8

Veterans Affairs

8.1 Chapter eight considers the role of the Department of Veterans' Affairs (DVA) in the care of wounded and injured veterans, and considers some of the issues of DVA's service model and veteran care more broadly. It examines DVA's claims and compensation process, identifies the current claimant cohort and the long term support infrastructure and case management arrangements that DVA has in place to support veterans of recent conflicts.

Department of Veterans' Affairs

8.2 DVA submitted that following a long period of predominantly peacetime service, the Australian Defence Force (ADF) has undertaken a range of extensive and intensive operations since 1999. This has seen a significant numbers of soldiers, sailors and airmen and women deploy on operations, exposing permanent and reserve force ADF personnel to the risk of wounding and injury. With advances in medicine and rehabilitation, both the ADF and DVA have developed considerable experience and strong systems for delivering care to, and supporting the recovery of, ADF personnel wounded or injured on operations. For those with serious wounds and injuries, ongoing care and support may be required over their lifetime.[1] Major General (MAJGEN) (Retired) Elizabeth Cosson AM CSC, DVA's First Assistant Secretary Client and Commemorations, told the Committee:

> Over the course of its 94 years of operation, DVA has developed a strong and proud history supporting men and women who have

1 Department of Veterans' Affairs, *Submission 18*, p. 3.

> offered service to our nation, and the families who have made sacrifices to support them.[2]

8.3 It was submitted that veterans from recent deployments are a diverse group with different perspectives and service delivery expectations to veterans from earlier conflicts. The challenge facing DVA is ensuring that it meets the needs of all those entitled to its services – those who have been with them for many years, those who are accessing their services for the first time today, and those who will access their services into the future. DVA submitted that its range of clients includes veterans and war widows aged over one hundred years old, to children as young as one year old. DVA accepted that it has an ongoing role in the care and support for all of these clients.[3]

8.4 DVA claimed to have invested significantly in its understanding of the characteristics of the contemporary cohort of veterans, including those who have been wounded or injured. This understanding was said to be helping DVA develop and transform its service delivery models for this cohort. A priority for the Department's applied research program is younger veterans, and veterans transitioning out of conflict zones and into civilian life.[4]

8.5 Ms Judy Daniel, DVA's First Assistant Secretary for Health and Community Services, gave evidence that they believe they now have a strong understanding of the needs of the different cohorts, and particularly the contemporary cohorts who have seen service over the last decade of deployments.[5]

DVA's role

8.6 DVA's submission to the Inquiry highlighted that the Department is a major national purchaser and provider of health and community care services worth around $5.5 billion a year. DVA uses this purchasing power to ensure that all clients, including the wounded or injured, are able to access health and care services in each state and territory. This health care is provided by both the public and private sectors and across the spectrum of service delivery from hospital inpatient and community care services, to primary care in general practice settings.

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2 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 8.

3 Department of Veterans' Affairs, *Submission 18*, p. 3.

4 Department of Veterans' Affairs, *Submission 18*, p. 7.

5 Ms Judy Daniel, First Assistant Secretary Health and Community Services, *Committee Hansard*, 9 October 2012, p. 9.

8.7 DVA purchases healthcare services over the course of a client's lifetime after discharge, including through periods of acute illness. Services include:

- General medical consultations that provide access specialist medical and dental services;
- A range of allied health services such as physiotherapy and psychology services;
- Rehabilitation, including psychosocial rehabilitation;
- Hospital services in both public and private sectors, including inpatient and outpatient services;
- Pharmaceutical benefits that provide access to an array of pharmaceuticals and wound dressings;
- Home care services designed to assist those veterans and war widows or widowers who wish to continue living at home, but who need a small amount of practical help. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance;
- Community nursing services to meet an entitled person's assessed clinical and/or personal care needs in their own home;
- Counselling services including through the Veterans and Veterans Families Counselling Service (VVCS); and
- Other services such as transport, including the transport of a carer or attendant where medically necessary.[6]

DVA's service model

8.8 DVA submitted that in 2010, the Department established a program to develop new service models, in order to respond to the changing needs and expectations of the contemporary veteran cohort. This program has implemented a new service model for widow/ers and dependants of contemporary veterans, providing a primary point of contact to help dependants access DVA entitlements and support from other agencies.

8.9 Another new service model is in the early stages of development and will assist contemporary ADF members and veterans who have been wounded or injured in service and who have complex and/or multiple needs. The model will respond to different levels of complexity in care, and work with the ADF member support framework to ensure the effective management of transition into civilian life and ongoing support. As well

6 Department of Veterans' Affairs, *Submission 18*, p. 20.

as meeting the needs of those wounded or injured on operations, the model is also for those who become injured or ill from peacetime service.

8.10 Wounded and injured contemporary veterans were consulted in the development of the model. A practitioner workshop has also been held with ex-service organisations that advocate on behalf of veterans for claims and appeals, and Defence organisations.

8.11 DVA submitted that other activities to support the development of this new model include:

- Simplifying how information is provided to clients about entitlements and DVA services,
- Improving the process of notifying DVA of wounded/injured personnel,
- Clarifying roles and responsibilities of all involved in supporting the wounded/injured member and their family, and
- Ensuring DVA's client contact model provides appropriate levels of support to the client and his or her family.[7]

DVA's client expectations

8.12 It was submitted that DVA surveyed the veteran and ex-service communities to help the Department understand what it does well, where things can be improved, and how services might be adapted to meet new and emerging needs. This provided them with client expectations about how DVA service delivery should be structured:

- Person-centred. The seriously wounded/injured veteran should be at the centre of planning and support that is then organised to assist the person to achieve their maximum level of independence and autonomy. This means simplifying their experience with DVA, and offering flexibility and responsiveness to their unique situation with a view to self-sufficiency. It also means placing decision-making with the person, to determine their own life direction and working with providers to assist with the achievement of identified and agreed goals.
- A proactive approach to the provision of support. The framework for the provision of support should be grounded in the notion that the DVA system takes the initiative for support in consultation with the seriously wounded/injured veteran and their family. This would range from early claim acceptance and pre-completed paperwork at the hospital bedside, identifying and coordinating the type of support and assistance they need. This could include offering equipment packages

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

matched to the person's disability and needs through to pre-emptive renewal of domestic support services as appropriate.

