review to the AAT stage. The expenses associated with appealing a decision to the AAT represent an insurmountable barrier for many veterans. The cohort of veterans and veterans' families covered under DRCA, this barrier thus applies to appeals generally – they are effectively denied the right of appeal for DVA delegates

[14] *Senate Foreign Affairs, Defence and Trade References Committee*, "The Constant Battle: Suicide by Veterans", August 2017, accessed 21 June 2018, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Foreign_Affairs_Defence_and_Trade/VeteranSuicide/Report, xiv.


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decisions. Given that in 53.3% of cases before the VRB the DVA delegate's decision is set aside, this represents a significant injustice for these veterans.[15]

The preceding two points should be facilitated by a comprehensive review of VRB funding to ensure the Board has sufficient resources to handle the increased workload that will result. Both the expansion of ADR to Queensland, as well as the expansion of VRB access to appeals under DRCA, can be expected to attract a high volume of additional work for the VRB. This increased workload should be considered reasonable to take on given the glaring discrepancy in the existing system, which gives full rights to some veterans and arbitrarily denies them to others. DRCA clients and veterans in Queensland should not have to bear the full cost of underfunding in the veterans' space.

RSL NSW does not support the right to legal representation at the VRB for a number of reasons:

- The VRB was created specifically to provide a lawyer-free, non-adversarial environment.
- With the ADR rollout leading to a great reduction in the number of VRB cases proceeding to full hearings, the number of cases which would be affected by this change is dwindling.
- The opportunity to engage legal representation is provided at the AAT stage of an appeal, for those veterans and families who desire it.
- AAT cases require significantly more preparation by advocates, and the possibility of facing a lawyer at the VRB would unnecessarily add this workload to all VRB cases, significantly compromising efficiency.
- The VRB will already potentially face a funding shortage as the ADR rollout expands to Queensland, and the Board potentially opens to DRCA cases as per Recommendation 21 – legal representation would compound this problem.
- The right to legal representation, even if allowed only under special conditions decided on a case-by-case basis by the principal member, would risk complicating an effective process for little practical benefit.

Recommendations:

20. The rollout of ADR should continue, and opportunities should be explored to further increase the efficiency of the appeals process.

21. Appeals to the Veterans' Review Board should be immediately opened to DRCA claims (preferably along with the acceptance of Recommendation 23 regarding a review of VRB funding).

22. The right to legal representation, currently available at the AAT, should not be extended to the VRB.

23. A review of VRB funding should be conducted to ensure it has sufficient resources to handle the increased workload that will result from the expansion of ADR to Queensland, as well as the expansion of VRB access to DRCA claims (as outlined in Recommendation 21).

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[15] *Veterans' Review Board*, "Veterans' Review Board Annual Report 2016–17", 2017, accessed 28 June 2018, http://www.vrb.gov.au/pubs/VRB%20Annual%20Report%202016-17-inclFrontBack.pdf, 11.



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**A Holistic National Model for Advocacy and Support Services**

*Inquiry Questions:*

- *How could the administration of the claims and appeals process be improved to deliver more effective and timely services to veterans in the future?*
- *Are advocates effective? How could their use be improved? Are there any lessons that can be drawn from advocates about how individualised support could be best provided to veterans?*
- *Do the governance arrangements for the veterans' support system encourage good decision making — from initial policy development to its administration and review? If not, what changes could be made?*

Even with simplifications and streamlining, the legislative framework will remain necessarily complex, and so an improved claims and appeals/advocacy model will be essential. Ideally, steps can be taken to significantly minimise the demand for claims assistance and advocacy (which currently far exceeds supply), with DVA clients increasingly able to manage the process themselves. However, this is a long-term goal, and an efficient, effective and consistent system is urgently required in the meantime. The development of the recommendations below was informed, in part, by a round table discussion hosted by RSL NSW in mid-June 2018 which brought together various stakeholders within the veterans' advocacy space, drawing on extensive experience in appeals, advocacy, legal representation, and TIP/ATDP training.

Comparable advocacy and support service models in other sectors, such as the National Disability Insurance Scheme, have implemented a region-based tender process for service providers. However, the cost of funding a well-trained physical presence across the entire country, along with the hypothetical scenario of separating a veteran from their advocate or support worker when a region changes providers, makes this model problematic. Due to their relative numbers and geographic distribution, veterans will be better and more efficiently served by a simpler, leaner model.

The Senate Foreign Affairs, Defence and Trade References Committee's August 2017 report, *The Constant Battle: Suicide by Veterans*, recommended the establishment of *"a Bureau of Veterans' Advocates to represent veterans, commission legal representation where required, train advocates for veterans and be responsible for advocate insurance issues"*.[16] RSL NSW supports the general spirit of this recommendation but differs on key details as follows.

RSL NSW recommends the creation of a peak body of ESO service providers to establish firm ESO stewardship and self-regulation of the sector, modelled on the Australian Council for International Development (ACFID), the peak body of accredited NGOs delivering international aid services. DVA should commit to funding the operations of this body, which would constitute a joint venture of major ESOs, created as a separate legal entity, independent of DVA. Amongst other duties (detailed in Recommendation 26), the body would be responsible for formally accrediting ESOs offering professional services for veterans and veterans' families (rather than organisations limiting their activities to political advocacy and lobbying). Accredited ESOs would be recognised as member

[16] *Senate Foreign Affairs, Defence and Trade References Committee*, "The Constant Battle: Suicide by Veterans", 153.

organisations of the peak body, which would serve as a condition of access to DVA funding through its Building Excellence in Support and Training (BEST) grants programme (as per Recommendation 38). Accreditation would be based on a thorough assessment of an ESO's record of meeting specified requirements and standards, including in service quality and consistency; competency and stability of claims advisors, advocates and support workers; fundraising; governance; financial reporting; and complaints handling.

The peak body would maintain a Code of Conduct for member organisations to maintain their accreditation, modelled on that of ACFID. This would define standards of best practice, and require the adoption of annual reporting, appropriate checks and balances, and an independent complaints-handling process. As in ACFID, the Code should accommodate the different approaches of member organisations by building on their shared values, and the peak body should assist member organisations (and prospective member organisations) to meet their obligations under the Code with advice and support where appropriate. This would create barriers to entry of new ESOs and the continued operation of small existing ones, however, defragmentation of the ESO sector is in the best interests of veterans and veterans' families.

As ACFID has a partnership with The Department of Foreign Affairs and Trade, so too should a peak body of professional ESO service providers have a formal partnership with DVA, with the terms of the relationship set out in a Partnership Memorandum of Understanding. As noted above, and detailed in Recommendation 38, DVA funding for professional ESO service providers through its BEST grant programme would be limited to accredited member organisations of the peak body, with shares calculated according to each organisation's share of specified workload metrics. This would establish an incentive for the body to hold member organisations to a high standard, and for those organisations to ensure a high quality of service, thus introducing a much-needed system of formalised self-regulation in the veterans' advocacy and support services space. In addition, the partnership would encourage open and constructive dialogue between DVA and the ESO sector to improve outcomes for veterans and their families.

The body should be governed by a Constitution, developed jointly by founding member organisations in consultation with DVA, which will set out the powers and structure of a Council, Board, and Code of Conduct Committee. It would maintain a small administrative office in Canberra, with Board members and management staff selected to bring expertise in governance, service standards and accreditation management, and with operations funded by DVA. Importantly, it would not house or employ veterans' advocates or support workers, instead simply overseeing and coordinating their work.

A peak body of professional ESO service providers should have responsibility for:

- administering the formal accreditation of professional ESO advocacy and support service providers assessed as meeting specified standards of service quality and consistency; competency and stability of claims advisors, advocates and support workers; fundraising; governance; financial reporting; and complaints handling;
- maintaining a Code of Conduct defining standards of best practice that should be adhered to by accredited member organisations, including a requirement for annual reporting, appropriate checks and balances, and an independent complaints-handling process;

- establishing a review process, conducting regular audits (every three to five years), and reporting publicly on the compliance of accredited member organisations;
- maintaining strong working relationships with DVA, the Department of Defence, and the Defence Force Ombudsman (with broadened responsibilities as outlined below and in Recommendation 27), while maintaining a non-partisan stance overall;
- engaging member organisations, implementing a formalised and structured system of connectedness and knowledge sharing between advocates, claims advisors, support workers and carers, both professional and volunteer (including a reporting-back process), and facilitating cooperative problem solving through joint service delivery;
- coordinating and leading member organisations, while being accountable to them for performance; and
- administration of the Advocacy Training & Development Program (ATDP).

