

# A Better Way to Support Veterans: Productivity Commission Draft Report Dec 2018

## *Information Request 5.1*

The Commission was told that the data record on Sentinel significantly understates the incidence of most types of work health and safety incidents. What aspects of Sentinel contribute to this and what might be done to improve reporting rates?

### **RESPONSE**

WHS issues:

- Members have reported concerns they are asked to do things in training and day to day that put them at unnecessary risk.
- This has potential to result in lack of faith in the ADF in terms of responding to potential risks - This may lead to Members under reporting as they do not feel anything is going to be addressed.

Confidentiality:

- Would members be more likely to report near miss or other issues should there be an option of reporting confidentially?

Are near misses captured by Sentinel?

- If there is no way to report near miss incident/potential hazards, the ADF are unable to identify risk areas which might help with implementing prevention strategies therefore decreasing overall incident rate.
- Are injuries/near misses whilst members are on deployment/exercise captured by Sentinel? If not, this will lower the incident rate.

Education:

- Are members encouraged/given time to submit reports? Are they educated regarding the importance of this and shown tangible outcomes from having submitted reports. If they were to see actions arising from submitting a report, this may increase compliance.

Data captured:

- If a member submits an incident report at time of injury, are they able to modify this to capture more details on diagnosis, severity of injury and time lost? This would potentially give more oversight in terms of the injury incidence and severity.
- Currently Sentinel relies on members providing correct information regarding the incident and resulting injury. Members may be unaware at time of injury, just how bad it is and/or under report for fear of this impacting their job.
- Could there be a section of Sentinel that can be updated by THP once a diagnosis has been confirmed – link this to DeHS?

Data capture in Sentinel focuses on a specific event occurring which has led to an injury. If a member has an injury as a result of an accumulation of stressors, how does this get recorded? Could the Sentinel system be amended so that members can initially flag if it is an acute injury or an accumulation and depending on which is flagged, different information is then requested?

### **Information request 6.1**

The Commission is seeking information (both quantitative and qualitative) on return to work outcomes from Australian Defence Force and Department of Veterans' Affairs rehabilitation programs.

Areas of particular interest include the appropriateness of comparing return to work outcome measures in military and civilian contexts and what approaches to return to work are affective both in-service and post-service.

### **RESPONSE**

#### **ADF outcome measures:**

ADF use standard clinical outcome measures as approved by HWCA (generally OMPQ, DASS) which focus on pain related psychosocial barriers that might impact RTW or current Mental health symptoms of member. The outcomes of these measures are considered when determining if rehab is required for a member, but they do not directly impact goals (they are either on a RTW programme or medical transition). Rehab providers can provide some psychosocial support (more so with goal 3) but this is limited.

#### **DVA outcome measures:**

Life Satisfaction indicators is a more holistic view. Allows the veteran to self-report current satisfaction in numerous areas of life and work which can help lead to further discussions regarding current support requirements. Allows for development of specific goals to address main concerns and may increase engagement of the veteran if they feel they are directing (to some extent) the direction of rehab support, rather than it being dictated to them. Regular review of the LSI allows all stakeholders to see how much progress is being made, not just with RTW, but also return to life.

Comparison of the LSI and clinical outcome measures is not realistic – they look at very different aspects of a persons' health and wellbeing and are used in very different circumstances. It may be beneficial for the LSI to be used within ADF rehab programme and widen the scope of rehabilitation to allow for more psychosocial support for members. In addition, clinical outcomes measures can (and are used) within DVA rehabilitation to monitor specific pain related or mental health concerns.

#### **Successful approaches:**

Early intervention:

Data indicates that the risk profile of discharged members dramatically change from primary concerns related to career and financial stability to risks relating to mental health, difficulties adjusting to change/maladaptive coping strategies and ingrained negative injury beliefs. As a Rehab provider for both ADF and DVA we see significant delays in DVA referring a Member for rehabilitation once they have discharged with an average referral timeframe of over 2 years (over 1500 referrals). Early intervention (as soon as the member discharges) from DVA could reduce these risks from escalating, with the timely engagement pilot run by DVA showing good results with managing member care and transition. In addition, it is known that younger veterans, are more at risk of developing significant secondary mental health conditions 1-2 years post discharge, around the same time they are referred – this increases the complexity of any rehabilitation intervention – early intervention may result in these secondary conditions being less severe due to the veteran having rehabilitation support focussed on their needs.

If early intervention assists with managing the veteran's transition and providing holistic support, it might be assumed that positive outcomes are going to be more likely, including RTW outcomes.

The current delay for referral from DVA could negatively impact RTW rates...if a veteran has no support on leaving ADF for over 6 months and is getting income, why are they going to be motivated to engage with rehab and RTW. There needs to be a seamless process for members to continue with rehab from ADF goal 3 programmes, straight on to a DVA plan. Veterans need to have some control over their goals to ensure they feel listened to. More and more, rehab is becoming prescriptive, rather than holistic which could impact engagement and outcomes.

### ***Information Request 6.2***

The Commission is seeking further views on the potential use of consumer-directed care for the rehabilitation service providers to veterans on alternatives for providing more tailored, person centred rehabilitation services.