- Valuing family relationships. The needs of families and the support of family relationships should be considered in everything that is done in terms of care and support. Feedback suggests that the involvement of the spouse or partner is preferred in discussions about the treatment or other needs of wounded or injured personnel.
- Single point of contact. DVA should have a designated person who is the primary contact point for the seriously wounded/injured veteran. This could be someone in a case management or case coordination role.
- Defence/DVA partnership. Roles and responsibilities of the two agencies should be clearly identified and made explicit to all stakeholders at the outset, with a team approach taken to the planning of support on a person-centred basis.[8]

Claims process

8.13 DVA submitted that it is transforming its practices in how it recognises service-related injuries. They are doing this in response to emerging needs from the contemporary cohort and to provide a more flexible, simple and comprehensive process for recognising service-related injury. This includes when and how claims may be made, so it is more flexible and simple for clients. DVA has also assumed a more visible and pro-active presence in the ADF, with DVA officers having an on-base presence and providing information to ADF personnel while they are serving.

8.14 Up until recently, DVA usually received and assessed claims for service-related injuries either as personnel were discharging from the ADF, or after they had discharged. This had been considered consistent with the responsibilities of DVA for meeting the needs of veterans once they have left the ADF. Over time, with the addition of new legislative arrangements, personnel have also needed to make claims under a specific piece of legislation, and some have needed to make multiple claims under different legislative arrangements.

8.15 The knowledge and evidence about the effects of military service has developed over time. DVA submitted that this cumulative knowledge and experience will benefit the current and future group of ex-serving

8 Department of Veterans' Affairs, *Submission 18*, p. 11.

men and women, including those who have sustained wounds or injuries from recent operations.[9]

When claims may be made

8.16 DVA has been working with the ADF to inform and encourage personnel to lodge claims for service related injuries closer to the time of wounding or injury. This enables these injuries to be recognised by DVA at the earliest opportunity. DVA submitted that this may occur while the member is still serving in the ADF, even if they are not currently receiving treatment for the condition and that this is important because:

- ADF personnel are able to provide information regarding the claim about their condition closer to the time when the event or events causing the condition occurred – which subsequently assists DVA investigate the circumstances which led to the injury or disease;
- It helps DVA to identify health, rehabilitation and compensation needs early, which helps with better health outcomes for DVA's clients and long term management of the accepted condition; and
- It may also allow DVA to pay compensation for service-related injuries if appropriate in a timelier manner (including if the ADF member is still serving).

8.17 DVA submitted that its updated model does not prevent personnel lodging claims at a later stage if they choose or need to do so. Personnel can still lodge claims as they are discharging or after discharge. DVA acknowledged that for some conditions, symptoms may only become apparent after many years.

8.18 Finally, DVA submitted that the aim is to provide more flexibility to serving and ex-serving personnel as to when they are able to lodge a claim.[10]

How claims may be made

8.19 DVA submitted that since 2004 its claim process has been mainly structured around three acts, with the passage of the *Military Rehabilitation and Compensation Act 2004* (MCRA) which joined the *Veterans Entitlement Act 1986* (VEA) and the *Safety, Rehabilitation and Compensation Act 1988* (SRCA).

8.20 DVA is now moving towards a single claim process rather than separate claims under different pieces of legislation. This will be for claims for

9 Department of Veterans' Affairs, *Submission 18*, p. 12

10 Department of Veterans' Affairs, *Submission 18*, p. 12.

DVA to accept a condition as service-related, or for claiming reassessment for a previously accepted condition. Claims will be considered under all relevant legislation to ensure clients have access to the full range of benefits for which they are eligible.

8.21 The single claim process will be based upon electronic processing. This will help ensure clients are kept informed throughout the claim process and electronic file management will make service and medical records more accessible to any DVA claims assessor working on entitlements for a client. The feedback received from ex-service representatives and departmental staff following a trial was said to show that a single claim form is far less complex for clients.[11]

Pro-active support for making claims

8.22 DVA submitted that it continues to work with the ADF to ensure it receives early notification of when personnel are wounded, ill or injured and the specific needs the individual, with the ADF member's consent. This includes contact with different areas of the ADF, including the Defence Community Organisation (DCO), the ADF Rehabilitation Program, commanding officers or a Defence Welfare Board.

8.23 As discussed earlier, DVA has also introduced the On Base Advisory Service which places specially trained DVA staff at over 35 Defence bases on either a full or part-time basis. This on base presence assists serving and discharging ADF personnel find out about services including rehabilitation, compensation, health services, and support, as well as encouraging the early lodgement of any claims.[12] General Cosson told the Committee:

> We now have a more visible and proactive presence on ADF bases. We are also working closely with the ADF to make the process of discharge from military into civilian life as smooth as possible, including for those personnel who have sustained wounds or injuries from their service. With Defence we have a strong commitment to working together, and with this in mind, DVA is focused on providing the right support through rehabilitation and timely access to services and benefits.[13]

11 Department of Veterans' Affairs, *Submission 18*, pp. 13–14.

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

13 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 8.

Veterans' reactions to DVA services

8.24 Veterans vary in their assessment of DVA services. It was submitted that the support and interactions with DVA can be very positive[14] and that if your problem is accepted the care is excellent.[15]

8.25 The Committee received evidence, however, that the image of DVA with some veterans and the veteran support community was often far from positive. The Committee received evidence that:

- In at least one instance, there was no DVA support in Townsville and the member in question was managed through Brisbane. The submission highlighted the importance of personal contact in setting a rapport;[16]
- The process is complex, opaque and stressful and in many cases there were problems that appeared to be due to errors or omissions made by the advocate;[17]
- The process of recognition by the DVA of an individual's psychiatric diagnosis is for many ex-servicemen/women a gruelling, prolonged, invalidating and dehumanizing experience that complicates, aggravates and perpetuates the pre-existing psychological distress suffered by veterans and their families;[18]
- DVA is viewed by 'a lot' of ADF members as a hindrance to their claims being approved, and are therefore reluctant to discuss personal matters with DVA;[19]
- Many veterans become disillusioned and give up [making claims] in disgust, feeling further alienated by politicians and bureaucrats;[20]
- DVA are a disgrace, as is the entire compensation system and that DVA will use any excuse they can find to not pay a fair and correct compensation amount;[21]
- If you need to get more conditions accepted it can be hard to wait to go through the DVA claims system and jump all the hoops;[22]

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14 Name withheld, *Submission 6*, p. 2.
15 Name withheld, *Submission 14*, p. 2.
16 Name withheld, *Submission 2*, p. 2.
17 Name withheld, *Submission 5*, pp. 1, 7.
18 Dr Andrew Khoo, Clinical Director TPH Group Therapy Day Programs, *Submission 3*, p. 5
19 Returned and Services League of Australia WA Branch, *Submission 4*, p. 1.
20 Name withheld, *Submission 5*, p. 7.
21 Name withheld, *Submission 9*, pp. 1-2.
22 Name withheld, *Submission 14*, p. 2.

