6

Falling Through the Cracks

6.1 This chapter considers the three outcomes available to an Australian Defence Force (ADF) member who has been wounded or injured on Operations; a full return to work, transfer specialisation, or discharge. This Chapter also considers the medical classification process, and moves toward the role that the Department of Veterans' Affairs (DVA) plays in the recuperation process post-discharge. It also considers a reassessment of veteran health care eligibility.

6.2 The Department of Defence (Defence) submitted that they have a new policy to confirm the Member Support Coordination arrangements. Member Support Coordination is the overall coordination effort required to ensure that a member, whose circumstances meet the definition of complex, is effectively supported throughout their recovery, rehabilitation and either their return to duty or transition from the Australian Defence Force (ADF). Responsibility for the initiation and management of such coordination resides with the member's Commander.[1]

Return to work

6.3 Major General (MAJGEN) Angus Campbell DSC AM, Deputy Chief of Army, told the Committee that of the then 249 personnel physically wounded in Afghanistan (two from Navy and the rest from Army), 69 per cent had returned to full duties.[2]

6.4 Defence submitted that they are committed to ensuring that, for those servicemen and women who become wounded and injured due to their

---

1 Department of Defence, *Submission 17*, p. 19.

2 Major General (MAJGEN) Angus Campbell DSC AM, Deputy Chief of Army, *Committee Hansard*, 19 March 2013, p. 6.

participation on Defence operations, their recovery, rehabilitation and return to work is a priority.

6.5 The increased focus on a recovery-based, return to work approach to rehabilitation in the ADF has seen a significant increase in rehabilitation referrals and rehabilitation programs over the past two years.[3] Air Marshal Mark Binskin AO, Acting Chief of the Defence Force, advised the Committee that Defence has extended the time that wounded, ill and injured personnel can remain on rehabilitation programs with the express intent of retaining them in the ADF.[4]

6.6 The Committee received evidence, however, that this has not always been the case. One Defence member, despite consistently requesting rehabilitation back into the workforce, submitted that the ADF was not willing to interpret the progressive nature of the return to work goals and jumped straight to transition out of the ADF, presupposing a negative rehabilitation outcome.[5] Young Diggers, however, submitted that when a member can return to work, the arrangements in general appear reasonable.[6]

6.7 The Australian Centre for Post-traumatic Mental Health (ACPMH) highlighted the importance of ensuring a clinically sound and consistent assessment practice. This included integration with general health services noting that it will be critical that the assessment process is ongoing. This would then ensure that assessments retains a focus on maximising rehabilitation outcomes, whether within Defence or through discharge.[7]

Change of employment

6.8 The history of the ADF over many years has shown that personnel who have been wounded or injured may still be able to perform duties that support the more active personnel, such as clerical support, administration of stores, transport and movement control. The Vietnam Veterans' Association of Australia (VVAA) encourage the ADF to provide retraining and employment to wounded and injured veterans no longer

3 Department of Defence, *Submission 17*, p. 19.

4 Air Marshal (AIRMSHL) Mark Binskin, Acting Chief of the Defence Force (CDF), Department of Defence, *Committee Hansard*, 9 October 2012, p. 1.

5 Name withheld, *Submission 6*, p. 2.

6 Young Diggers, *Submission 22*, p. 1.

7 Australian Centre for Post-traumatic Mental Health, *Submission 23*, p. 2.

able to maintain the military skills and knowledge that would otherwise be lost.[8]

6.9 Through clinical and occupational rehabilitation services, Defence argues that it is successfully reducing the impact of injury or illness, including mental health conditions, and returning significant numbers of ADF personnel to the workforce.[9] The Chairman of Soldier On, Professor Peter Leahy AC, agreed, making the point that:

> As we went to war and we started getting wounded soldiers again, the question was: how do we keep these people? That is where we are at the moment culturally and that is why I applaud what [Lieutenant General] Ken Gillespie and [Lieutenant General] David Morrison are doing: they are keeping their soldiers, they are retraining them and, where they can, they are giving them jobs that they can do.[10]

6.10 Major General (MAJGEN) (Retired) John Cantwell AO DSC praised the ADF remarking that 'We have grown up'. He told the Committee that in the past, a medical downgrade had meant automatic discharge. The ADF is now being smarter and trying to retain skills where possible. The result being that there are people with missing limbs working in headquarters or elsewhere:

> Why on earth cannot someone who has shown some difficulties emotionally be looked after, given a job that is not so demanding and difficult, with flexible hours, a chance to get some therapy and to stay in uniform for a bit longer.[11]

Medical Employment Classification Review Board

6.11 The Returned and Services League of Australia (RSL) Queensland Branch submitted that there are serious issues with the time taken by the ADF to arrange Medical Employment Classification (MEC) Review Boards (MECRB), which currently take three to four months to convene.

6.12 Further, DVA is not always advised of the results of the MECRB decision for the member to separate from the ADF, and therefore their claims for compensation may not be finalised by the time the member separates from the ADF.[12]

---

8 Vietnam Veterans' Association of Australia, *Submission 27*, p. 4.

9 Department of Defence, *Submission 17*, p. 19.

10 Professor Peter Leahy AC, Chairman, Soldier On, *Committee Hansard*, 27 November 2012, p. 6.

11 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 11.