In tandem with this proposal, RSL NSW proposes the Defence Force Ombudsman (the Commonwealth Ombudsman) be tasked with analysing veteran complaint data from a range of sources, including official and informal channels. This would enable the office to identify systematic and emerging issues in DVA, the Veterans' Review Board, the proposed peak body of ESO service providers (as per Recommendation 24), and all associated programmes. This responsibility would be in addition to the office's current role of acting on complaints relating to the ADF, Department of Defence, and DVA in cases where no right of appeal exists. The Defence Force Ombudsman's remit should include review of the quality of DVA's administration and its advice to government. Analyses stemming from this recommendation would be used to inform decision making as well as a two-yearly review of the legislation surrounding Veterans' compensation and rehabilitation. This proposal is inspired by Canada's *Office of the Veterans Ombudsman*.[17]

On a micro level, RSL NSW does not recommend specific changes to the geographic structure of the claims, advocacy and welfare operations of individual ESO service providers. Beyond the core team of professional claims advisors and support workers based at RSL NSW's head office in the Sydney CBD, the organisation currently employs a claims advisor in the Hunter region and a support worker in western Sydney. There is demand amongst the RSL sub-Branch network to expand this in-person service. Access to services in rural and regional areas is at present grossly deficient, and where the funding exists, the expansion of this service may be possible. However, Australia is too large and sparsely-populated a country for either the ESO community or DVA itself to guarantee a physical service nationwide. RSL NSW's DefenceCare team is stronger for being a centralised hub, rather than dispersed around the state. Having many claims advisors, advocates and support workers in a single office creates opportunities for group learning and reflection, and collective support. RSL NSW therefore recommends that professional ESO service providers commit to exploring and investing in strategies and infrastructure to enable and expand non-physical communication between major cities and regional hubs (Skype interviewing, for example). If Recommendation 24 is actioned, this commitment should be formalised as a condition for accreditation with the proposed peak body. A range of services should be available to expand access to high-quality advocacy and support services

[17] *Office of the Veterans Ombudsman*, "Our Mandate", accessed 28 June 2018, http://www.ombudsman-veterans.gc.ca/eng/about-us/mandate.

to all veterans and veterans' families living in rural and regional areas, regardless of age or level of disability.

Recommendations:

24. Immediate steps should be taken to create a peak body of ESO service providers as a joint venture of major professional ESOs, based on the Australian Council for International Development (ACFID) model in the international development sector. DVA should commit to funding the operations of this body, which should be governed by its own Constitution, should maintain a Code of Conduct, and should be formally partnered with DVA under a Partnership Memorandum of Understanding to establish a system of self-regulation in the veterans' services sector.

25. Membership of this peak body should be open to professional ESO service providers which meet specified standards of service quality and consistency; competency and stability of claims advisors, advocates and support workers; fundraising; governance; financial reporting; and complaints handling; and which can maintain accreditation by demonstrating ongoing compliance with the peak body Code of Conduct.

26. This peak body of professional ESO service providers should have responsibility for:
    - administering the formal accreditation of professional ESO advocacy and support service providers assessed as meeting specified standards of service quality and consistency; competency and stability of claims advisors, advocates and support workers; fundraising; governance; financial reporting; and complaints handling;
    - maintaining a Code of Conduct defining standards of best practice that should be adhered to by accredited member organisations, including a requirement for annual reporting, appropriate checks and balances, and an independent complaints-handling process;
    - establishing a review process, conducting regular audits (every three to five years), and reporting publicly on the compliance of accredited member organisations;
    - maintaining strong working relationships with DVA, the Department of Defence, and the Defence Force Ombudsman (with broadened responsibilities as outlined below and in Recommendation 27), while maintaining a non-partisan stance overall;
    - engaging member organisations, implementing a formalised and structured system of connectedness and knowledge sharing between advocates, claims advisors, support workers and carers, both professional and volunteer (including a reporting-back process), and facilitating cooperative problem solving through joint service delivery.
    - coordinating and leading member organisations, while being accountable to them for performance; and
    - administration of the Advocacy Training & Development Program (ATDP).

27. The responsibilities of the Defence Force Ombudsman (the Commonwealth Ombudsman) should be broadened to include analysing veteran complaint data from a range of sources, including official and informal channels. This would enable the office to identify systematic and emerging issues in DVA, the Veterans' Review Board, the proposed peak body of ESO service providers (as per Recommendation 24), and all associated programmes. The office's remit should further include review of the quality of DVA's administration and its advice to government. Analyses

stemming from this recommendation would be used to inform decision making as well as a two-yearly review of the legislation surrounding Veterans' compensation and rehabilitation.

28. Professional ESO service providers should commit to exploring and investing in strategies and infrastructure to enable and expand non-physical communication between major cities and regional hubs (Skype interviewing, for example). If Recommendation 24 is actioned, this commitment should be formalised as a condition for accreditation with the proposed peak body.

**The future of professionals and volunteers in the veteran's sector**

Today's veterans consistently express a desire and expectation for a modern, professional system of advocacy and support services. Unlike volunteers in general, professionals are subject to a process of regular review and feedback, and are accountable for their advice, decisions and behaviour. This helps to ensure a high standard of competency and service, minimising the high percentage of claims that progress to the VRB due to missing evidence. Aside from lacking defined standards for quality or consistency, the existing volunteer-based system is failing due to the aging of volunteer welfare and pensions officers. The few professionals entering the sector to replace them are receiving grossly insufficient funding and support, and RSL NSW expects these factors to bring the current system to breaking point within the next 5 - 10 years.

The rise of professionals in the veterans' sector needs to complement and support the existing volunteer system, with volunteers continuing to act as the eyes and ears of the system at the grass roots level. Beyond assisting veterans by identifying health needs and available DVA benefits, volunteers should be tasked with recognising vulnerable veterans and families, and making early referrals to professional claims advisors, advocates and support workers when appropriate.

While RSL NSW takes steps to protect the well-being of its own claims advisors, advocates and support workers, its model is not replicated across the country and many in such roles lack access to support – particularly volunteers. Volunteers in the veterans' sector regularly deal with severely mentally ill clients and often struggle to set and maintain essential professional boundaries to safeguard against causing further harm. Many are DVA clients themselves and have little or no support in their roles. RSL NSW is aware of first responders from small ex-service and other non-government organisations unknowingly enabling and encouraging damaging behaviour, spending days with vulnerable clients without considering the risk or impact on their own health and families, providing emergency housing in their own homes and exhausting their own financial resources, and even starting physical relationships or engaging in violent exchanges with veterans in crisis. The inescapable reality is that volunteers on the ground will always deal with incredibly difficult situations which put both veterans, themselves, and potentially their families at risk. But right now, well-meaning amateurs are all too often worsening the situation vulnerable veterans find themselves in.

To ensure ongoing quality of service and foster strong outcomes for veterans and veterans' families, RSL NSW proposes that all volunteer advocates, claims advisors ('pensions officers') and support workers ('welfare officers') individually require the endorsement of a professional ESO (which has itself been accredited as per Recommendation 25) in order to practice and to qualify for indemnity insurance through the Veterans' Indemnity and Training Association (VITA). This requirement should


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not apply to those volunteers holding an appropriate professional qualification and current accreditation with the relevant professional organisation. While professionals, by definition, will be held to a higher standard of accountability, there is no reason to hold volunteers to a low standard, either of service or of accountability. Veterans should receive an excellent standard of care and advice, regardless of who is providing it.

This proposal would mean that the endorsing ESO would have responsibility to ensure all volunteers it endorses are appropriately trained and supported. This model would go a long way toward alleviating the dire situation faced by many volunteers by creating enforceable standards of training and support for volunteers in the sector. In many cases RSL NSW is aware of, DVA has failed to step in when under-trained volunteers have unintentionally exacerbated the state of vulnerable veterans. Major ESOs would receive DVA funding toward this responsibility (as per Recommendations 36 & 37) and would thus be well placed to oversee volunteers in the sector, ensure they are trained and supported effectively, demand a consistently high standard of work, and have difficult conversations when this is not possible. With reputation, accreditation and funding at stake, major ESOs which already possess the capacity to fulfil this role would receive a strong incentive to do so effectively. This will also help to address the current dearth of familiarity with DRCA and MRCA legislation in the volunteer advocate and claims advice community.