- DVA operates like an insurance company, works at a snail's pace with no accountability for slow or non-response to claims, is adversarial and quite often incompetent in its administration;[23]
- There is pain, anguish and secondary trauma related to the difficulties and the frustrations in trying to navigate a complex, often bureaucratic, fragmented and entitlements-driven healthcare system;[24] and
- There are 'significant problems' with the DVA assessment process, that DVA are not forthcoming in providing feedback, that the basic DVA framework is not geared to providing adequate support to the widening profile of veterans, and that on base advisors are 'scarce and hard to communicate with'.[25]

8.26 Carry On (Victoria) submitted that experiences such as these results in veterans distrusting in DVA and 'all too often' support organisations are approached by veterans who have not been in touch with DVA at a time when they should be.[26] The Executive Officer of Carry On, Mr Simon Bloomer, said they would like to see DVA have a more flexible case management process and be able to identify an individual's needs, and whether they need more active case management or not.[27]

8.27 Defence Families of Australia (DFA) submitted that income assessments following wounding or injuries sustained during operations should be based on the members' own losses in earning capacity, and that the income of a spouse should not be included when assessing pensions.[28]

8.28 DVA responded to these concerns by acknowledging that the system is not perfect but insisted that it is getting better. DVA stressed to the Committee, however, that there is no evidence for claims of a steadily increasing proportion of claims proceeding to the Veterans' Review Board (VRB) or the Administrative Appeals Tribunal:

> The underlying rate at which DVA accept primary claims has not changed a great deal for post-traumatic stress disorder, depression or alcohol abuse, and similarly, the proportion of primary claims decisions that go to the VRB do not show significant differences overall over the last three years.[29]

23 Name withheld, *Submission 16*, p. 2.

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

25 Name withheld, *Submission 40*, pp. 1-2.

26 Carry On (Victoria), *Submission 10*, p. 1.

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

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

29 Mr Sean Farrelly, First Assistant Secretary Rehabilitation and Support, *Committee Hansard*, 9 October 2012, p. 10.

8.29 Dr Andrew Khoo, a consultant psychiatrist and the Director of Group Therapy Day Programs at Toowong Private Hospital (TPH), submitted that DVA had made some progress towards alleviating the problems with the DVA compensation process. This had included increasing numbers of DVA delegates/case managers and reducing their case loads, and providing training including guidance on common veteran psychological problems, typical veteran presentations and communication skills.[30]

Claims paperwork

8.30 The Committee received evidence that the legalities of making claims requires that injured veterans are frequently forced to seek legal advice adding stress and cost to the process and that the volume of information provided by DVA leaves individuals confused about their post-transition financial prospects.[31] Mr Michael (Baron) von Berg MC of the Veterans' Advisory Council of South Australia told the Committee:

> The digger is a pretty simple sort of individual — a wonderful individual, but simple — who does not really know how the system works. Therefore they need help as to how the system works.[32]

8.31 The Committee was told that the submission of claims is a 'confusing and difficult process for veterans to undertake'.[33] The Returned and Services League of Australia (RSL) advocated for a simplified claim form. Rear Admiral (RADM) (Retired) Ken Doolan AO told the Committee of a soldier with a legitimate claim who was so daunted by the paperwork that he had not completed the claim application:

> It is confusing … it was all too difficult and he had just put it in the drawer and was going to leave it there. These [problems] do exist.[34]

8.32 The Committee also heard that DVA travel entitlements are cumbersome for the veteran to administer.[35] National Convenor of DFA, Ms Julie Blackburn, told the Committee from their perspective, the claims process did need to be simplified to speed up the transition of claims and processes between Defence and DVA. The feedback from Defence

30 Dr Andrew Khoo, Clinical Director TPH Group Therapy Day Programs, *Submission 3*, p. 5.

31 Name withheld, *Submission 2*, p. 2; Name withheld, *Submission 6*, p. 2.

32 Mr Michael (Baron) von Berg MC, Veterans' Advisory Council of South Australia, *Committee Hansard*, 8 February 2013, p. 24.

33 Name withheld, *Submission 40*, p. 1.

34 Rear Admiral (RADM) (Rtd) Ken Doolan AO, National President Returned and Services League of Australia, *Committee Hansard*, 12 March 2013, p. 5.

35 Name withheld, *Submission 16*, pp. 11-14.

families is that it is still an incredibly complicated system to make a claim, so much so that an advocate is often needed in order to be able to navigate the system.[36]

8.33 DVA responded by telling the Committee that the complaints and feedback management system has come a long way as acknowledged by the May 2012 Australian National Audit Office (ANAO) report into the *Management of Complaints and Other Feedback by the Department of Veterans' Affairs*.[37]

8.34 In response to the ANAO report, DVA increased staff training and informed supervisors in relation to the use of the complaints and feedback management system. DVA's six-weekly executive management group meetings go through the report of complaints and compliments to get some trend analysis and to understand the issues clients are raising. DVA's quality assurance checks found that most of the mistakes were made during data entry. The ANAO report did recognise that DVA now has better systems, but still needed to do more regarding training and it was because of that DVA implemented the training program.[38]

Delays in claims

8.35 It was submitted that in some instances, claims can become bogged down in a lengthy appeals process and in some cases drag on for more than a year.[39] During this protracted process, the veteran and their partner are often at 'wits end' and may be experiencing financial difficulty, the view being that DVA deliberately drag the process out in the hope of discouraging the applicant from persisting.[40]

8.36 The Committee also heard several instances of claims paperwork being lost requiring resubmission, or other irregularities in the paperwork.[41]

8.37 DVA responded that for determination of initial liability claims and permanent impairment claims, the target is 120 days on average. DVA advised that for:

- Initial Liability – the average time it took to finalise initial liability claims in 2011-12 was 158 days;

36 Ms Julie Blackburn, National Convenor Defence Families of Australia, *Committee Hansard*, 12 March 2013, p. 1.

37 ANAO, *Management of Complaints and Other Feedback by the Department of Veterans' Affairs*, 3 May 2012.

38 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 9.