12 Returned and Services League of Australia, *Submission 11*, p. 3.

Discharge and transition

6.13 The ADF Rehabilitation Program aims to support a member's return to work in current or different duties or trade or, if this is not possible, they will be rehabilitated, medically separated and supported to transition to the civilian environment.[13] General Cantwell sympathised:

> There is not necessarily a happy ending. Some people will be medically downgraded, and permanently so. They will then be shown the door, unfortunately. I have met people like that. It has broken their hearts.[14]

6.14 There was widespread praise of the support provided by Defence and DVA which was described as mostly very good[15] or excellent.[16] The Returned and Services League (RSL) of Australia's South Australian branch believed that the transition from the ADF is well handled by the ADF and the broader RSL organisation believes that there is generally good support provided by DVA and other agencies to ensure that the management of these personnel is efficient and is handled with empathy. However the RSL submitted that this that but should be enhanced.[17]

6.15 Notwithstanding the generally positive view of the provided by Defence and DVA, some members submitted that they received no help, counselling, or support from the ADF or DVA while their discharge was being processed.[18] Young Diggers submitted that if the member is going to be discharged, then in some cases the treatment deteriorates as the member gets closer to discharge.[19]

6.16 Within the mental health sphere, the ACPMH highlighted the importance of mental health service system clinical roles being clearly demarcated and delineated, and that providers are trained and capable of delivering current evidence-based interventions for the key post-operational mental health problems and disorders. This requires high quality and consistent training models, effective on-going clinical supervision opportunities, and quality assurance mechanisms.[20]

---

13 Department of Defence, *Submission 17*, p. 19.

14 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 11.

15 Young Diggers, *Submission 22*, p. 1.

16 Soldier On, *Submission 18*, p. 4.

17 Returned and Services League of Australia, *Submission 11*, p. 2.

18 Name withheld, *Submission 14*, p. 2.

19 Young Diggers, *Submission 22*, p. 1.

20 Australian Centre for Post-traumatic Mental Health, *Submission 23*, p. 3.

6.17 The RSL Western Australian Branch (RSL WA) submitted that entitlements and avenues of appeal need to be better explained and that the RSL should be nominated for this role.[21] The Committee did hear that members were often unaware of their entitlements when they are preparing to discharge.[22]

Medically unfit for further service

6.18 Defence submitted that in an effort to achieve a seamless transition for a member, the various elements of Defence (including Joint Health Command, the three Services, and the Defence Community Organisation (DCO)) and DVA work closely and collaboratively. Defence highlighted the particular importance of early involvement of DVA to ensure that the appropriate arrangements for support post-discharge are understood.[23]

6.19 Dr Andrew Khoo, a consultant psychiatrist and the Director of Group Therapy Day Programs at Toowong Private Hospital (TPH), submitted that care should also be taken to involve the ADF member as much as is reasonably possible in decision making. He noted that the process of resolving the loss of one's career path is easier for an individual if they feel that it was their considered choice, or at least that their difficulties were acknowledged. He submitted that a collaborative process of medical discharge would allay the feelings of abandonment by the Services often reported in recently discharged personnel.[24]

6.20 It was pointed out that this perception of rejection contributes in a significant way to anger and guilt, both of which are poor prognostic factors in post-traumatic stress disorder (PTSD), anxiety disorders, mood disorders and substance use.

6.21 Defence submitted that ADF members are referred to a regional ADF Transition Centre as soon as it is deemed likely that they may be classified as 'MEC 4' (indicating a member is neither employable nor deployable), and therefore medically separated from the ADF. There are 18 regional ADF Transition Centres that advise and assist members and their families on accessing whole-of-government transition support services, completing Defence separation requirements and accessing separation benefits and entitlements.

6.22 As part of the separation preparation, the ADF Transition Centre links members to a variety of services including DVA compensation,

---

21 Returned and Services League of Australia WA Branch, *Submission 4*, p. 1.

22 Mr Mervyn Jarrett, President, Young Diggers, *Committee Hansard*, 25 March 2013, p. 19.

23 Department of Defence, *Submission 17*, p. 19.

24 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, pp. 4–5.

ComSuper, Centrelink, Veterans and Veterans Families Counselling Service (VVCS) and other support services as required.[25]

6.23 The Vietnam Veterans' Association of Australia (VVAA) submitted, however, that the medically unfit for further service process (as assessed by their welfare officers, pension officers and advocates) lowers the moral of those personnel affected in that they feel uncertain of their future prospects and that they have no control of their situation. This was said to lead to stress and depression, and in many cases leads to the need for mental health treatment that may not otherwise be required.[26]

6.24 Organisations such as Soldier On are assisting with programs linking soldiers to employment in the private sector and have five veterans currently being supported through the recruitment process and being matched to jobs.[27]

Member support coordination

6.25 In a recently released Defence Instruction, Defence has recognised that Defence members who find themselves in complex circumstances that have the potential to restrict, alter or end their service, require effective command-initiated and coordinated support. Such circumstances may result from being wounded or injured on operations, but also equally apply to those diagnosed with a serious illness or suffering some other injury resulting in significant disruption to the member's career and/or personal and family circumstances.