This proposal will require additional funding in line with Recommendations 36 & 37, however, it will be cost effective by maximising the utility of volunteers (who will be looked on more favourably by an increasingly discerning cohort of younger veterans) and thus reducing the demand for BEST grant funding of professional ESO service providers. It will also avoid the vast expense that would come with DVA individually accrediting and auditing volunteers nationwide. RSL NSW estimates a five-year timeframe would be necessary for the transition to compulsory accreditation of volunteers in the veterans' sector.

While compulsory endorsement by accredited ESO service providers will inevitably precipitate a reduction in active volunteer numbers due to the perceived and actual effort involved, the assurance of a consistent standard of service quality is considered a worthy justification for this step. To offset the impact of this reduction, compulsory volunteer endorsement should be paired with efforts to attract more young volunteers, and adequate public funding of professional ESO advocacy and support service providers. Both of these points will be discussed in the sections that follow.

Beyond the macro-level structure of professionals, volunteers and ESOs, there are issues to be addressed in the system of training itself. Taking the RSL NSW sub-Branch network as reflective of the national situation, while the majority of volunteers in the veterans' sector before the rollout of the Advocacy Training & Development Program (ATDP) had undertaken TIP welfare and/or pension courses, only some were regularly refreshing their qualifications, and almost none had a degree or other qualification in community support. Anecdotally, RSL NSW is aware that volunteer take-up of ATDP has thus far been meagre, and many volunteers will retire rather than update their skills. Without proper training, advocates and claims advisors are more likely to relay their own negative experiences with DVA to others, on some occasions causing younger veterans to avoid DVA entirely rather than find someone else to help with their claim. Poorly trained advocates and claims advisors may lack an awareness of the professional and personal boundaries essential to assisting the severely

mentally ill, and their management styles may lead to delays in the DVA process which a well-trained claims advisor or advocate, whether professional or volunteer, could avoid. The potential negative impact on both parties of such a relationship is severe.

For volunteers, ATDP provides a good foundation for a training package, however, the incoming programme lacks structure and professional rigour; it is currently run and overseen by volunteers and not subject to auditing. However, recent attendance by professional RSL NSW claims advisors suggests that the content of ATDP courses is quite good, and it may simply be poor course availability and the programme's overly-bureaucratic administration at fault. The proposed peak body of professional ESO service providers (Recommendation 24) should take over responsibility for the administration of ATDP (as per Recommendation 26) and commit to regular review of programme content and ensuring a basic minimum standard of course availability in rural and regional Australia.

ATDP was expressly built for volunteers and is not sufficient training for professionals. Professional ESOs should be expected to train claims advisors, advocates and support workers to a higher standard, however, there is no need for a one-size-fits-all professional training model. Veterans will lack genuine choice without variety, and competition will encourage excellence and innovation in training and support models. The role of the peak body proposed in Recommendation 24 in accrediting and auditing professional ESO service providers, will ensure a high standard of service in the veteran' sector through effective self-regulation. Beyond the useful basic standard of ADTP, ESOs should be free to train endorsed volunteers to a higher standard.

Additionally, DVA should investigate the viability and potential benefits of training sessions for individual veterans and family members to manage their own claims independently, including navigating the legislation, and identifying and collecting relevant supporting documentation. Options should be explored to run claims workshops either online (perhaps linked to the online claim form) or face-to-face (with classes run on a rotating basis in rural, regional and metropolitan population centres around the country). Those applying for the course could be screened for mental illness and other areas of vulnerability such as trauma, and if necessary referred on to a professional claims advisor. This programme would ease the demand for expensive and difficult legislative reform, as well as the cost of funding professional claims advisors through the BEST grants programme. Training younger veterans in basic claim lodging would also help to create a pool of potential volunteers to sustain and strengthen the sector and increase its efficiency into the future.

The veterans' sector will continue to reflect the demographic of the Australian Defence Force, in which the majority of personnel are male. Efforts to increase female recruitment into the ADF will gradually erode biases against women but will also see a greater demand for female-focused services. Women in Defence face additional, distinct challenges to their male colleagues, which are at present poorly understood and catered for in the veterans' compensation, rehabilitation and welfare system. 13% of RSL NSW volunteer pensions officers are women. RSL NSW therefore recommends that professional ESO service providers commit to genuine strategies aimed at increasing the number of female claims advisors, advocates, support workers, and other client-facing staff.



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Recommendations:

29. All volunteer advocates, claims advisors ('pensions officers') and support workers ('welfare officers') should individually require the endorsement of a professional ESO (which has itself been accredited as per Recommendation 25) in order to qualify for indemnity insurance through the Veterans' Indemnity and Training Association (VITA). This requirement should not apply to volunteers holding and appropriate professional qualification and current accreditation with the relevant professional organisation.
30. Beyond the useful basic standard of ADTP, ESOs should be free to train endorsed volunteers to a higher standard. There is no need, however, for a one-size-fits-all professional training model to be adopted by ESO service providers, although they should be expected to train their paid claims advisors, advocates and support workers to a higher standard than the ATDP.

31. DVA should investigate the viability and potential benefits of training sessions for individual veterans and family members to manage their own claims independently, including navigating the legislation, and identifying and collecting supporting documentation. Options should be explored to run claims workshops either online (perhaps linked to the online claim form) or face-to-face (with classes run on a rotating basis in rural, regional and metropolitan population centres around the country). Those applying for the course could be screened for mental illness and other areas of vulnerability such as trauma, and if necessary referred on to a professional claims advisor.

32. Professional ESO service providers should commit to genuine strategies aimed at increasing the number of female claims advisors, advocates, support workers, and other client-facing staff, including via a condition of accreditation with the peak body proposed in Recommendation 24.

**Support for families and volunteer carers**

*Inquiry Questions*

- *Has the non-liability coverage of mental health through the white card been beneficial?*

Many of the calls received by RSL NSW about veterans in crisis come from their families, particularly parents and partners, who frequently act as carers for vulnerable veterans. When veterans suffer from serious mental health conditions, their family members can live in a traumatic environment, and often endure domestic violence and controlling behaviour, experience feelings of isolation, exhaustion and chronic sorrow, and/or begin to mirror the symptoms of the veteran (e.g. hyper-vigilance, anxiety, depression, anger, frustration, social isolation). Unfortunately, DVA currently offers little direct support to families of veterans, despite family members often having made significant, albeit indirect sacrifices for the defence of Australia and its interests by caring for the veterans themselves. In June 2014, RSL NSW led a carer's forum at DVA's Sydney office, bringing together carers and partners of younger veterans with accepted mental and/or physical injuries, as well as specialists from VVCS. The forum allowed carers to share their experiences and identify areas of intense difficulty in everyday life. Both the experiences of forum participants and the documented counselling records of RSL NSW suggest that the physical and mental health of many carers of veterans may be severely compromised. Ultimately, efforts to support families of veterans, including partners, parents, children and other carers, will promote better health outcomes and recovery rates for veterans themselves.

The most urgent needs of carers and families of vulnerable veterans are:

- clear, understandable, and readily accessible information about the veteran's condition, how best to manage it at home, and support services available;
- access to programmes to build resilience in families of veterans to cope with trauma;
- access to mental health support (including counselling, peer support, workshops, etc.);
- respite from the constancy responsibility, and from feelings of isolation, exhaustion and chronic sorrow;
- financial support for family members forced to leave work or take excessive leave without pay to care for the veteran;
- practical impact-minimisation support including cleaning, maintenance, and safety in the home;
- adequate transition support for medically discharged veterans and their families, who often experience the sudden loss of support networks and housing due to a hastened departure from Defence;
- support for the children of vulnerable veterans, and recognition of their specific needs; and
- surety that the veteran will continue to receive high-quality care when family members are no longer able to provide it themselves.

To begin to provide support to the primary carers of vulnerable veterans, access to mental health support currently available under DVA's Non-Liability Health Care programme should be extended to the immediate families of veterans, including parents and partners. RSL NSW is immensely supportive of this programme, which has proved invaluable for veterans by offering fully-covered mental health treatment without the need for a diagnosis or proof of connection to military service, and without connection to the outcome of any concurrent claim for compensation. The programme is one of the most valuable DVA has initiated, and strongly highlights the Department's commitment to helping veterans. Both veterans and family members of veterans often come to RSL NSW at breaking point, and this programme allows them to immediately access specialist help while their DVA claim is processed.