39 Name withheld, *Submission 16*, p. 5.

40 Name withheld, *Submission 5*, p. 7.

41 See name withheld, *Submission 14*, p. 2; Name withheld, *Submission 40*, p. 2.

- Permanent Impairment – in 2011-12, the average time it took to finalise permanent impairment claims was 127 days; and
- Incapacity payments – the Department endeavours to finalise claims within 120 days on average. However, there is a mechanism to provide interim payments to clients prior to finalisation of their claims. In 2011-12 the average time it took to finalise claims for incapacity payments was 104 days.

8.38 DVA submitted that the claims process can be protracted as it may involve the claimant having to attend medical appointments, waiting for medical reports, seeking further medical opinion or requesting documentation from the claimant or from the Department of Defence.[42]

DVA attitude/onus of proof

8.39 The Committee heard that there is a perception that DVA will seek to deny or downgrade a claim in the first instance. It was submitted that there is a common view that DVA is seen as 'a large and opaque department that is geared towards protecting the public purse, hides behind bureaucratic processes, lacks a sense of urgency, and distrusts its client base'.[43]

8.40 Dr Khoo told the Committee that he has seen, as a conservative estimate 700 to 1,000 ex-military people with PTSD. He estimated that between one in 10 and one in 15 of the veterans he has treated in the last 10 years had reported a smooth experience in their process to gain DVA recognition and compensation.

8.41 Dr Khoo told the Committee that he believes the attitude of DVA seems to have changed from supportive to suspicious. He said that, in his experience, current and former ADF members very rapidly become demoralised and intimidated, and that most of them are additionally traumatised, to a varying extent, by the claim recognition and compensation process:

> It is a bureaucratic maze, … there are three different acts. … it is very complicated. It is difficult for these people to talk to their own family members, let alone to talk to someone on the end of the phone with no mental health training and no understanding of how difficult the situation has been for them. It is difficult for

42 Department of Veterans' Affairs, *Submission 41*, p. 2

43 Name withheld, *Submission 5*, p. 7.

these people to read a magazine, let alone to fill out reams of paperwork. They have lost faith in the system.[44]

Current claimants

8.42 In the 10 years from 2002 to 2012, DVA accepted 20,577 of 35,490 mental health claims under the VEA and MRCA involving a total of 24,900 veterans.[45] DVA submitted that, for the contemporary cohort of veterans from the East Timor, Solomon Islands, Afghanistan, and Iraq conflicts (see Table below), as at March 2012 there were almost 5,000 veterans from these conflicts known to DVA as having service-related health conditions with around 11,700 accepted conditions. The top three conditions include PTSD, tinnitus, and sensori-neural hearing loss.

Table 8.1 Summary of DVA accepted conditions by recent conflicts (March 2012)

	East Timor	Solomon Islands	Afghanistan	Iraq	Net Total
Veterans with an accepted condition	3,004	309	1,201	1,020	**4,973**
Total number of accepted conditions	6,835	611	2,789	2,207	**11 ,697**
Average conditions/veteran	2.28	1.98	2.32	2.16	**2.35**

Source *Department of Veterans' Affairs, Submission 18, p. 9*

8.43 The contemporary cohort has served in the context of reform and cultural change in the ADF. This includes the changing role of women in the Defence Force, with increasing numbers of women deployed and the Government formally agreeing to the removal of gender restrictions from ADF combat roles.

8.44 Most of the contemporary veteran cohort continues to be young to middle aged males. The median length of service in the Defence Force is seven years and just over half of serving personnel in the permanent force are aged under 30 years. In 2011, 86% of the ADF permanent forces were male, compared to 87% in 2007.

44 Dr Andrew Khoo, Clinical Director TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, pp. 15, 16.

45 Department of Veterans' Affairs, *Submission 41*, p. 1; see Submission for further details.

8.45 Compared to previous cohorts, DVA considers that the contemporary cohort is:

- Less likely to join and participate in formal organisations;
- More likely to use social network media and less likely to use mainstream media; and
- More likely to live in non-nuclear family and household arrangements. That said, many will have young families and most will be either married or partnered.[46]

Claimants' families

8.46 DVA submitted that the families of ex-serving personnel are a priority in terms of understanding the contemporary cohort. DVA has been undertaking a research program to assess the impact of service on the health and welfare of the families of deployed personnel, for Vietnam and Timor-Leste veterans. The program is helping DVA and Defence better understand the impact of deployment on families and the kinds of support services that would best help these families.[47]

Deployed civilians

8.47 The Committee notes that in certain instances Defence civilians are deployed on operations and while to date none have been injured, there is potential for the development of psychological issues within this cadre. One submitter believed that the Australian Defence Organisation is not yet mature enough to recognise that civilians are not 'ADF members in a suit', and suggests that a large portion of its civilian workforce may be suffering from conditions like PTSD.[48]

DVA's cultural transformation

8.48 MAJGEN (Retired) Dave Chalmers AO CSC, First Assistant Secretary Client and Commemorations, told the Committee that the secretary of the Department is very concerned to see that DVA does not exhibit the characteristics reported in some submissions. It was said that DVA aims to be client-centric and is looking to empathise with clients and understand the perspective of its clients. He said DVA wants to make sure that they have processes in place which make it as easy as possible for

46 Department of Veterans' Affairs, *Submission 18*, pp. 9–10.

47 Department of Veterans' Affairs, *Submission 18*, p. 10.

48 Name withheld, *Submission 16*, p. 3.

people to apply for compensation and make claims. The aim is to be as transparent as possible for the client and to minimise barriers so that the process is not harrowing.