6.26 Defence states in the Instruction that it is committed to supporting members, and their families, who find themselves in complex circumstances throughout the member's recovery, rehabilitation and either their return to duty or transition from the ADF. Member support may also involve interaction with a range of service providers internal and external to Defence.[28]

6.27 Member Support Coordination is therefore the overall coordination effort required to ensure that a member in complex circumstances is effectively supported throughout their recovery, rehabilitation and either their return to duty or transition from the ADF. The RSL's National Conditions of Service Committee submitted that their only criticism of the new policy is that it places strain on the member's parent unit.[29]

---

25 Department of Defence, *Submission 17*, p. 19.

26 Vietnam Veterans' Association of Australia, *Submission 27*, p. 5.

27 Professor Peter Leahy AC, Chairman, Soldier On, *Committee Hansard*, 27 November 2012, p. 4.

28 Department of Defence, *Member Support Coordination*, DI(G) PERS 11-3, 30 January 2013.

29 Returned and Services League of Australia, *Submission 11*, p. 5.

Health care support transition

6.28 Defence advised the Committee that the transition from ADF managed health care and support to that managed by DVA is the responsibility of the relevant single Service. Transition support services provided by the Directorate of National Programs in DCO seek to ensure that members and their families remain well informed, and are encouraged to access educational, financial, rehabilitation, compensation and other government services to facilitate a sound transition.

6.29 Informing military members of these transition support services is one of the roles of the regional ADF Transition Centres, where members are required to finalise their administrative arrangements well before their date of separation from the ADF.

6.30 Defence submitted that if a member is on a Rehabilitation Program, then prior to separation the Joint Health Command assigned Rehabilitation Consultant ensures the member understands, and has access to, all appropriate services and ensures the member completes all required separation tasks. The ADF Rehabilitation Program provides access to vocational and functional assessments to assist the member in determining appropriate vocational choices post-separation. The Rehabilitation Consultant also works closely with ADF Transition Centres and the DVA to provide information to assist in their determination regarding funding and training requirements.

6.31 Defence submitted that it is also committed to providing flexible support for those military members who need to separate at short notice for medical or compassionate reasons. Separating members are provided with effective and appropriate rehabilitation support. The Rehabilitation Consultant liaises with all key stakeholders including the treating doctor, ADF Transition Centres, DVA and DCO to ensure all ongoing services required are in place, including medical assistance and vocational rehabilitation, before their transition to civilian life.

6.32 In addition to the regional ADF Transition Centres, information on transition support services is available through a variety of resources. For example, the ADF Transition Handbook is a quick guide to transition information, and support and is available on the internet.

6.33 Defence advised the Committee that the DVA On Base Advisory Service (OBAS) was introduced as a Support to Wounded, Injured and Ill Program (SWIIP) initiative in October 2011 at selected bases around Australia. Skilled DVA staff provide information, advice and support to all ADF members on matters relating to the provision of the DVA services and benefits. This service is provided using an agreed visit schedule ranging from five days/week to one or two days per week or month. This ensures

a more streamlined and integrated approach between Defence and the DVA to support wounded, injured or ill ADF members.[30]

6.34 Functions of the DVA On Base Advisory Service are to:

- Provide information and support relating to DVA services and benefits to all ADF personnel who seek assistance;
- Provide support for any current or prospective compensation claims;
- Provide early identification of health, rehabilitation and income support requirements post discharge;
- Liaise with ADF Rehabilitation Program to identify injured personnel and provide appropriate advice and support;
- Liaise with Support Coordinators and other Defence personnel dealing with injured ADF personnel and provide appropriate advice;
- Present and participate in transition management seminars and information sessions and events;
- Where requested, brief ADF personnel and families as part of their pre- and post-deployment briefings;
- Identify and report on trends and issues arising; and
- Develop and maintain relationships with the ADF community, Garrison Health Operational Staff, ADF rehabilitation consultants, Welfare Boards and where necessary, the Defence Transition Cell.[31]

6.35 Defence submitted that the co-location of DVA officers in Joint Health Command health facilities wherever possible has encouraged a collegiate approach between the two Departments ensuring ADF personnel are provided timely and accurate advice. A commitment to the longer term availability of this service has been undertaken and this includes ongoing access to existing infrastructure capability within Defence health facilities.

6.36 The implementation of the DVA OBAS is a significant service delivery enhancement for members of the ADF. Member enquiries to the On Base Advisory Service have steadily increased since the service's inception, and feedback received in relation to the service has reportedly been positive.[32]

6.37 Nevertheless, RSL WA submitted that there is a problem with some members understanding that all aspects of their claims need to be recorded and documented prior to separation, and that considerable support is required in this critical area of activity. RSL WA submitted that

30 Department of Defence, *Submission 17*, pp. 19–20.

31 Department of Veterans' Affairs, *Submission 18*, p. 14.

32 Department Defence, *Submission 17*, p. 21.

this also needs to be strongly enforced by ADF administrative staff well before separation and not left to the individual to ensure it is done.[33]

How DVA recognises service-related injuries

6.38 DVA submitted that if a serving or ex-serving ADF member has a medical condition (including due to injury or wounding) for reasons related to their service, then he or she may make a claim to DVA for rehabilitation, compensation, care, or a combination of these. DVA assesses claims to establish if there is a connection between an illness, injury or disease and service in the ADF.

6.39 DVA submitted that it operates under complex legislative arrangements. Most claims are assessed under one or more of three pieces of legislation:

- the *Veterans' Entitlements Act 1986* (VEA);
- the *Safety, Rehabilitation and Compensation Act 1988* (SRCA); and
- the *Military Rehabilitation and Compensation Act 2004* (MRCA).

6.40 Claims under VEA or MRCA are assessed using Statements of Principles for any disease, injury or death that could be related to military service, based on sound medical-scientific evidence.

6.41 The Repatriation Medical Authority (RMA) consists of a panel of practitioners eminent in fields of medical science whose role is to determine the Statements of Principles which are the factors that 'must' or 'must as a minimum' exist to cause a particular kind of disease, injury or death. Claims under SRCA are assessed using available medical evidence to support consideration of a disease, injury or illness.