The families and other volunteer carers of vulnerable veterans would also benefit immensely from a comprehensive peer support programme providing practical support in an ongoing, sustainable and efficient format which would complement formal mental health services. In 2014, RSL NSW prepared a joint business plan with DVA for a two-year trial of a coordinated, best practice peer support programme, which would have created Defence-specific support networks in NSW in partnership with Carers NSW and ARAFMI, established organisations already supporting carers in other sectors. At the time, the estimated cost of a two-year trial was $380,525 ($174,315 in year 1 and $206,210 in year 2), however, funding could not be sourced. To provide a service at maximum efficiency, future efforts at establishing a peer support programme for carers of vulnerable veterans, including family members, should explore opportunities to incorporate a Defence-focused programme within existing carers' programmes throughout Australia, avoiding the need to duplicate existing services. Importantly, RSL NSW has heard evidence of weak outcomes from those who have participated in online support groups. Thus, a future programme should focus on local, face-to-face support networks allowing and encouraging carers can come together and help each other with practical support and advice.

Recommendations:

33. Mental health support currently available under DVA's Non-Liability Health Care programme should be expanded to the immediate families of veterans, including parents and partners, to maximise outcomes for veterans themselves. This aligns with Recommendation 19 of the Senate Foreign Affairs, Defence and Trade References Committee's August 2017 report, *The Constant Battle: Suicide by Veterans*.[18]

34. DVA should explore opportunities, in partnership with major ESO service providers and other experienced NGOs supporting carers across Australia, to introduce a comprehensive peer support programme for the families and other volunteer carers of vulnerable veterans. The programme should focus on creating local, face-to-face support networks allowing and encouraging carers can come together and help each other with practical support and advice, rather than online support groups. An effort should be made to incorporate this programme within existing carers' programmes throughout Australia to avoid duplicating existing services.

**DVA funding for ESO service providers**

DVA could offset future costs by investing more funding now to build professional capacity within major ESOs. A high-quality system for veterans' advocacy and support services will require government to commit to setting aside adequate resources to fund capacity in ESO service providers. Fortunately, the resulting benefits from properly funding ESOs providing claims advice, advocacy and support services to veterans include opportunities to minimise costs for DVA in other areas. When advocacy works well, both professional and volunteer, it saves DVA an enormous expense in time and resources that would otherwise be spent processing incomplete or poorly-compiled applications. Advocates and claims advisors can ensure veterans and families lodging claims and appeals with DVA are guided efficiently through the correct procedures with a minimum of angst and anger, while support workers help those who inevitably fall through the cracks in the system, and who would otherwise create greater expenses for DVA down the track. While improvements to the compensation and rehabilitation system (by reducing complexity or increasing veteran/staff capability) will gradually decrease the need for ESO advocacy and support services, it is unlikely that the need for these services will ever disappear, at least not in the foreseeable future, due to the intricacies of military service, its impact on veterans, the realities of medical diagnosing, and the need to ensure value for taxpayers.

In the financial year 2016-17, DVA's "Payments to ex-service organisations" comprised $4m in total.[19] This was steady compared with 2015-16, and down from $5m in 2014-15.[20] The total DVA budget for 'Health and Wellbeing' in 2016-17 was $5.3bn, meaning just 0.075% went towards building structural capacity in the ESO sector to support and guide veterans through their claims.[21] For comparison, DVA had a total budget for commemorations of $47.2m in the same period, which went towards commemorative events, war graves and educational resources.[22] Government funding for ex-service

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18 *Senate Foreign Affairs, Defence and Trade References Committee, "The Constant Battle: Suicide by Veterans"*, xvi.

19 *Department of Veterans' Affairs*, "Annual Reports 2016–17", 2017, accessed 2 July 2018, https://www.dva.gov.au/sites/default/files/files/about%20dva/annual_report/2016-2017/DVA-AnnualReports-00-ALL-2016-17.pdf, 180.

20 *Department of Veterans' Affairs*, "Annual Reports 2015–16", 2016, accessed 10 July 2018, https://www.dva.gov.au/sites/default/files/files/about%20dva/annual_report/2015-2016/annrep2015-16.pdf, 157.

21 *Department of Veterans' Affairs*, "Annual Reports 2016–17", i.

22 Ibid., i.



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organisations is microscopic within their total budget, and the veterans' advocacy and support sector thus relies heavily on charitable goodwill to continue offering a free service. The approach of DVA to funding professional ESO service providers ignores the growth in demand for professional services, particularly amongst younger veterans, and constitutes a gross underappreciation of the value these services represent for DVA.

At present, DVA offers funding to ESOs providing compensation and welfare assistance to current and ex-serving Defence personnel through its Building Excellence in Support and Training (BEST) grants programme. The value of a BEST grant to an individual ESO is determined based on its claims and advocacy workload as a percentage of the national workload – with the total available funding shared accordingly. RSL NSW proposes formalising the role of BEST grants through a joint funding model in line with that of the National Disability Insurance Scheme, whereby both DVA and an ESO provider of claims, advocacy and/or support services to veterans would contribute equally towards service provision, each bearing half the funding cost.

Much of the RSL NSW welfare workload involves financial assistance and homelessness support to veterans, provided as thanks for veterans' sacrifice, rather than compensation for a specific impact of their service. This work is rightly funded by charitable income. However, two specific professional support services provided by ESOs stand apart: counselling and case management. Professional ESO counselling services fill the gap for those for whom dealing with DVA in any capacity (including VVCS) can trigger or exacerbate a condition. In this way these services complement DVA's Non-Liability Health Care programme without overlapping or duplicating costs. Importantly, the 50-50 funding model proposed and outlined above ensures that DVA funding for ESO counselling services will, for the cases which require it, save DVA the expense of counselling under its Non-Liability Health Care programme, for which it must pay the entire fee, rather than it being shared with the ESO. Case management involves long-term support for clients with special or complex needs – specifically, identifying a client's needs in totality, and sourcing and coordinating access to services. The social worker, counsellor or psychologist providing the service will also regularly bring together the clients treating health specialists to reflect on the progress of treatment in case conferences, and act as an independent and objective 'reality check' for vulnerable veterans and families grappling with the opportunities and limitations of DVA and other benefits and programmes. The process can also serve to train and empower the carers and families of veterans to be more in control of the treatment, and successfully manage progress themselves. Case management can make an enormous difference for vulnerable veterans struggling to steer their own rehabilitation, however, this service currently represents the largest gap in service provision across the veterans' sector as a whole.

As with DVA's Non-Liability Health Care programme, the national demand and potential workload for professional ESO counselling and case management is difficult to quantify. These services cater to those whose complex needs are not being met by the suite of programmes and services offered by DVA at present – the vulnerable veterans and families most likely to fall through the gaps of the system, for whom dealing with DVA can be a triggering factor for severe mental health conditions. Funding for non-DVA programmes to help these veterans and their families should be viewed as an outsourcing of programmes that DVA rightly ought to be funding to organisations in a much stronger position to offer them (due simply to their better reputation and independence from DVA). Professional ESO counselling and case management should not be seen as a luxuries or a duplication

of existing programmes. DVA should fund these programmes through an additional, uncapped portion of the total BEST grant funding pool. The value of this part of an individual BEST grant to an ESO service provider should be based on that ESO's documented and reported workload (measured number of sessions and their duration), and the DVA schedules of fees for Social Workers (Mental Health), with DVA to pay half the fee as outlined above.[23] As a guide, RSL NSW provided 91 counselling sessions for veterans and their family members in 2017 at no charge to the clients. RSL NSW employs one part-time counsellor working three days per week to provide this service, and turns no clients away. Sessions are generally one hour in length and conducted in-office. The DVA schedule of fees ascribes a rate of $90.80 per 50+ minute consultation in rooms.[24] This amounts to a total cost of $8,262.80 within the Sydney area, where the majority of RSL NSW clients are located, and this would thus give a guide target for DVA's funding contribution of $4,100 for this region, based on a 50-50 share of spending.

BEST grants under this future funding model will require one further component, covering reasonable costs for the training and support of volunteers endorsed by a professional ESO service provider as per Recommendation 29. This proposal will prove cost effective for DVA by maximising the utility of volunteers (who will be looked on more favourably by an increasingly discerning cohort of younger veterans) and thus limiting the other proposed components BEST grant funding by reducing demand for professional service offered by ESOs. It will also avoid the vast expense that would come with DVA individually accrediting and auditing volunteers nationwide to achieve the same impact on service quality and consistency. Funding for this purpose should be included as a final component of an ESO's BEST grant, and DVA should investigate the appropriate level of funding per volunteer endorsed in consultation with the major professional ESO service providers likely to be endorsing volunteers. Factors to consider in this investigation will include the cost of training and refresher courses through ATDP, travel expenses for volunteers to attend courses, and compensation for missed work and associated expenses, including child care, hiring farm hands, etc. Costs incurred by ESOs opting to train volunteers to a higher standard than ATDP would most likely not be factored into the BEST grant provision for endorsing volunteers but should also be investigated.