8.49 He said that DVA is working towards that aim through a cultural transformation process — the On Base Advisory Service is one such cultural change. He told the Committee that DVA's outreach services are improving, and that they are looking at going online, having introduced the online MyAccount system to make it easier for people to access and understand DVA services. The transition process is being driven by the secretary and it does involve a cultural change:

> The department is certainly in the process of transition and cultural change to improve, in every way, the services that it offers to veterans and widows. ... We can always improve our systems.[49]

8.50 DVA went on to submitt that its Cultural Change program takes a blended learning approach, involving a broad range of delivery mechanisms, including face-to-face workshops, presentations at various forums, specific training for certain job roles, on-the-job training and e-learning, where appropriate. The objectives of the program are to:

- improve staff understanding of our diverse client group, particularly the contemporary clients;
- help build client-focused relationships between DVA staff and clients; and
- enhance DVA's client service culture and delivery.

8.51 The areas covered include:

- understanding military culture and the impact it can have on mental health;
- sessions involving current and former serving members talking about their military experiences and their experiences dealing with DVA;
- sessions involving senior DVA management, including the Secretary, covering the strategic challenges facing DVA;
- managing challenging behaviours from clients;
- suicide awareness;
- strategies for dealing with complex cases; and
- strategies for taking a more client-centric or whole-of-client approach to service delivery.[50]

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49 MAJGEN (Rtd) Dave Chalmers AO CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 19 March 2013, p. 2.

50 Department of Veterans' Affairs, *Submission 41*, p. 4.

Ongoing health care and support

8.52 DVA submitted that as at March 2012, they provide support to almost 335,000 clients, whether by a pension, allowance, or treatment card. As discussed, DVA claimed to be transforming the way it is dealing with clients across a range of functions, in order to provide more flexibility in support and care.

8.53 DVA submitted that it is continuing to expand its range of communication channels, including options for clients to deal with the Department online. These new channels are complementary and will not replace the traditional forms of communication, as veterans and their families will still be able to contact the Department via telephone, face-to-face, fax, email or mail.[51]

8.54 Additionally, DVA stressed to the Committee that strategies have been put in place for dealing with vulnerable or at risk clients, including:

- The Client Liaison Unit which assists in the interactions between DVA and vulnerable clients, including those with complex needs. Clients may be referred from within the Department if there is a breakdown in relationship between client and an area of the Department; and
- Case coordinators for clients with complex needs who have caused, or may be in danger of causing, harm to themselves or to others. Case coordinators assist at-risk clients with complex needs to navigate DVA services and benefits in order to minimise their risk of self-harm and maximise their quality of life. Coordinators also provide a primary point of contact for clients and assist them and their families with other psychosocial needs external to the Department to help them enhance their quality of life. Participation in case coordination is voluntary and therefore a client can choose to accept or decline the service.[52]

Case management

8.55 Associate Professor Robert Atkinson AM RFD, Clinical Associate Professor in Orthopaedic Surgery with the University of Adelaide, submitted that a process to 'spot check' a patient's journey and procedures to acknowledge success and identify if and where improvements could be gained was warranted.[53]

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51 Department of Veterans' Affairs, *Submission 18*, p. 18.

52 Department of Veterans' Affairs, *Submission 18*, p. 18.

53 Associate Professor Robert Atkinson AM RFD, *Submission 1*, p. 1.

8.56 Other evidence suggested that the DVA case management process requires 'thorough investigation and update'[54] or at least that the service provided by case managers lacks a level of appropriate care[55] or effort[56]. The Vietnam Veterans' Federation has received complaints about restrictions on retraining outsourced case managers, and the quality of some who are sometimes 'young and inexperienced'.[57]

8.57 The Australasian Services Care Network (ASCN) highlighted in their submission that support of the 'patient's journey' with a quality case management system is paramount for effectiveness. This not only ensures the correct therapeutic regime is delivered, but has the potential to deliver a better quality of life and a more effective cost management process.[58]

Ex-serviceman involvement

8.58 The Returned and Services League of Australia WA Branch (RSL WA) submitted that while their assessment is that DVA has competent Case Managers, at times members feels more comfortable talking about their problems with an ex-service member.[59] This was a recurring theme with veterans noting that having another veteran as a Case Manager (who may even be suffering from the effects of PTSD or other mental health issues themselves) who has a genuine desire to help other veterans and give something back to the community is beneficial.[60] 'Soldier F' told the Committee:

> [My experience with DVA has been] excellent. I have got a very good counsellor …. He has looked after me. He has really put the right claims in for me. He has helped me out. … He actually served with my father in Vietnam so he has a lot of experience and has helped out immensely.[61]

8.59 It was submitted that there is variability in the level of service and range of difficulties in the claims process in different states and that a standardised approach to recruitment, training and ongoing evaluation of Case Managers is needed to assist in delivering a consistent level of

54 Name withheld, *Submission 2*, p. 2.
55 Carry On (Victoria), *Submission 10*, p. 2.
56 Name withheld, *Submission 16*, p. 3.
57 Vietnam Veterans' Federation, *Submission 25*, p. 1.
58 Australasian Services Care Network, *Submission 39*, p. 2.
59 Returned and Services League of Australia WA Branch, *Submission 4*, p. 1. Name withheld, *Submission 40*, p. 1.
60 Name withheld, *Submission 5*, p. 7.
61 Soldier F, *Committee Hansard*, 25 October 2012, p. 11.

service through these outsourced arrangements, to include counselling skills.[62]

8.60 MAJGEN Cosson responded that a range of initiatives have been put in place to try to respond to the contemporary veteran issue. Client and Commemorations Division has been established to make sure that DVA understand the client and emerging needs. She told the Committee that a powerful, interactive 'Understanding Military Culture' workshop is conducted which engages ex-serving personnel to lead discussions on what it is like to have military service and what it means to them and their family. More recently, DVA has been emphasising connecting with the clients:

> Look at them as a person, not as a claim and not as a condition; treat the client as a whole person and with their family; and actually make that connection, pick up a telephone and talk to the client about what their needs are or what the contemporary veteran needs are.[63]

8.61 From a treatment point of view, Professor Sandy McFarlane AO told the Committee that he believes a clinician who understands the culture, the structure of the organisation and how to address the issues of the ongoing functioning of those individuals within the organisation is needed. Using people outside the system who do not have an intimate knowledge from an occupational perspective is, he says, a critical issue.[64] Dr Glen Edwards told the Committee 'It is veterans who help veterans'.[65]

8.62 Professor David Forbes, the Director of the Australian Centre for Post-traumatic Mental Health (ACPMH) did not doubt that an ex-serviceman would bring an intimate knowledge of Defence. He said, however, that it was not a key ingredient and does not compare to the support and intervention that a health professional would provide.[66]

8.63 MAJGEN Cosson advised that since 2010, DVA started putting more emphasis on dependants, particularly young widows. DVA has interviewed them and talked to them about what their experience has been with DVA. She told the Committee that the wives were very frank and they told DVA about some of the areas of concern — that DVA gave

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62 Name withheld, *Submission 5*, p. 8.