6.42 DVA noted that in its 2010-11 Annual Report, the RMA stated that since its inception, it has determined 1,833 Statements of Principles, with 304 particular kinds of injury or disease currently covered by these Statements of Principles.

6.43 DVA submitted that if a claim is accepted, then services may include rehabilitation (including vocational assistance), medical treatment (either through reimbursement of medical or care expenses or the use of White or Gold Repatriation Treatment Cards), attendant care, household services, and a range of other benefits – depending upon the particular illness, disease or injury, and its level of severity.

6.44 Financial assistance may also be provided for an inability or reduced ability to work, or to recognise the effects of a permanent impairment resulting from a service-related event.[34]

33 Returned and Services League of Australia WA Branch, *Submission 2*, p. 1.

34 Department of Veterans' Affairs, *Submission 18*, p. 13.

Stepping Out

6.45 DVA's Veterans and Veterans' Families Counselling Service (VVCS) run Stepping Out which is designed to help the transition from the ADF to civilian life. In the program, participants learn about:

- The experience of change as part of life,
- The transition from the ADF to civilian life,
- Skills for planning ahead,
- Skills for staying motivated and adaptable,
- Expectations, attitudes and troubleshooting, and
- Maintaining relationships and seeking support.

6.46 This voluntary Program is held over two full days and is available across Australia through the fifteen VVCS centres. It is available for all ADF personnel and their partners who are in the process of separation from the ADF or have separated in the last twelve months. Currently serving personnel attending the program are considered to be on duty for the duration of the program, and the program is endorsed by the ADF.[35]

6.47 Stepping Out is a voluntary program which was developed for ADF members and their partners who are about to leave the military, or those who have recently done so. DVA has increased marketing of Stepping Out over the last three years, including presenting at all transition seminars and on key ADF bases. This has increased the take-up of the program from 138 in 2008-09 to 333 in 2010-11, and DVA anticipate the uptake continuing to increase.[36]

Defence/DVA connectivity

6.48 DVA submitted that once they have left the military, former personnel who are wounded, injured or ill from operations are a sub-group of veterans with operational service, and all ex-serving personnel. Accordingly, wounded or injured personnel from recent operations share characteristics with their contemporary peers on top of the unique experience of and needs arising from their own injury.

6.49 Between 4,000 and 6,000 personnel leave the ADF each year to form the broader group of all ex-serving ADF personnel. This includes those who retire, resign, or who are discharged, including for medical reasons. This

35 Department of Veterans' Affairs, *Submission 18*, p. 16.

36 Ms Judy Daniel, First Assistant Secretary, Health and Community Services, Department of Veterans' Affairs, *Committee Hansard*, 9 October 2012, p. 9.

broader group has a range of different service experiences, including peacetime service.

6.50 Some personnel with peacetime service only may also become ill or injured as a result of their service, for instance from serious accidents such as the 1996 Black Hawk helicopter accident.[37]

6.51 Just over 60 per cent of serving personnel in a recent Defence survey reported that they had been deployed, including 43 per cent reporting they had multiple deployments. As at June 2011, this level of deployment contributed to a count of around 45,000 surviving veterans with operational service from conflicts since 1999.[38]

6.52 Defence submits that it ensures ADF members receive a smooth transition to the DVA and other support agencies. This includes a handover from the ADF Rehabilitation Consultant of key information and the Rehabilitation Authority to the DVA.[39] Air Marshal Binskin highlighted the importance of Defence's close cooperation with DVA to ensure the transition from ADF managed care and support to DVA managed care and support is seamless.[40]

6.53 Similarly, DVA submitted that it is working closely with the ADF to make the process of discharge from the military into civilian life as smooth as possible, including for those personnel who have sustained wounds or injuries from their service.[41]

6.54 For personnel discharging from the military, the move to civilian life (also known as 'transition') can be a stressful process. For those who are wounded, injured or ill there are additional challenges, including accessing care and support that will address their needs appropriately. For instance, an ADF member may also be changing locations and not able to access the same health care or rehabilitation provider. They may also need specialised assistance in re-location and setting up arrangements at home, work, and for transport.[42]

---

37 On 12 June 1996, two Black Hawk helicopters collided and crashed at the High Range Training Area near Townsville, resulting in the deaths of 18 Australian Regular Army personnel and injuries to a further 12 personnel.

38 Department of Veterans' Affairs, *Submission 18*, pp. 7-8.

39 Department of Defence, *Submission 17*, p. 20.

40 AIRMSHL Mark Binskin AO, Acting CDF, Department of Defence, *Committee Hansard*, 9 October 2012, pp. 1-2.

41 Department of Veterans' Affairs, *Submission 18*, p. 15.

42 Department of Veterans' Affairs, *Submission 18*, p. 15.

6.55 The Committee repeatedly heard that ensuring that transition arrangements between Defence and DVA for clients are as seamless as possible is a priority for both agencies. DVA quoted Minister Snowdon:

> …as well as having responsibility for Veterans, I also have responsibility in the Defence portfolio, for Personnel matters. And what is clear to me that the leadership in both organisations understand the need for collaboration and integration in servicing the needs of our current serving veterans. Particularly those in transition.
>
> And that's why since I took the job, now just on twelve months ago, I have worked hard to bring the Defence and Veterans Departments closer together.[43]

6.56 DVA further submitted that in May 2012, the Secretaries of the DVA and Defence and the CDF agreed key principles for delivering the best possible outcomes for all ADF personnel past and present. These principles set out the responsibilities of both agencies and how they will work together.