In sum, the initial total DVA target for the annual funding of professional ESO service providers should comprise:

- a base amount to boost strategic capacity within major ESOs;
- a supplementary, uncapped amount to cover professional counselling and case management services, based on an ESO's documented and reported workload (measured in hours worked, number of clients, and number of sessions) together with the DVA schedules of fees for Social Workers or (if the need can be demonstrated) Psychologists/Clinical Psychologists (with DVA to cover half the cost as outlined above); and
- an additional amount per volunteer trained and supported by an ESO, to be investigated by DVA in consultation with major professional ESO service providers, as outlined above.

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[23] *Department of Veterans' Affairs*, "Social Workers (Mental Health) Schedule of Fees Effective 1 July 2018", 1 July 2018, accessed 24 August 2018, https://www.dva.gov.au/sites/default/files/files/providers/SocialMentalHealthFeeJuly18.pdf.

[24] Ibid., 1.



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After a detailed investigation as outlined above (and per Recommendation 36), the appropriate yearly DVA contribution to professional ESO service providers will be higher than recent years' levels of $4m-$5m but not immensely so. Some level of uncertainty in the funding figure is necessary and justifiable, as the demand for professional ESO counselling and case management services, which are the ultimate source of uncertainty in the funding model, cannot be estimated precisely. The DVA target contribution for an equivalent counselling service to that provided by RSL NSW – $4,100 in 2017 (half the total expense) – provides a rough guide as to the likely total national expense in this area.

Achieving an efficient distribution of funding in the ESO sector is as important as ensuring the funding is adequate. In 2017 RSL NSW, through RSL DefenceCare, received two BEST grants (applications are submitted biannually) with a combined value of $191,281. This represents just 31.1% of the running costs for the claims and advocacy arm of RSL NSW alone, well short of the 50% share called for in the funding model proposed above. This is not to mention the absence of DVA funding for existing counselling services, or to build strategic capacity. Taking a broader view, this also represents just 4.78% of DVA's total $4m expenditure through its BEST grants programme in 2016-17. As the major professional provider of veterans' claims advice, advocacy and support services in Australia's most populous state, this share of the total available funding constitutes a gross underappreciation of the value professional ESO service providers represent for DVA. For the funding model outlined above to be successful and effective in improving outcomes for veterans and veterans' families, RSL NSW considers that the total available resources need to be focused on meticulously vetted professional ESOs providing relevant services, to ensure these organisations receive the funding necessary to make an impact. Specifically, the access to funding through the BEST grants programme should be limited to professional ESO service providers accredited by the proposed peak body of professional ESO service providers as per Recommendation 25. While this will obstruct the entry of new ESOs in the sector, and affect the continued operation of small existing ones, the ESO sector is currently far too fragmented, and some consolidation will allow for stronger outcomes for veterans and veterans' families.

Recommendations:

35. ESOs providing professional counselling and case management services (and accredited as per Recommendation 25) should be eligible to receive BEST grant funding from DVA to support these services, alongside the funding already available for claims advice and advocacy services. The specific funding model is outlined in Recommendation 37 below.

36. BEST grants should also cover reasonable costs associated with the training and support of volunteers endorsed by a professional ESO service provider as per Recommendation 29. DVA should investigate the appropriate level of funding per volunteer endorsed in consultation with the major professional ESO service providers likely to be endorsing volunteers. Factors deserving consideration in this investigation will include the cost of training and refresher courses through ATDP, travel expenses for volunteers to attend courses, and compensation for missed work and associated expenses, including child care, hiring farm hands, etc., and costs incurred by ESOs opting to train volunteers to a higher standard than ATDP.

37. DVA should review its funding of professional ESO service providers and formalise the role of BEST grants through a joint funding model whereby both DVA and an ESO provider of claims, advocacy and/or support services to veterans would contribute equally towards service provision, each bearing half the funding cost. RSL NSW recommends an initial total DVA target for the annual funding of professional ESO service providers comprising:
    - a base amount to boost strategic capacity within major ESOs;
    - a supplementary, uncapped amount to cover professional counselling and case management services, based on an ESO's documented and reported workload (measured in hours worked, number of clients, and number of sessions) together with the DVA schedules of fees for Social Workers or (if the need can be demonstrated) Psychologists/Clinical Psychologists (with DVA to cover half the cost as outlined above); and
    - an additional amount per volunteer trained and supported by an ESO, to be investigated by DVA in consultation with major professional ESO service providers, as outlined above.

38. DVA should ensure its BEST grants are awarded only to meticulously vetted professional ESOs providing relevant services (i.e. those accredited with the proposed peak body as per Recommendations 24 & 25) to ensure funds are not spread overly thinly.

## Consumer-Directed Care

*Inquiry Questions:*

- *What role should ESOs play? Are there systemic areas for improvement in the ESO sector that would enhance veterans' wellbeing?*
- *For those veterans who receive compensation, are there adequate incentives to rehabilitate or return to work? Are there examples of other compensation schemes that provide support for injured workers and successfully create incentives to rehabilitate or return to work?*
- *Are transition and rehabilitation services meeting the needs of veterans and their families? Are veterans getting access to the services they need when they need them? What could be done to improve the timeliness of transition and rehabilitation services, and the coordination of services? What changes could be made to make it easier for ADF personnel to transition to civilian life and to find civilian employment that matches their skills and potential?*
- *How should the effectiveness of transition and rehabilitation services be measured? What evidence is currently available on the effectiveness of transition and rehabilitation services? How can the service system be improved?*
- *In some countries, rehabilitation services are provided to the families of severely injured and deceased veterans. Is there a rationale for providing such services in Australia? If so, what evidence is there on the effectiveness of these services?*

Since the introduction of DRCA (initially as SRCA) and then MRCA, the veteran space has begun to incorporate an aspect of rehabilitation – a broad effort to fix broken bodies and minds through retraining or otherwise giving purpose in life, rather than focusing narrowly on pensions or lump sum payments. Over the past two decades, however, DVA's rehabilitation efforts have been largely prescriptive and clinical. Such treatment options, while extensive and based on sound medical evidence, fail to account for a client's individual circumstances and requirements. Flexibility is limited, and RSL NSW is regularly approached by veterans who find that their particular needs are not catered for amongst funded treatment options. Unfortunately, clinical treatments also tend to be expensive and may require further treatment to counteract unintended side-effects.

At its core, the clinical model for rehabilitation focuses on ill health rather than well-being or good health. While this may seem a flippant distinction, it has highly significant ramifications for treatment outcomes. Like other members of the community, veterans increasingly express their desire for a say in the services they receive. The following case studies drawn from the experience of RSL NSW are worthy of consideration:

- A young veteran severely injured in Afghanistan, with impairment points just short of 100 (100 points equates to death), focused on painting and art to better manage his chronic pain and mental ill-health, allowing him to reduce his medications significantly, improve his diet and lose a considerable amount of weight gained since discharge.
- Another young veteran found acupuncture of great benefit in the management of pain caused by service injuries.

- After attending an equine programme with other veterans, a homeless veteran started working with horses regularly and found this gave him a purpose and motivation, leading to great increase in his quality of life.

Like much of the veterans' sector, DVA can be highly insular, paying scant attention to developments and experiences in, for example, the Australian aged care and disability sectors. Both of these sectors have moved away from the clinical model in favour of an outcomes-focused consumer-directed care (CDC) model, which involves individual funding for services that suit the needs of the client – effectively a 'bucket of money' to use according to their priorities.[25] DVA has not yet sufficiently explore consumer-directed care models.

Experience shows that non-clinical treatments as varied as yoga and sport, assistance dogs (currently a DVA trial programme), and carer-assisted travel can have a powerful impact on a client's well-being. They help in the management of chronic pain and/or mental illness (often reducing their reliance on medication), as well as restoring self-esteem and a sense of purpose and utility in life.[26] CDC empowers the client to have more control over their life and to be in charge of decisions about their lifestyle and support. It focuses on the person's individual strengths and life goals, placing their needs at the centre of the services and support. With the assistance of a professional case manager when necessary, the person chooses and manages the services they access to the extent they can and wish to do so, including who will deliver services, and when. Most people understand there is an overall financial limit to what they can receive, but choosing within that limit, with the help of a case manager available to guide them, will give veterans the chance to invest their energy in what is most important to them to maximise their quality of life. Ultimately, the model recognises that the only measure of a successful outcome is from the client themselves, their carer and clinician.