63 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, pp. 10-11.

64 Professor Alexander (Sandy) McFarlane AO, *Committee Hansard*, 8 February 2013, p. 1.

65 Dr Glen Edwards, *Committee Hansard*, 8 February 2013, p. 11.

66 Professor David Forbes, Director Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 14.

them too much information, did not personalise the process, and that DVA needed to do a lot more work in engaging with them.

8.64 She went on to explain that this led to DVA establishing new service coordinators to have one-on-one contact with the dependants, and, importantly, establishing a very close connection with Defence and DCO early in the process. She said that DVA have done a similar round of work with soldiers who have returned seriously wounded and injured, and their families:

> It is a journey through their life that we will be part of – establishing that journey map with them was really important work for us, really helping our staff understand that contemporary veterans do have different needs and different expectations, but it all comes down to the communication.[67]

Long term injuries and illnesses

8.65 DVA acknowledged to the Committee that they are aware that there are also longer term injuries and illnesses that may emerge over time, either due to the delayed onset of symptoms or due to advances in knowledge and diagnosis such as:

- For mental health, some conditions may take some time for symptoms to present. For example, PTSD, anxiety, or depression may have a delayed onset months or years after a causal event or events;
- Traumatic brain injury has come under increasing attention by military medicine in terms of concussive injuries. As a result of blast injuries and the use of improvised explosive devices in recent Middle East Areas of Operations (MEAO), mild traumatic brain injury (MTBI) is emerging as a particular focus. While there is an international body of evidence on the prevalence and impact of this injury, there is also ongoing discussion on the methods used to measure and diagnose it, particularly as the symptoms may mask PTSD or other mental health disorders; and
- Musculoskeletal conditions resulting from traumas to the body in either a minute or major way may also emerge over time. For some, this can also include the need for ongoing pain management and managing potential risks of mental health problems associated with ongoing pain.

67 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 11.

8.66 DVA also acknowledged that each injury is unique in terms of effects on the individual and their family, and the care and support they subsequently need. While members remain in the military, the ADF has primary responsibility although there are some areas that DVA can provide support to them. DVA takes full responsibility for care and support for those wounded or injured personnel who leave the ADF. The types of care and support include:

- Medical treatment and care, such as occupational therapy, physiotherapy or allied health treatment;
- Mental health treatment;
- Rehabilitation services;
- Home modifications, including for access points to the home and for use of kitchens and bathrooms;
- Motor vehicles, for instance hand control options and wheelchair options;
- Home equipment, such as kitchen packs with appropriate knives, non-slip mats, one-handed tools/implements, specialised beds, custom wheelchairs and home exercise/gym equipment;
- Domestic, gardening and personal care services; and
- Financial support, short or longer term.[68]

8.67 RSL South Australia highlighted the importance of support for the carers and families of seriously wounded soldiers.[69]

Rehabilitation

8.68 DVA submitted that the passage of the MRCA increased the focus and primacy placed on rehabilitation as part of the overall repatriation system for current and former serving men and women. For wounded or injured ex-serving personnel, rehabilitation is an essential part of their overall care and support.

8.69 Greater success in rehabilitation and retention within the ADF means that those who are discharged are generally in higher needs categories than they would be in any other civilian rehabilitation or compensation scheme. The options of return to work in their original and usually preferred workplace or a similar position elsewhere in the ADF may have been exhausted. The ADF member has to pursue new opportunities and challenges while sometimes dealing with increased incapacity.

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68 Department of Veterans' Affairs, *Submission 18*, pp. 8–9.

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

8.70 DVA's response is to use a tailored approach to meet the needs of the individual after discharge, which addresses social, psychological, vocational and educational factors based upon the following principles:

- Care and respect for the client is paramount;
- Early intervention processes and practices must operate;
- Whole of person rehabilitation needs must be addressed;
- The client, and their significant other, must be actively involved in the development of an appropriate rehabilitation plan/program with realistic goals;
- All key stakeholders must be actively involved in an effectively coordinated plan/program of activities; and
- Rehabilitation plans must be focussed on outcomes.

8.71 Rehabilitation programs can include medical, dental, psychiatric, in-patient and out-patient care; physical exercise and physiotherapy; psychosocial training and counselling; aids and appliances; and modifications to workplaces, homes and cars. Attachment C of Submission from the Department of Veterans' Affairs sets out the 'whole of person' approach used in rehabilitation, including medical, psychosocial, and vocational aspects.[70]

8.72 The Committee received evidence that current DVA vocational rehabilitation does not support all younger veterans in obtaining meaningful employment. The Committee was informed that some veterans who cannot undertake physical occupations due to the extent of their wounds and injuries are missing support such as higher level education due to legislative limitations.[71]

Chronic disease management

8.73 DVA is also working on new methods for chronic disease management and care coordination. For instance, DVA submitted that the Coordinated Veterans' Care Program is a positive step to improve the wellbeing and quality of care for chronically ill Gold Card holders, including through team based care and careful targeting of chronically ill patients. The program pays general practitioners and nursing providers to coordinate care for Gold Card holders who are at risk of hospitalisation. Through

70 Department of Veterans' Affairs, *Submission 18*, pp. 18–19.

71 Name withheld, *Submission 40*, pp. 4–5.

improved community based care, the program is intended to improve the health of participants by:

- Providing ongoing planned and coordinated care from the general practitioner and a nurse,
- Educating and empowering participants to self-manage their conditions, and
- Encouraging the most socially isolated to participate in community activities.[72]

8.74 RSL South Australia submitted that long-term care of seriously wounded personnel who require 24 hour support is not being met with the placement of these individuals into aged care facilities or disabled group homes.[73]