6.57 DVA has had a long involvement with helping ADF personnel move into civilian life. They submitted that from 2000 to 2011, the Department under contract from Defence, delivered a Transition Management Service for full-time serving personnel leaving the ADF on medical grounds. Following the cessation of the Department's role in this service, Defence has resumed full responsibility for the service though DVA continues to actively support Defence in the transition process.[44]

Connectivity perceptions

6.58 Young Diggers submitted that when a member gets a medical discharge their transition through to and including DVA is mostly very good, as is the ongoing health care[45] and the ACPMH submitted that the past decade has witnessed a significant increase in the collaborative relationship between Defence and DVA.[46]

6.59 The Committee received evidence, however, that instances of poor communication between Defence and DVA are occurring and families are not receiving the support they are entitled to require.[47] The RSL Victoria Branch submitted that ensuring communications between Defence and

---

43 Returned and Services League of Australia National Congress, 20 September 2011; via Department of Veterans' Affairs, *Submission 18*, p. 15

44 Department of Veterans' Affairs, *Submission 18*, p. 15.

45 Young Diggers, *Submission 22*, p. 1.

46 Australian Centre for Post-traumatic Mental Health, *Submission 23*, p. 2.

47 Name withheld, *Submission 2*, p. 2

DVA is vital and that poor communications have meant that treatment, rehabilitation and benefits support to ADF members wounded or seriously injured on operations has 'gone awry'.[48] RSL Queensland's State President, Mr Terence Meehan, advocated improvement in communications between the two Departments:

> Expedite the removal of the gulf that has existed between the Department of Defence and the Department of Veterans' Affairs. I am aware that both departments are working very hard to remove it, but it should be a seamless transition so that people who have put their lives on the line for Australia in uniform when they leave the Australian Defence Force and their families should continue to be looked after.[49]

6.60 Associate Professor Malcolm Hopwood, Clinical Director of the Austin Health's Psychological Trauma Recovery Service (PTRS), gave evidence that transition management was not as effective as would be desired. PTRS submitted that many individuals leaving the ADF are at risk of having, or have, an established mental health disorder and they are very concerned that there is often a significant delay after leaving the ADF before members receive effective mental health care. PTRS emphasised that it is a shared responsibility between Defence and DVA.[50]

6.61 Associate Professor Susan Neuhaus CSC submitted that it would appear that there are also a number of vulnerabilities, particularly for those without established claims, and for those who may not be aware of the linkages of their condition to their service. This is of particular relevance post transition from the ADF.[51]

6.62 Defence Families Australia (DFA) suggested that a single identification reference number for Defence personnel that is also used with DVA is needed to address this connectivity issue and recommended that the Personnel Management Keys Solution (PMKeyS) number be used by different agencies, making tracking of an individual simpler.[52]

6.63 Defence submitted that they are currently engaging with DVA on the possibility of a single identification (ID) number that works across both Departments. The aim would be to reduce complexity and resolve proof

---

48 Returned and Services League of Australia, *Submission 11*, p. 4.

49 Mr Terence Meehan, Queensland State President, Returned and Services League of Australia, *Committee Hansard*, 12 March 2013, p. 6.

50 Associate Professor Malcolm Hopwood, Clinical Director, Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, pp. 2, 7.

51 Associate Professor Susan Neuhaus CSC, *Submission 31*, p. 3.

52 Defence Families of Australia, *Submission 8*, p. 3; Ms Julie Blackburn, National Convenor, Defence Families of Australia, *Committee Hansard*, 12 March 2013, p. 3.

of identification from the start of a member's service by using an existing numbering system rather than introducing an additional number, but this will require further consultation and scoping.

6.64 Defence, through Joint Project 2080 Phase 2b.l a (the Defence Personnel Systems Modernisation (DPSM) project), has proposed to implement a 'Single Person ID' which will be integrated into PMKeys and will improve the ability to track individuals through a variety of relationships within Defence, over time. Defence went on to submitted that they are currently progressing through the design release of this phase of the project and will continue to consult with the DVA and other relevant stakeholders in relation to the possibility of a single identification number.[53]

6.65 The Committee feel that implementation of a single identification number is a fundamental and important initiative.

Recommendation 11

The Committee recommends that the departments of Defence and Veterans' Affairs expedite the development of a unique service/veteran health identification number.

6.66 The Legacy Australia Council submitted that an organisational gap exists in the continuity of care for wounded and injured personnel at the boundary between the Defence and DVA. They submitted that the organisational structure makes very difficult the achievement of unity of effort or to achieve continuity of care and support. A poor transition of a veteran from Defence to DVA complicates and extends their recovery at greater expense to Government and greater distress the veteran and their family.[54] General Cantwell agreed:

> I think there is still some difficulty in getting people to engage properly with DVA. I was very well managed by the Department of Veterans Affairs in my own transition, and I am very grateful for that. But I was a General and I probably got special treatment … Not every young man and young woman that we are discharging from the military has those advantages. There are some gaps in the ability of those people to engage with DVA.[55]

53 Department of Defence, *Submission 28*, p. 12.

54 Legacy Australia Council, *Submission 12*, p. 3.

55 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 6.