The key characteristics of a CDC model are as follows:

- The client is encouraged to articulate their needs and goals, with the help of a case manager if they need or desire it, and to have an active role in their own rehabilitation.
- Service providers work in partnership with the client and case manager to develop a care or service plan, asking 'what matters to you?' rather than 'what is the matter with you?'
- The client has a greater understanding of how their package of services is funded and the cost of services they choose, and is able to monitor their budget and expenditure.
- A case manager, if engaged, monitors services to ensure they continue to meet the client's needs.
- Depending on a specialist's assessment of the client's capability of managing their own progress and decision making, CDC can operate across a broad range or continuum, from a high level of control (where the client is involved in the decision-making regarding types of care, who delivers it, and how it is delivered) to a low level of involvement.
- CDC tends to be more strongly favoured by younger people.

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[25] *My Aged Care*, "Consumer Directed Care (CDC)", accessed 20 July 2018, https://www.myagedcare.gov.au/help-home/home-care-packages/consumer-directed-care-cdc.

[26] See, for example, Billingsley Kaambwaa, Emily Lancsar, Nicola McCaffrey, Gang Chen, Liz Gill, Ian D Cameron, Maria Crotty, and Julie Ratcliffe, "Investigating consumers' and informal carers' views and preferences for consumer directed care: A discrete choice experiment", *Social Science & Medicine*, 140 (2015).

RSL NSW strongly supports DVA moving to a consumer-directed care model for veterans' rehabilitation, initially through a comprehensive trial programme. As younger people tend to be more comfortable with self-directed service and choice, the trial phase should be limited to DRCA and MRCA clients, with the final programme extended to VEA clients on an opt-in basis. The Department is already taking small steps in this direction, including through an ongoing assistance dog trial programme, however, this model should become the main focus of veterans' rehabilitation services.

Importantly, the programme must be supported with access to professional case management. Case managers can guide clients through their rehabilitation, ensure they correctly identify their needs, understand the treatment options available and the potential benefits and limitations of each, protect them from being taken advantage of, and provide a disinterested assessment of their progress. As with any segment of the community, veterans and their families will differ widely in their capability to manage this process effectively themselves. When a client submits a claim for rehabilitation services, a DVA delegate or case manager should conduct an initial assessment to determine the client's suitability for a consumer-directed care model of rehabilitation. Different clients can be offered individualised levels of control and flexibility along a continuum from a high level to a low level as noted above. Those veterans or family members identified as vulnerable or at-risk, either by DVA staff (in line with Recommendations 9 & 10) or through an assessment passed on by Defence, should be encouraged to engage either an internal DVA case manager (when an initial assessment deems it likely that their vulnerability stems from their service, and the client is comfortable dealing with departmental staff), or an ESO/independent professional case manager (in other cases). Veterans not identified as vulnerable or at-risk should still be informed of the availability of professional ESO case management services. While a professional case manager can relieve the stress that vulnerable veterans may face when navigating the system of rehabilitative services on their own, case management should remain strictly optional for all veterans and family members applying for rehabilitation services.

As previously stated, most clients appreciate and respect the financial limits on their rehabilitation, however, to ensure a high standard of accountability, a new CDC model should make approval of any treatment contingent upon the support of the client's assigned case manager. This will anchor the new CDC model in the existing clinical model, rightly valued by DVA for its focus on sound medical evidence. This ensures veterans' rehabilitation efforts are open to neither the reality nor the perception of abuse. Further, DVA clients receiving rehabilitation support through the CDC model should participate in a minimum yearly review along with a DVA delegate, their carer, and case manager. This review should provide a safe environment to assess the success of their treatment and ways to improve it if necessary. If a client's treatment has not been particularly helpful to them, care should be taken to avoid any perception of a threat that the treatment will be terminated prematurely when adjustment is possible.

Finally, a comprehensive model of CDC for veterans' rehabilitation must be more flexible than existing small-scale trial programmes. This need was highlighted by the example of a recent client of RSL NSW, who found yoga useful for managing chronic pain but could gain DVA approval only to visit an exercise physiologist, rather than group classes. This was despite a specialist recommendation for the latter, and the condition imposed eliminated the relaxed, informal setting that group classes would have provided, as well as the social element that was key to the treatment. A reasonable level of flexibility

in the Department's approach would have been the difference between the client pursuing rehabilitation on his own terms, or becoming frustrated and disillusioned with the process, and losing hope.

Recommendations:

39. DVA should implement a comprehensive five-year trial programme of a consumer-directed care model for rehabilitation services to veterans with service covered by DRCA and MRCA. If successful in improving outcomes for veterans, this model will be extended to VEA clients on an opt-in basis. When a client claims for rehabilitation services, a DVA delegate or case manager should conduct an initial assessment to determine the client's suitability for a consumer-directed care model of rehabilitation. Different clients can be offered individualised levels of control and flexibility along a continuum from a high level to a low level.

40. The new model should be supported with access to professional case management. Those veterans or family members identified as vulnerable or at-risk, either by DVA staff (in line with Recommendations 9 & 10) or through an assessment passed on by Defence, should be encouraged to engage either an internal DVA case manager (when an initial assessment deems it likely that their vulnerability stems from their service, and the client is comfortable dealing with departmental staff), or an ESO/independent professional case manager (in other cases). Veterans not identified as vulnerable or at-risk should still be informed of the availability of professional ESO case management services. Case management should remain strictly optional for all veterans and family members applying for rehabilitation services.

41. The new CDC model for veterans' rehabilitation should make approval of any treatment contingent upon the support of the client's assigned case manager.

42. DVA clients receiving rehabilitation support through the CDC model should participate in a minimum yearly review along with a DVA delegate, their carer, and case manager, to assess the success of the client's treatment in a safe, non-threatening environment, and ways to improve it if necessary.



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## Department of Defence Role in Transitions

*Inquiry Questions:*

- *Are incentives sufficiently aligned between agencies, or are there areas of conflict that could be better managed? If there are any incentive problems how can they be resolved?*
- *What obligations should be placed on the ADF and individual unit commanders to prevent service-related injuries and record incidents and injuries when they occur? To what extent do cultural or other issues create a barrier within the ADF to injury prevention or record-keeping?*
- *The ADF is not financially accountable for the cost of compensation or for the cost of treating service-related injuries and illnesses after a veteran leaves the ADF. Is this a barrier to the ADF having an adequate focus on preventing injury and illnesses and providing early intervention and rehabilitation support? If so, how might this be remedied?*

Lingering gaps in communication between DVA and the Department of Defence continue to detrimentally impact outcomes for veterans and families, as do deficiencies in Defence's collection and sharing of incident, injury and illness records. When a serving Defence member goes through the Defence health system, the treating doctor or specialist should be required to flag the incident and resulting condition as service-related on the individual's medical record. This will streamline claim processing times significantly, and further reduce clients' stress associated with collecting information to prove a condition is service-related years after an incident occurred.

The points above will have little positive consequence without cooperation between DVA and Defence to improve waiting times for DVA delegates accessing Defence personnel records. Accurate information to back up a veterans' claim is crucial to fairly determining the appropriate outcome and, if applicable, rate of compensation. Delegates currently face very long delays in accessing basic service-related information. The burden of information collection can add significant pressure to an already stressful process for veterans and their families, as can long waiting times. Inter-Departmental cooperation to streamline the sharing of information is urgently required in this regard.

One further avenue for Defence to improve the transition process involves collaboration with ESOs at a local level towards a community integration support service. Integration into a local community, within a broader Australian society, is a critical component of a successful transition, and is essential for an ADF member to become a contributing and valued member of Australian society. When a Defence family is posted to a new location, the Defence Community Organisation (DCO) recognises the importance of integration by providing community integration support for the family in their new town or suburb. Aside from the physical movement of house hold effects, this support consists mainly of a 'welcome pack' containing useful contact information for local services (schools, doctors, child care, sporting clubs, mechanics, hair dressers, play groups, community groups such as Rotary and Lions, Church communities, etc.) as well as a range of other useful local community information (such as a calendar of local events). DCO also offers a range of practical help, such as making direct introductions (particularly for schools). While this may seem a frivolous programme, it can make an immense and genuine difference in the lives of Defence families otherwise in upheaval due to the sudden loss of connections and support networks.