#### **RESPONSE**

- May increase engagement of veterans as they will lead direction of services?
- However, may extend the RTW process if members are not motivated to RTW and have “control” of their rehab direction

### ***Information request 7.1***

The commission is seeking feedback on the period of time that Joint Transition Command should have responsibility for providing support to Members and former Members of the Australian Defence Force who require that support.

#### **RESPONSE**

Should transition be discussed with members on a regular basis – throughout their service - rather than waiting until the member is injured/unwell and have to medically discharge? The time is stressful anyway and if they have not previously been exposed to transition discussions, this can be overwhelming.

Could there be an annual component that all members have to complete in relation to transitions? Online courses in resume’s etc, face to face meetings with transitions officers to help with RPL for their ADF skills/qualifications?

This regular input/discussion about transitioning from defence may mean members are more prepared and make the process less traumatic.

Currently, transition support ends on the day of discharge with delays (as noted above) in getting rehabilitation support from DVA. With increased mental health presentation identified in members after transition, ongoing support is vital. The required timeframe is likely to vary from member to member, depending on mode of discharge and health. Members could be triaged at time of discharge to determine support needs with this being regularly reviewed and support increasing/decreasing as needed.

Support could be ceased once DVA have referred for rehabilitation (if the member is entitled) or for up to 2 years (highest MH risk timepoint) for those with no DVA claims accepted.

### ***Information request 7.2***

The commission is seeking information to inform the design of the proposed veteran education allowance. In particular:

1. At what rate should the veteran allowance be paid?
2. Should eligibility for the veteran education allowance be contingent having completed minimum period of service? If so, what should that minimum period be?

Should any other conditions be put on eligibility for the veteran education allowance?

#### **RESPONSE**

How does this initiative differ from the DVA Step Up to Incapacity Payment initiative that commenced in November 2018 and is in place until June 2022? This provides veterans with 100% incapacity payments whilst enrolled in full time education.

#### **Eligibility:**

Defining eligibility (particularly noting the length of minimum service suggested before being eligible) then discriminates against those who have been medically discharged early in their career. These members leave with potentially less transferable skills due to inexperience and do not get the CTAS funding for any vocational services either. This population is known to be at increased

risk of mental health issues 1-2 years post transition, with poorer transition outcomes noted – lack of access to re-training could confound this issue further

**Conditions:**

Does there need to be any adjustment to conditions that are currently placed on veterans accessing education through the step up to Incapacity payments initiative:

- Medical clearance for course and post course career
- Full Vocational Assessment and LMR

**Information request 7.3**

The Commission is seeking further information on the transition needs of members when they leave the Reserves.

**RESPONSE**

Medically discharging Reservists can access support via the ADF Rehabilitation programme and MAY be able to access CTAS depending on qualifying service.

Should all members be referred to a transition assessor and if deemed at risk of failed transition, be provided with counselling/support with addressing medical management/psychosocial barriers?

**Information request 8.2**

The Commission is seeking participants' views on whether there is merit in the Specialist Medical Review Council remaining as a standalone organisation, or whether its role should be folded into an augmented Repatriation Medical Authority review process that brings in additional medical specialists.

**RESPONSE**

A standalone organisation may be viewed as being more impartial than if the RMA is responsible for doing medical assessment.

**Information Request 12.1**

What are the costs and benefits of further integration between superannuation insurance benefits and the veteran compensation scheme, and how might this integration be achieved?

**RESPONSE**

A single incapacity payment would allow focus to be on rehabilitation and recovery whilst the veteran is provided financial support with the aim to RTW and RTL. The use of the words "pension" and "entitlements" can suggest an inability to recover and focus on the negative aspects of the injuries.

A single payment would improve clarity for veterans, with one source of income from one party. It would reduce the administrative burden associated with having to lodge claims to multiple parties and undergo assessment by multiple parties.

A single payment would require better communication between ADF, DVA and CSC to ensure delays were minimised and entitlements calculated correctly.

***Information Request 15.1***

Given the Gold Card runs counter to a number of key design principles, the Commission is seeking feedback on whether a future system should have a coloured health card system. If not, what are the other options?

In particular, the Commission is seeking feedback on the benefits and costs of providing the Gold Card to dependants, service pensioners and veterans with qualifying service at age 70.

**RESPONSE**

Should a Gold card entitlement be delayed until retirement age – and then assessed based on need/disability rather than just qualifying service?

Until then, focus is on managing illnesses and injuries and rehabilitation/recovery. During this time, DVA pay full fee for treatment rather than veteran having to pay a gap. This may encourage increased participation in treatment and thus decrease costs of rehab longer term.

Should Gold cards be limited to the veteran only?

***Information Request 17.1***

The Commission is seeking feedback from participants on how the two scheme approach would work for veterans who currently have claims under multiple Acts. What factors should determine which scheme these veterans are covered by for their future claims? Should these veterans be given a choice of which scheme would cover them going forward?

**RESPONSE**

Current claimants should be given choice (should this have an age limit or be assessed based on likely capacity to gain employment?) i.e younger veterans with claims accepted by VEA but should have reasonable success of RTW, then they could be transferred to the new scheme where the focus is rehabilitation and not financial incentives?.

They need to be educated on which scheme will be better for them.