6.67 Professor Neuhaus also agreed with this assessment. She told the Committee that despite 'immense efforts' by DVA in particular to reach down into the group transitioning out of the ADF, there remain those who fall between the gaps in what is inherently a 'prismatic and polarised system'. She argued that it is a system where an accepted claim remains the gateway to accessing care.[56]

6.68 Austin Health's PTRS' principal concern with current arrangements lay in the distance between care arrangements under the auspices of the ADF, and those under the auspices of DVA, with the outcome being that many individuals with operationally related mental health disorders are often without treatment for an extended period after leaving the ADF.[57] Mr Tony Ralph, President of Brisbane Legacy highlighted that:

> Continuity of care is critical, and it is essential for organisational collaboration between all departments … and the wider community and health sector providers.[58]

6.69 Professor Neuhaus submitted that a system integrated across the spectrum of 'service-to-veteran' health care would not only provide greater equity of health care for all with service related health conditions, but would enable greater coordination and synergy between multiple care providers and agencies.[59]

6.70 Similarly, South Australia's Veterans' Health Advisory Council (VHAC) submitted that there is a need to improve local coordination of care and the development of a network of interested mental health professionals. The lack of funding and clear service delivery models has not led to any sustained coordination at the local level, at least in South Australia, they submitted. VHAC recommended the development of an agreed assessment procedure between ADF and DVA services, whether these services are in the private or public sector, and the establishment of coordinated clinical network of service providers who are known to provide evidence based care. Such a network would have components that address those who have first presentation and acute illnesses, as well as the need to establish long term coordinated rehabilitation services.

6.71 VHAC submitted that this would be a more effective and efficient delivery system. It would enable better management of demand, given that evidence indicates that interventions are more effective if they are provided early in the course of a disorder. Services were also said to be

---

56 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 16.

57 Psychological Trauma Recovery Service, *Submission 24*, p. 4.

58 Mr Tony Ralph, President, Brisbane Legacy, *Committee Hansard*, 7 December 2012, p. 15.

59 Associate Professor Susan Neuhaus CSC, *Submission 31*, p. 3.

required to address the diverse needs of different genders, and of families. VHAC submitted that there is a need for the future Mental Health Delivery system to be more robust and flexible, but coordinated.[60]

6.72 Additionally, DFA highlighted that there are barriers associated with the Privacy Act that reduce continuity of care for ADF members and sharing of information between ADF and DVA, providers and locations.[61]

6.73 Professor Sandy McFarlane AO summarised the issue and submitted that mental health services provided to currently serving members and ex-serving personnel should be at the same standards or better than those provided to the Australian community, which was a recommendation of the Dunt Report (the *Review of Mental Health Care in the ADF and Transition through Discharge*).

6.74 Professor McFarlane submitted that the nexus between Defence and DVA is even more important for those with mental health disorders than those with physical injuries due to the fact that many individuals with psychiatric injuries arising from being a member of the ADF are discharged without being diagnosed or treated. Professor McFarlane submitted that the Dunt Report has been, and should remain, the key driver to improving mental health care in the ADF. Professor McFarlane submitted that a number of its recommendations have taken on a new urgency with the findings of the 2010 A*DF Mental Health Prevalence and Wellbeing Study*, due to the rates of disorder identified.[62]

Electronic Health Records

6.75 DVA is also working with other agencies to help implement a new Personally Controlled Electronic Health Record (eHealth record). Participation in the eHealth record system is voluntary, with functions available incrementally from July 2012. The eHealth record system is open for consumer registration.

6.76 The VVCS information management system is planned to be compatible with the eHealth record system. If they consent to an eHealth record, VVCS clients can have summary information about services they receive from VVCS included in their eHealth record. If the client wishes, this summary information can be made available to other health care providers and their VVCS counsellor can see important information from other service providers.

---

60 Veterans' Health Advisory Council, *Submission 33*, pp. 2-6.

61 Defence Families of Australia, *Submission 8*, p. 3.

62 Professor Alexander (Sandy) McFarlane AO, *Submission 30*, pp. 4-6.

6.77 The eHealth record will assist in the transition process for current serving ADF personnel, in terms of appropriate care coordination for clients, including for those wounded or injured.

6.78 DVA has, since 2006, used an electronic system to manage requests to Defence for service and medical records to streamline the claims process and ensure records are returned to Defence as necessary.[63] MAJGEN Elizabeth Cosson AM CSC, the First Assistant Secretary, Client and Commemorations in the DVA admitted that at the moment, the Defence and DVA Information Technology systems do not communicate 'as effectively as you would want them to'.[64] Mr Sean Farrelly, the First Assistant Secretary for Rehabilitation and Support with DVA, told the Committee that:

> Systems do need to talk to each other and it is not as straightforward as any of us would like, but we are working hard on it.[65]

6.79 DVA is now working with Defence to ensure maximum interoperability with Defence's Joint eHealth Data and Information System Project. The purpose of this project is to develop and implement an ADF electronic health information system that will link health data from recruitment to discharge. It will generate an electronic health record for ADF personnel that with the client's consent may be used by health care providers after discharge. This system will also assist with claims for rehabilitation and compensation, enabling DVA staff to have shared access to necessary documentation.[66]

Retention of records

6.80 The RSL National Conditions of Service Committee submitted that Defence medical history files be released only to the member whilst he or she is alive, and that their permission be required for dissemination within the medical fraternity. They submitted that after a member's death, they should not be publicly released for a term of thirty years.[67]

63 Department of Veterans' Affairs, *Submission 18*, p. 21.

64 Major General Elizabeth Cosson AM CSC, First Assistant Secretary, Client and Commemorations, Department of Veterans' Affairs, *Committee Hansard*, 9 October 2012, p. 12.

65 Mr Sean Farrelly, First Assistant Secretary, Rehabilitation and Support, Department of Veterans' Affairs, *Committee Hansard*, 9 October 2012, p. 12.