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The DCO programme is possible due to the relatively limited number of communities with a Defence presence, however, the freedom to move to any community worldwide upon discharge means DCO does not provide its service during transitions from Defence, when a veteran and their family are likely to be at their most vulnerable. The gap left by the discontinuation of local community integration support during transition is well suited to be filled by the local ESO sector, as it would be a non-clinical programme relying simply on local area knowledge/contacts as well as contact with the discharging ADF member. Through its State Branches in each capital city, and respective sub-Branch networks across the country, RSL is the ESO best placed to deliver this programme.

Establishing contact with a discharging ADF member would require a mechanism (with appropriate privacy protections) for Defence/DCO to alert the RSL when an ADF member discharges into a particular area. This may require an 'opt in' provision for the ADF member before the service is activated. The community integration support service provided at the local level by each RSL sub-Branch could be coordinated through a single point of contact for DCO at each RSL State Branch, with a support package based on that currently provided by DCO for new postings.

This type of support would promote the development of a positive relationship between the veteran and the local RSL sub-Branch. It is a type of support that respects a veteran's pride and independence and gives practical help to their family who have been uprooted one last time in support of the veterans. The programme will lay a foundation of trust to encourage the veteran to approach RSL early is additional assistance is needed in the future.

Recommendations:

43. When a serving Defence member goes through the defence health system, the treating doctor or specialist should be required to flag an incident and resulting condition as service-related on the individual's medical record.

44. DVA and the Department of Defence should explore joint opportunities to improve waiting times for DVA delegates accessing Defence personnel records.

45. The Defence Community Organisation should collaborate with RSL in each state and territory (as the ESO with the greatest geographical reach and overall capacity) to produce a local community integration support service consisting of a 'welcome pack' of useful information and contact details for local services, organisations and events, together with practical assistance including making direct introductions to schools, etc. This would require a mechanism for Defence to alert the RSL when an ADF member discharges into a particular area, with appropriate privacy protections and potentially an 'opt in' provision for the ADF member before the service is activated.



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## Additional Points

A number of veteran and ESO ‘mapping’ projects have recently been conducted or are currently ongoing, however, there remains no authoritative data on where veterans live. The patchy provision of veterans’ services across the country will be difficult to remedy as long this remains the case. To obtain an accurate understanding of the geographic distribution of veterans, RSL NSW recommends that the Australian Bureau of Statistics include in the 2021 Census of Population and Housing specific questions to identify those with past or current defence service.

Recommendations:

46. The Australian Bureau of Statistics should include in the 2021 Census of Population and Housing specific questions to identify those with past or current defence service.



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## Concluding Remarks

In pursuing reform and improvement within DVA and the broader veterans' sector, the needs of both the current and future generations of defence personnel should stand as a guide, specifically:

- A professionalised national model to ensure nation-wide access to a consistent, high-quality standard of advocacy and support services for veterans;
- Adequate and accessible training and support for both professionals and volunteers in the sector, including advocates claims advisors, support workers, carers, and families of veterans;
- A shift towards a consumer-directed care model of rehabilitation focused on outcomes; and
- Minimisation of inefficient spending (on everything from one-size-fits-all medical treatments to DVA offering services already provided by ESOs) as a means of maximising both well-being of veterans and their families, and value for taxpayers.

In particular, RSL NSW urges the need for DVA to concentrate resources towards build strategic capacity in major ESO service providers. The intricacies of military service, its impact on veterans, the realities of medical diagnosis, and the need to ensure value for taxpayers, combine to prevent radical simplification of the system for compensation and rehabilitation, and so the crucial role of ESO service providers is unlikely to disappear. Yet the diminishing capacity of volunteer advocates and claims advisors bring the volunteer-based system of advocacy to its knees within the next 5 - 10 years.

RSL NSW appreciates the focus of the Productivity Commission on the issues around the system of veterans' compensation and rehabilitation, and appreciates the opportunity to contribute its voice and experience. RSL NSW strongly urges consideration of the recommendations put forward in this submission.

RSL NSW notes that a separate scoping study is ongoing, having been commissioned by DVA to investigate the veterans' advocacy space. The Veteran's Advocacy and Support Services Scoping Study is being led by Mr Rob Cornall AO, and is running concurrently with the Productivity Commission's inquiry. RSL NSW has made a separate submission to this study.



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**Appendix 1: Summary of Recommendations**

1. The existing three Acts should be maintained rather than merged or replaced, with such efforts instead directed towards simpler and more effective areas of improvement in order to achieve more immediate results.

2. DRCA clients should be entitled to a DVA Gold Card on equivalent impairment points to VEA and MRCA clients.

3. The existing Gold, White and Orange DVA health entitlement cards should be renamed to 'Full', 'Partial' and 'Pharmaceuticals' respectively, without garish colouring, to remove their connotation as prizes to be won.

4. All current Statements of Principles should be extended to apply to claims under DRCA, and future SoPs should be applied to all three Acts simultaneously.

5. All 31 Streamlined Conditions under MRCA should also be applied to DRCA claims.

6. Where they do not apply already (23 of the total 31), all Streamlined Conditions under MRCA should also be applied to VEA claims, and future streamlining should be applied to all three Acts simultaneously.

7. DVA should commit to regular reporting on is progress in actioning the recommendations of the Australian National Audit Office's 2018 report, *Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs*, and in meeting key service standards.

8. The implementation of DVA's Veteran Centric Reform programme should continue, and opportunities should be explored to hasten the process.

9. DVA should explore options to implement a policy that vulnerable or excessively combative clients, for whom dealing directly with DVA may be triggering or exacerbating their condition, be referred to an accredited professional ESO claims and advocacy service (as defined in Recommendation 25) or, if appropriate, an internal DVA case manager.

10. DVA should conduct an internal capability review and investigate the need for comprehensive frontline staff training in dealing with vulnerable clients and frequent verbal abuse, including successfully identifying vulnerable and at-risk clients; and appreciation of the breadth of day-to-day realities of life in Defence, including on the specific challenges faced by women in Defence.

11. In line with its Veteran Centric Reform programme, DVA should set a target of 15% of frontline staff drawn from suitable candidates with Defence backgrounds by 2020.



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12. DVA should commission a thorough, independent investigation of its current schedules of fees, comparing its payments for services against the AMA schedule of fees and an appropriately sized sample of actual health specialists' fees across the country, and commit to providing adequate and reasonable payments for each listed item based on the findings.

13. Upon the completion of this investigation, DVA should explore the need for a compliance programme to ensure specialists do not charge DVA clients more than non-DVA clients for the same services.

14. DVA should make a list of registered health care providers publicly accessible on their website, based on the Department's internal register of health care providers which have advised they will accept the DVA fee as full payment for health care services.

15. DVA funding for research should be made conditional upon the inclusion of 'clinical applications' as a research outcome. This research should then be distributed to major ESO service providers (for forwarding on to advocates, etc.) and made easily available online.

16. The preceding two recommendations should be facilitated by a redesigned DVA website, prioritising the presentation of thorough information in a simple, clean and intuitive format.

17. DVA should set up a direct-line help desk for professional advocates, claims advisors and support workers to have direct access to DVA delegates who can answer technical questions.

18. DVA should work more closely and cooperatively with individual clients, via an advocate or claims advisor when appropriate, to fill gaps in the evidence attached in support of a claim. When a claim is unsuccessful despite this communication, the veteran and/or their family should be informed openly, sensitively and promptly of the specific reasons for the outcome.

19. DVA and the Department of Defence should implement a joint campaign highlighting the breadth of veteran status, specific entitlement programmes and the progress of Veteran Centric Reform. The participation of Defence in this project would help to reach current-serving members, including Reservists, before they discharge and begin transition. This aligns with Recommendation 20 of the August 2017 Senate report, The Constant Battle: Suicide by Veterans.

20. The rollout of ADR should continue, and opportunities should be explored to further increase the efficiency of the appeals process.

21. Appeals to the Veterans' Review Board should be immediately opened to DRCA claims (preferably along with the acceptance of Recommendation 23 regarding a review of VRB funding).

22. The right to legal representation, currently available at the AAT, should not be extended to the VRB.



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23. A review of VRB funding should be conducted to ensure it has sufficient resources to handle the increased workload that will result from the expansion of ADR to Queensland, as well as the expansion of VRB access to DRCA claims (as outlined in Recommendation 21).

24. Immediate steps should be taken to create a peak body of ESO service providers as a joint venture of major professional ESOs, based on the Australian Council for International Development (ACFID) model in the international development sector. DVA should commit to funding the operations of this body, which should be governed by its own Constitution, should maintain a Code of Conduct, and should be formally partnered with DVA under a Partnership Memorandum of Understanding to establish a system of self-regulation in the veterans' services sector.