Mental health

8.75 MAJGEN Cosson gave evidence that there is a comprehensive range of programs, services and benefits provided by DVA and available for former serving ADF members and their families. This includes the VVCS, PTSD programs, online mental health information and support, and medical and hospital services. [74]

8.76 Ms Judy Daniel, First Assistant Secretary, Health and Community Services explained that provisions within DVA legislation allow for non-liability health cover for PTSD, anxiety and depressive disorders. That arrangement means that health cover is available on diagnosis, without the need to go through the compensation process and link the condition to service. The compensation process is different and separate. There is, however, provision to provide access to mental health treatment.[75]

8.77 To reach members of the veteran and ex-service community on mental health matters, including those who are reluctant or unable to seek help, the Department uses education and awareness activities to promote good mental health and help-seeking behaviours. *At Ease* is a self-help website[76] offering mental health and wellbeing information and resources for veterans and serving personnel, their families, friends and carers as well as health providers.

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72 Department of Veterans' Affairs, *Submission 18*, p. 22.

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

74 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 8.

75 Ms Judy Daniel, First Assistant Secretary Health and Community Services, *Committee Hansard*, 19 March 2013, p. 4.

76 See <www.at-ease.dva.gov.au>.

8.78 A focus for DVA is developing new channels of communication to strengthen their engagement with contemporary veterans and their families, including new technologies such as mobile phone applications. A range of mobile phone applications are either being developed or in preliminary planning stages, including:

- An Australian version of the United States Veterans' Affairs PTSD Coach with enhanced functionality and engagement with allied mental health providers (through *At Ease*) and VVCS providers to incorporate the application into treatment regimes;
- *The Right Mix* alcohol management to assist contemporary veterans manage their drinking behaviours;
- Suicide awareness tools and information to support those at risk and their families, under the *Operation Life* framework; and
- A mobile version of the *Wellbeing Toolbox* providing interactive self-care tools to support personnel who are leaving the ADF.

8.79 These initiatives are in a context of a wide range of mental health treatment services that are purchased and provided by the Department, including GP services, psychiatric services, psychologist services, pharmaceuticals, and hospital services. In addition, DVA also supports direct services through the VVCS, which provides free and confidential counselling either face-to-face at one of the 15 VVCS Centres nationally, or through the 24-hour hotline.[77]

8.80 The Committee agrees that VVCS is a very good organisation offering a wide range of programs and counselling services to veterans and their families.[78]

8.81 Non-liability healthcare is available to eligible veterans with PTSD, anxiety and depressive disorders to treat these conditions. Non-liability health care provides access to treatment for eligible clients (this includes those who have sustained wounds or injuries from operational service). Those with non-liability cover for these conditions have access to a range of clinically needed mental health services, irrespective of whether or not the PTSD, anxiety and depressive disorders is service-related.

8.82 The work of Defence in identifying mental health prevalence through the *2010 ADF Mental Health Prevalence and Wellbeing Survey* will be an important consideration for DVA's approach to mental health in the future.[79]

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77 Department of Veterans' Affairs, *Submission 18*, pp. 19–20.

78 Name withheld, *Submission 16*, pp. 8–9.

79 Department of Veterans' Affairs, *Submission 18*, p. 20.

8.83 RSL WA submitted that there is evidence that there is an increase in mental health problems, resulting in more ADF personnel discharging with mental and other undiagnosed conditions.[80]

8.84 Associate Professor Susan Neuhaus CSC submitted that the previously noted fragmentation of Defence and DVA health care systems meant that, while ADF personnel wounded and injured during service in operational areas are acknowledged, the burden of 'unseen wounds', in particular the results of mental health injury sustained on recent operations, are not likely to emerge for many years. Additionally, the physical impacts of service may also take a considerable time to be recognised (e.g. back injuries, effects on future fertility or cancer risk).

8.85 There are 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. As previously noted, 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 linkage of their medical condition to a particular aspect of their service.[81]

8.86 The civilian health sector is also often unaware of a younger veteran's service history and little systematic assessment occurs of the associated risk factors which may have contributed to their current health status.[82]

8.87 DFA also noted that there needs to be greater public awareness of the unique needs of ADF members within the broader health system to ensure that health carers know how to identify and manage ADF or former ADF personnel that may be admitted or in their care.[83] This was echoed by Carry On (Victoria) who further recommended a deliberate ongoing monitoring program.[84]

8.88 DVA do not currently have a regular and formalised system for tracking those who have left the defence forces. As a means to address this gap, particularly for the contemporary veteran, DVA is ensuring that they have a good on-line presence using the internet. For example, the Touch Base program is a pilot program providing support for separating Defence Force members and short YouTube clips with a mental health focus. DVA

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

81 Associate Professor Susan Neuhaus CSC, *Submission 31*, pp. 2-3.

82 Veterans' Health Advisory Council, Submission 33, p. 3.

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

84 Carry On (Victoria), *Submission 10*, pp. 1-2.

submitted that this range of strategies also maintains awareness within the broader health service community.

8.89 DVA accepted that ensuring that the general health provider community has a good awareness of veterans' health issues and the impact military service can have on health is a challenge — in particular, mental health.[85]

8.90 The Australasian Services Care Network (ASCN) submitted that it is also important to involve the aged care industry to ensure adequate provisioning for later stages of life. ASCN submitted that a cooperative approach would be cost effective, particularly when increasing mental health issues have the potential to change age care demands. They also highlight that younger individuals requiring accommodation and services may require a change to the traditional description of 'aged care' to 'aged and chronic care'. They are concerned about the longer term effects of MTBI, as an example, and the potential relationship to early on-set Alzheimer's disease and dementia.[86]

Compensation

8.91 The Committee received evidence expressing a range of views on the provision of compensation for wounds and injuries. Some individuals reported a prompt and fair compensation process,[87] while others have had to wait substantial periods or are yet to receive compensation,[88] or that despite DVA having accepted liability, compensation for a permanent injury has not been provided and that DVA will use any excuse not to provide compensation.[89] The Committee also heard that incapacity payments should properly reflect the real financial losses suffered by veterans.[90]