66 Department of Veterans' Affairs, *Submission 18*, p. 21.

67 Returned and Services League, *Submission 11*, p. 6.

Memorandum of Understanding

6.81 DVA advised that a Memorandum of Understanding (MOU) between DVA and Defence has been developed to better coordinate the delivery of services to veterans, and particularly to create a continuum of service between Defence and DVA to ensure that there is clear responsibility at every point for one department or the other.

6.82 The MOU establishes key principles for the cooperative delivery of care and support arrangements for clients and is built on previous agreements between DVA and Defence, incorporating the formal recognition of responsibilities.

6.83 MAJGEN Dave Chalmers AO CSC, DVA's First Assistant Secretary for Client and Commemorations, told the Committee that Defence has the lead in caring for and supporting serving members. DVA has the lead in caring for and supporting widows, widowers and dependants, and wounded, injured or ill ex-service members. DVA is also responsible for providing compensation and other support to eligible serving and former members.[68]

United Minister

6.84 The National President of the RSL, Rear Admiral (RADM) (Retired) Ken Doolan AO told the Committee that the RSL had argued for some years that the Minister for Veterans' Affairs and the Minister for Defence Science and Personnel should be the same minister and that the current situation was a 'happy mix'.[69]

Health care community awareness

6.85 Ms Veronica Hancock, the Assistant Secretary for Mental and Social Health in DVA, told the Committee that DVA has several ways of engaging with providers, including some specific online training for community nurses. The training is designed to assist in recognising issues they may be related to an individual's war service. DVA has produced a mental health advice book specifically for general practioners designed to alert them to the sorts of symptoms and issues that they might be

68 MAJGEN Dave Chalmers AO CSC, First Assistant Secretary, Client and Commemorations, *Committee Hansard*, 19 March 2013, p. 3.

69 RADM (Rtd) Ken Doolan AO, National President, Returned and Services League of Australia, *Committee Hansard*, 12 March 2013, p. 6.

encountering when dealing with veterans.[70] Dr Graeme Killer, Principal Medical Advisor with the Department of Veterans' Affairs said:

> It is all about recognising veterans. As soon as someone comes in you ask them if they have military service, and if they do, a red light should come on.[71]

6.86 Professor David Forbes, Director of ACPMH, advised that the Centre worked with general practitioners to encourage them to more consistently ask questions about whether their patients are serving members, or have been serving members of the Defence Force. Professor Forbes told the Committee that ACPMH understands that, in many cases, general medical practioners may not even recognise that the patients they treat have been members of the ADF, and may not think to relate a medical condition to military service.[72]

6.87 Professor Neuhaus submitted that this complexity, and the lack of a unique veteran identifier within Federal, State and Territory Health organisations, creates challenges as it relies on the individual and/or their health professional to make a link between their medical condition and a particular aspect of their service.[73]

6.88 Professor Neuhaus told the Committee that the health community does not have a very good concept of what a contemporary veteran looks like, particularly in terms of reservists and women. She said that without a specific identifier or longitudinal tracking system that recognition was missing. She told the Committee that it was routine to identify Aboriginal and Torres Strait Islanders presenting to general practioners or hospitals for assistance. Medical admission forms routinely have a check-box to identify Aboriginal and Torres Strait Islander heritage; a similar check-box could identify ex/servicemen and veterans to assist healthcare professionals that a patient's medical condition could be associated with service.

Longitudinal tracking

6.89 Professor Forbes highlighted that providing longitudinal tracking or online identification systems can benefit the individual. The alternative would be to contact veterans who leave Defence on a periodic basis to

70 Ms Veronica Hancock, Assistant Secretary, Mental and Social Health, *Committee Hansard*, 19 March 2013, p. 1.

71 Dr Graeme Killer, Principal Medical Advisor, Department of Veterans' Affairs, *Committee Hansard*, 19 March 2013, p. 2.

72 Professor David Forbes, Director, Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 12.

73 Associate Professor Susan Neuhaus CSC, *Submission 31*, p. 3.

remind them about the DVA's existence and the fact that it is there to support them. Such an arrangement would also recognise that sometimes it can take time for physical or psychological issues to present.[74]

6.90 Carry On (Victoria) gave evidence that DVA should take up a greater monitoring role for all ex-servicemen, not just veterans.[75]

Uncontested healthcare liability

6.91 The Committee is concerned that a significant difference exists in the treatment of personnel who discharge with a condition that is recognised by DVA, and those who discharge and subsequently develop a service-related condition.

6.92 Professor Neuhaus told the Committee that in her opinion, a simpler, more elegant solution to the whole issue of veterans 'falling through the cracks' may be to consider an uncontested healthcare liability for all Australian servicemen and women who have served on active duty.

6.93 She submitted that, by accepting the system of comprehensive healthcare for life (which has parallels with the no-fault motor vehicle injury compensation schemes, or a gold card equivalent) there is the opportunity not only to honour the covenant that Australian society has with those who put themselves in harm's way for national interests, but also to 'swathe through layers of entitlement bureaucracy and red tape', and thereby decrease the distress to service personnel and their families of having to establish and verify claims and the accompanying secondary trauma.[76] Dr Khoo agreed:

> We have to decrease the barriers to care, because that is the biggest problem in accessing the guys. … It's a great idea. … We have to be freer with funding and less suspicious that somebody is talking about something that they might not actually have and are trying to fool the system.
>
> [Have I ever treated a patient that was just trying to get something out of the system?] Yes, but no-one with PTSD … or any military guys.[77]

74 Professor David Forbes, Director Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 12.

75 Mr Simon Bloomer, Executive Officer Carry On (Victoria), *Committee Hansard*, 7 December 2012, p. 22.

76 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 17.