25. Membership of this peak body should be open to professional ESO service providers which meet specified standards of service quality and consistency; competency and stability of claims advisors, advocates and support workers; fundraising; governance; financial reporting; and complaints handling; and which can maintain accreditation by demonstrating ongoing compliance with the peak body Code of Conduct.

26. This peak body of professional ESO service providers should have responsibility for:
    - administering the formal accreditation of professional ESO advocacy and support service providers assessed as meeting specified standards of service quality and consistency; competency and stability of claims advisors, advocates and support workers; fundraising; governance; financial reporting; and complaints handling;
    - maintaining a Code of Conduct defining standards of best practice that should be adhered to by accredited member organisations, including a requirement for annual reporting, appropriate checks and balances, and an independent complaints-handling process;
    - establishing a review process, conducting regular audits (every three to five years), and reporting publicly on the compliance of accredited member organisations;
    - maintaining strong working relationships with DVA, the Department of Defence, and the Defence Force Ombudsman (with broadened responsibilities as outlined below and in Recommendation 27), while maintaining a non-partisan stance overall;
    - engaging member organisations, implementing a formalised and structured system of connectedness and knowledge sharing between advocates, claims advisors, support workers and carers, both professional and volunteer (including a reporting-back process), and facilitating cooperative problem solving through joint service delivery.
    - coordinating and leading member organisations, while being accountable to them for performance; and
    - administration of the Advocacy Training & Development Program (ATDP).



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27. The responsibilities of the Defence Force Ombudsman (the Commonwealth Ombudsman) should be broadened to include analysing veteran complaint data from a range of sources, including official and informal channels. This would enable the office to identify systematic and emerging issues in DVA, the Veterans' Review Board, the proposed peak body of ESO service providers (as per Recommendation 24), and all associated programmes. The office's remit should further include review of the quality of DVA's administration and its advice to government. Analyses stemming from this recommendation would be used to inform decision making as well as a two-yearly review of the legislation surrounding Veterans' compensation and rehabilitation.

28. Professional ESO service providers should commit to exploring and investing in strategies and infrastructure to enable and expand non-physical communication between major cities and regional hubs (Skype interviewing, for example). If Recommendation 24 is actioned, this commitment should be formalised as a condition for accreditation with the proposed peak body.

29. All volunteer advocates, claims advisors ('pensions officers') and support workers ('welfare officers') should individually require the endorsement of a professional ESO (which has itself been accredited as per Recommendation 25) in order to qualify for indemnity insurance through the Veterans' Indemnity and Training Association (VITA). This requirement should not apply to volunteers holding and appropriate professional qualification and current accreditation with the relevant professional organisation.

30. Beyond the useful basic standard of ADTP, ESOs should be free to train endorsed volunteers to a higher standard. There is no need, however, for a one-size-fits-all professional training model to be adopted by ESO service providers, although they should be expected to train their paid claims advisors, advocates and support workers to a higher standard than the ATDP.

31. DVA should investigate the viability and potential benefits of training sessions for individual veterans and family members to manage their own claims independently, including navigating the legislation, and identifying and collecting supporting documentation. Options should be explored to run claims workshops either online (perhaps linked to the online claim form) or face-to-face (with classes run on a rotating basis in rural, regional and metropolitan population centres around the country). Those applying for the course could be screened for mental illness and other areas of vulnerability such as trauma, and if necessary referred on to a professional claims advisor.

32. Professional ESO service providers should commit to genuine strategies aimed at increasing the number of female claims advisors, advocates, support workers, and other client-facing staff, including via a condition of accreditation with the peak body proposed in Recommendation 24.

33. Mental health support currently available under DVA's Non-Liability Health Care programme should be expanded to the immediate families of veterans, including parents and partners, to maximise outcomes for veterans themselves. This aligns with Recommendation 19 of the Senate Foreign Affairs, Defence *and Trade References Committee's August 2017* report, *The Constant Battle: Suicide by Veterans*.



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34. DVA should explore opportunities, in partnership with major ESO service providers and other experienced NGOs supporting carers across Australia, to introduce a comprehensive peer support programme for the families and other volunteer carers of vulnerable veterans. The programme should focus on creating local, face-to-face support networks allowing and encouraging carers can come together and help each other with practical support and advice, rather than online support groups. An effort should be made to incorporate this programme within existing carers' programmes throughout Australia to avoid duplicating existing services.

35. ESOs providing professional counselling and case management services (and accredited as per Recommendation 25) should be eligible to receive BEST grant funding from DVA to support these services, alongside the funding already available for claims advice and advocacy services. The specific funding model is outlined in Recommendation 37 below.

36. BEST grants should also cover reasonable costs associated with the training and support of volunteers endorsed by a professional ESO service provider as per Recommendation 29. DVA should investigate the appropriate level of funding per volunteer endorsed in consultation with the major professional ESO service providers likely to be endorsing volunteers. Factors deserving consideration in this investigation will include the cost of training and refresher courses through ATDP, travel expenses for volunteers to attend courses, and compensation for missed work and associated expenses, including child care, hiring farm hands, etc., and costs incurred by ESOs opting to train volunteers to a higher standard than ATDP.

37. DVA should review its funding of professional ESO service providers and formalise the role of BEST grants through a joint funding model whereby both DVA and an ESO provider of claims, advocacy and/or support services to veterans would contribute equally towards service provision, each bearing half the funding cost. RSL NSW recommends an initial total DVA target for the annual funding of professional ESO service providers comprising:
    - a base amount to boost strategic capacity within major ESOs;
    - a supplementary, uncapped amount to cover professional counselling and case management services, based on an ESO's documented and reported workload (measured in hours worked, number of clients, and number of sessions) together with the DVA schedules of fees for Social Workers or (if the need can be demonstrated) Psychologists/Clinical Psychologists (with DVA to cover half the cost as outlined above); and
    - an additional amount per volunteer trained and supported by an ESO, to be investigated by DVA in consultation with major professional ESO service providers, as outlined above.

38. DVA should ensure its BEST grants are awarded only to meticulously vetted professional ESOs providing relevant services (i.e. those accredited with the proposed peak body as per Recommendations 24 & 25) to ensure funds are not spread overly thinly.


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39. DVA should implement a comprehensive five-year trial programme of a consumer-directed care model for rehabilitation services to veterans with service covered by DRCA and MRCA. If successful in improving outcomes for veterans, this model will be extended to VEA clients on an opt-in basis. When a client claims for rehabilitation services, a DVA delegate or case manager should conduct an initial assessment to determine the client's suitability for a consumer-directed care model of rehabilitation. Different clients can be offered individualised levels of control and flexibility along a continuum from a high level to a low level.

40. The new model should be supported with access to professional case management. Those veterans or family members identified as vulnerable or at-risk, either by DVA staff (in line with Recommendations 9 & 10) or through an assessment passed on by Defence, should be encouraged to engage either an internal DVA case manager (when an initial assessment deems it likely that their vulnerability stems from their service, and the client is comfortable dealing with departmental staff), or an ESO/independent professional case manager (in other cases). Veterans not identified as vulnerable or at-risk should still be informed of the availability of professional ESO case management services. Case management should remain strictly optional for all veterans and family members applying for rehabilitation services.

41. The new CDC model for veterans' rehabilitation should make approval of any treatment contingent upon the support of the client's assigned case manager.

42. DVA clients receiving rehabilitation support through the CDC model should participate in a minimum yearly review along with a DVA delegate, their carer, and case manager, to assess the success of the client's treatment in a safe, non-threatening environment, and ways to improve it if necessary.

43. When a serving Defence member goes through the defence health system, the treating doctor or specialist should be required to flag an incident and resulting condition as service-related on the individual's medical record.

44. DVA and the Department of Defence should explore joint opportunities to improve waiting times for DVA delegates accessing Defence personnel records.

45. The Defence Community Organisation should collaborate with RSL in each state and territory (as the ESO with the greatest geographical reach and overall capacity) to produce a local community integration support service consisting of a 'welcome pack' of useful information and contact details for local services, organisations and events, together with practical assistance including making direct introductions to schools, etc. This would require a mechanism for Defence to alert the RSL when an ADF member discharges into a particular area, with appropriate privacy protections and potentially an 'opt in' provision for the ADF member before the service is activated.

46. The Australian Bureau of Statistics should include in the 2021 Census of Population and Housing specific questions to identify those with past or current defence service.