8.92 The Vietnam Veterans' Association of Australia (VVAA) submitted that 'a constant complaint' is in relation to the MRCA where a disability or injury can be accepted as service related, however the assessment of other entitlements (that is; treatment, rehabilitation and compensation) are subject to a further level of assessment. VVAA submitted that MRCA procedures can be lengthy and stressful to ex-service personnel when

85 Ms Judy Daniel, First Assistant Secretary Health and Community Services, *Committee Hansard*, 9 October 2012, p. 12.

86 Australasian Services Care Network, *Submission 39*, p. 2.

87 Name withheld, *Submission 2*, p. 1.

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

89 Name withheld, *Submission 9*, p. 1.

90 Name withheld, *Submission 16*, p. 8.

compared with the VEA because under the VEA, assessment is part of the acceptance process and handled in a much timelier manner.[91]

8.93 It was submitted to the Committee that permanent impairment assessments based on the Guide to the Assessment of Rates of Veterans' Pensions (GARP) and related legislation is geared to cater for senior veterans, and therefore fails to appropriately incorporate the different needs of younger veterans.[92]

8.94 Regardless, Austin Health's Psychological Trauma Recovery Service (PTRS) submitted that their strong recommendation is that the provision of treatment and rehabilitation remains separated from consideration of compensation.[93]

8.95 Dr Edwards' experience is that most veterans seek treatment for their health issues, not for compensation, despite often being economically disadvantaged due to their service. He submitted that there is an obligation to provide what is necessary to ensure the best quality of life for each ADF individual and family member.[94]

Research

8.96 Professor Neuhaus submitted that the inadequacy of appropriate services following the Vietnam conflict is well recognised and that it is in the area of PTSD that the greatest legacy from ADF operations in recent years is likely to come. She submitted that delays in recognising, understanding, or responding to the health issues of our current generation of ADF service personnel will impact not only individual veterans, but their families and the broader community, through the social and economic burden and health care cost to broader support systems.

8.97 She highlighted that it was critical, for current and future veterans, that active health advocacy and research is undertaken but that care of wounded, injured and ill service personnel and veterans is currently underpinned by a fragmented research agenda. She championed a national strategic health research program addressing the needs of ADF personnel wounded or injured on operations, and the subsequent veteran cohort.[95]

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

92 Name withheld, *Submission 40*, pp. 1, 4-5.

93 Psychological Trauma Recovery Service, *Submission 24*, p. 3.

94 Dr Glen Edwards, *Submission 34*, p. 3.

95 Associate Professor Susan Neuhaus CSC, *Submission 31*, pp. 3-4.

DVA's readiness for the future

8.98 DVA submitted that it believes its work to transform its service delivery models will position the Department well to manage the changing veteran environment. In particular:, the Department cited:

- The investment in understanding the characteristics of the contemporary cohort of veterans, including those who have been wounded or injured, means DVA is well placed to continue to meet client needs and expectations;
- The more flexible and simple process of when and how claims may be made, means greater responsiveness for recognising service-related injuries. The more visible and pro-active DVA presence in the ADF means personnel are more aware of the help and support they can access when they need it;
- The close work with the ADF will help 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; and
- The development of the new service models and other reforms places the client at the centre of service delivery, in order to allow DVA be able to provide a more pro-active and tailored service to meet client need.[96]

8.99 As to the likely future needs, DVA again acknowledged that some conditions may take some time before symptoms present or become known to the individual and his or her family, or before symptoms reach a level that the individual wishes to seek help (or is encouraged to do so by a spouse or family member). For instance, with the delayed onset of PTSD, symptoms may take years before they become apparent. Critically, DVA submitted that its system recognises delayed onset of symptoms and is sufficiently flexible to accommodate advances in knowledge and scientific evidence.

8.100 The knowledge and evidence about some wounds and injuries may also take some time to emerge, and there may be delays in diagnosis. As noted earlier, MTBI is an emerging issue as a result of blast injuries and the use of improvised explosive devices (IED) in the MEAO.

96 Department of Veterans' Affairs, *Submission 18*, p. 23.

8.101 DVA submitted that through its research program, and in collaboration with Defence, they will continue to monitor prospective health needs. Particular forthcoming studies include:

- The MEAO Prospective Health Study that will provide the most up to date information on current physical and psychological effects of this deployment, and
- Further analysis arising from the *2010 ADF Mental Health Prevalence and Wellbeing Study*.

8.102 The Department will also continue to consult with the ex-service community about emerging needs and how these needs may be effectively addressed.[97]

Committee comment

8.103 The Committee supports DVA's stated service delivery model which includes a single point of contact for case management. However noting the evidence raised during the Inquiry, the Committee believes that despite DVA's efforts to date, the veteran community still feels a great deal of dissatisfaction with DVA's services.

8.104 The Committee applauds DVA's intention to have a single electronic form claim process, responsive to all applicable legislation, and strongly encourages DVA to hasten its development.

8.105 The Committee notes that DVA provides free treatment for PTSD, depression and anxiety to eligible veterans with operational service, irrespective of whether it is service related.[98]

8.106 The Committee acknowledges that DVA has increased the training emphasis on cultural understanding and empathy by their Case Managers in dealing with customers but remains concerned about the ongoing issues reported to the Committee. The Committee agrees that there is an argument that ex-service personnel may bring a heightened understanding to the role of Case Manager, and should be preferentially employed in this capacity. The Committee notes, however, that these individuals themselves may be suffering ill health due to their service, and this risk would need to be carefully managed.

97 Department of Veterans' Affairs, *Submission 18*, p. 23.

98 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 8.

8.107 The Committee agrees that research into long term mental health and other related issues (for example links to Alzheimer's or dementia) is of paramount importance.

Recommendation 23

The Committee recommends that the Department of Veterans' Affairs:

- **Review the Statements of Principles in conjunction with the Repatriation Medical Authority with a view to being less prescriptive and allowing greater flexibility to allow entitlements and compensation related to service to be accepted;**
- **Periodically publish reports measuring success in adhering to their client service model;**
- **Periodically publish claim processing times; and**
- **Periodically publish claim success rates.**

Recommendation 24

The Committee recommends that the Department of Veterans' Affairs conduct a study, and publish the results, reflecting the issues raised in evidence during the Inquiry, concerning:

- **Developing a standardised approach to recruitment, including the preferential recruitment of ex-service members as Case Managers; and**
- **Training and ongoing evaluation of Case Managers.**