77 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, pp. 14-16.

6.94 Professor Neuhaus submitted that this would enable the medical system to prospectively follow the latest cohort of veterans, provide visibility on future health issues and identify any such issues early enough to intervene and thereby avoid the anguish seen following the Vietnam conflict. It would separate the issue of compensation entitlement from the issue of care and enable DVA and other key agencies to focus on the provision of appropriate, timely and responsive healthcare to those who have served, and possibly garner significant national cost savings. She contended that many of those costs are already currently being met by Commonwealth resources through the Medicare system.[78]

6.95 The Committee concludes that regardless of any subsequent findings about the circumstances of an injury, veterans being treated by DVA should continue to be treated by DVA given that the costs will be borne by the Commonwealth either way. Furthermore, this would ensure greater continuity of care for veterans.

6.96 The Committee agrees that an uncontested healthcare liability model would be appropriate for Australian veterans.

Recommendation 12

The Committee recommends that the Government conduct a cost-benefit study of a comprehensive uncontested veteran healthcare liability model and publish the results.

6.97 VHAC submitted that amongst healthcare administrators and providers at a State level, there is little understanding of the fact that members leaving the ADF do not automatically become DVA clients on discharge. The fact that ADF members may leave Defence with health conditions that do not attract a DVA entitlement, as well as having deployment related health conditions, adds to this confusion. The State health system only identifies members with a DVA entitlement rather than ex-ADF members more generally.

6.98 This lack of identification of military service means that some ADF members may present with an illness that would attract a DVA entitlement but its relationship to military service has not been identified or assessed as the individual is not recognized as being an ex ADF member.[79]

78 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, pp. 17, 20.

79 Veterans' Health Advisory Council, *Submission 33*, p. 3.

Medicare

6.99 Defence submitted that equity with provisions of the *Health Insurance Act 1973* underpins the basic entitlement to the range of medical services provided to members of the Permanent Forces. Usually the range of, and ease of access to, health care provided to such members will exceed that available through the public health care system because of the requirement to meet and maintain operational readiness. However, from time to time the Surgeon General Australian Defence Force will issue policies which may exclude or limit the provision of certain medical or dental treatment on the grounds that such treatment is contra-indicated or unnecessary for operational readiness.[80]

Committee comment

6.100 The Committee agrees with the basic concepts outlined in the Defence White Paper and affirms that it remains critical that:

- The service has adequate staffing with psychiatrists and clinically trained psychologists that augment the primary health care system and that professional development of staff remains a high priority;
- These services need to be provided in the context of an occupational health model that addresses rehabilitation in the ADF context;
- Adjustment programmes need to address the future risk associated with subclinical symptoms;
- The quality and adequacy of services provided to those injured on deployment depends on the standards of care provided within the broader ADF community; and
- An ongoing health surveillance programme identifies emerging trends of physical and mental disorder in those who have deployed and monitors their treatment and that these findings are an initial driver for the introduction of innovative and high quality services.

6.101 The Committee notes Acting CDF's evidence that:

> We do not want even one member to fall through the cracks or feel unsupported, but we recognise that at times mistakes will be made. We are committed to learning from these mistakes and ensuring that they are not systemic or repeated in the future. We will work hand in hand with DVA to ensure our system and support mechanisms remain relevant, sensitive to members and

80 Department of Defence, *Submission 17*, pp. 2–3.

families, and provide the services our members require, both while in service and following the transition from the services.[81]

6.102 The Committee is nonetheless concerned about the health and welfare of servicemen and women transitioning out of Defence and agrees that no one must be allowed to 'fall through the cracks'.

Recommendation 13

The Committee recommends that the departments of Defence and Veterans' Affairs coordinate to clarify the Australian Defence Force/Veteran service delivery models to reduce the complexity, overlaps and gaps in service identified in this report.

The Committee further recommends that it be provided with a progress report within six months, and a final implementation report within 12 months.

6.103 The Committee is of the opinion that priority should be given to allowing wounded or injured members to carry on within the broader Defence organisation, if they are unable to stay in uniform.

Recommendation 14

The Committee recommends that a wounded or injured soldier who wishes to remain in the Defence environment and applies for a position within the Australian Public Service, for which they have the required skills and competencies, be selected preferentially.

The Committee further recommends that the Government encourage private sector providers to take a similar approach to the preferential employment of wounded and injured soldiers.

6.104 While there has been some criticism of the lack of information technology connectivity between Defence and DVA, the Committee acknowledges that it is not a simple process to introduce seamlessly connected systems. The Committee is pleased to note that DVA is working with Defence to get early access to health and personnel systems where appropriate.

81 AIRMSHL Mark Binskin AO, Acting CDF, *Committee Hansard*, 9 October 2012, p. 1 .

Nonetheless the Committee is concerned that progress is hampering service provision to veterans.

Recommendation 15

The Committee recommends that the departments of Defence and Veterans' Affairs expedite the rectification of information technology connectivity issues.

The Committee further recommends that it be provided with a progress report within six months, and a final implementation report within 12 months.

6.105 The Committee also agrees that it is imperative that the national health system is able to track identify personnel potentially wounded, injured or harmed by service in the ADF and prompt recognition of the potential for a service-related medical condition.

Recommendation 16

The Committee recommends that:

- **as an immediate priority, the national healthcare community include a military/ex-military checkbox as a standard feature on all medical forms; and**
- **the Government commission a longitudinal tracking system to identify the engagement of military/ex-military personnel with the healthcare system.**