



26 June 2018

Submission from the Veterans and Veterans Counselling Service National Advisory Committee to the Inquiry into Veterans' Affairs' Legislative Framework and Supporting Architecture for Compensation and Rehabilitation for Veterans

The Veterans and Veterans Family Counselling Service (VVCS) has been the cornerstone of the Government's veteran mental health support response for 35 years. Its structure and function has evolved, in line with both the expectations of its expanding client base and the increasingly sophisticated understanding of best practice treatment of military trauma. To ensure it is well placed to respond with agility and client-centricity to future demands, VVCS continues to evolve and adapt its service offering.

Service Overview

VVCS is a nationally accredited (against the National Standards for Mental Health Services), military-aware, mental health service. The clinical service delivery model recognises that impact of military service rarely impacts on an individual in isolation. As such, eligibility to VVCS programs extends to the current or former Australian Defence Force (ADF) member's partner and children.

VVCS delivers services from 25 centres and through a national network of more than 1,200 outreach providers. VVCS provides:

- counselling for individuals, couples and families;
- case management for those with more complex needs;
- group programs to develop skills and enhance support;
- after-hours telephone counselling - ensuring support is accessible 24/7;
- information, education and self-help resources; and
- referrals to other services or specialist treatment programs as appropriate.

VVCS uptake

In total, 15,132 unique clients received VVCS counselling during 2016-17. This included the delivery of 94,726 counselling sessions. A further 2,070 clients received intake support and had their concerns resolved during their initial contact with VVCS or were referred to more appropriate services. Group programs were delivered for 832 participants. The VVCS after-hours service supported clients outside of business hours, with 6,622 calls answered. (DVA Annual Report 2016-17)

As at February 2018, VVCS had identified and managed 1,170 high risk client and/or complex needs cases as part of its Clinical Escalations Unit.

Outreach Counselling

The VVCS outreach provider network is an important element of the VVCS service model. VVCS has more than 1,200 clinicians, located all across Australia, who are registered to provide services on our behalf. These clinicians are private providers (psychologists (83%) and mental health accredited social workers (17%)), who have worked with VVCS to learn about the ADF-experience and are well versed in VVCS clinical expectations.

For clients in rural and remote areas, and town-based clients for whom travel to the centre is not practical, this is a very important part of our service system as it allows clients to see a well-trained, ADF-aware clinician close to home. In 2016-17, around 78 percent (or 11,801 of the 15,132 unique clients) of VVCS counselling clients saw an outreach clinician (source: DVA Annual Report 2016-17).

Telephone Counselling Service

VVCS runs a 24/7 wrap around service which includes an after-hours telephone counselling service designed to assist VVCS clients outside VVCS office hours.

VVCS Client Eligibility

Successive governments have committed to reviewing VVCS client eligibility on an ongoing basis to ensure community needs are met. This has resulted in iterative expansions of VVCS eligibility, most recently in 2016 and 2017. The most recent expansion occurred as part of the 2017 Budget, extending access to:

- the partners and children of current and former Australian Defence Force (ADF) personnel who hold a Repatriation Health Card - Gold or White for an accepted mental health disability. This will assist with early engagement and intervention both for ADF personnel and their families; and
- the former partners of current and former ADF personnel for a period of five years following separation, or for the duration of co-parenting responsibilities for a minor. This will assist in minimising the ongoing adverse effects of family breakdown on all parties.

Facilitated by the expansion of non-liability health care to all mental health conditions also announced in the 2017 Budget, the families of personnel with at least one day continuous full-time service now also have access to VVCS services. This expansion formally took effect on 1 July 2017.

VVCS does not turn members of the current and former serving community who are in crisis or distressed away, even when eligibility criteria are not met. This duty of care includes family members.

Background

In 2016, the Government committed to further expand client eligibility. This change came into effect on 1 April 2017 and extended access to:

- Family members of current and former ADF members who die by suicide or reported suicide.
- Siblings of ADF members killed in service-related incidents.
- Defence Abuse Response Taskforce complainants and their families.
- Adult children (over the age of 26) of post-Vietnam War veterans.

Any expansion requires Ministerial approval of a Determination under the Veterans' Entitlements Act 1986; the Determination is then executed by the Repatriation Commission.

National Advisory Committee

The VVCS National Advisory Committee (NAC) provides quality, independent, consultation-based advice to the Minister for Veterans' Affairs on the effectiveness of VVCS. The NAC meets three times a year at VVCS locations across the country. Secretariat support is provided by the VVCS National Operations team.

The role of the NAC is to:

- Provide independent and distinctive advice to the Minister on the needs of the veteran community and the ways in which these can be delivered by VVCS.
- Support the VVCS to develop programs and services that are:
 - responsive to the mental health needs of Australian veterans and their families
 - based on a health and wellness approach
 - co-ordinated with other mental health agencies
 - consistent with the government's mental health policy, enabling VVCS to be a key component of the Department of Veterans' Affairs delivery of community based mental health care.
- Provide guidance to VVCS on:
 - issues and needs within the veteran and defence communities that impact on the delivery of VVCS programs;
 - strategic service delivery partnerships that will enable VVCS to link with other providers in an integrated approach to mental health care.
- Assess and report to the Minister on the operations and quality of outcomes delivered to the veteran community through VVCS programs.

Through its consultation with VVCS staff, clients and other stakeholders, the NAC has identified several pertinent issues regarding the compensation and rehabilitation that affects veterans' mental health and mental health service delivery.

System Complexity

The policy and legislation around the Safety, Rehabilitation and Compensation Legislation Amendment (Defence-related) Claims Act 1988 (DRCA), the Military Rehabilitation and Compensation Act 2004 (MRCA) and the Veterans' Entitlements Act 1986 (VEA) is very confusing to the veteran, particularly where there is entitlement under more than one act. There are additional challenges for the veteran and their family experiencing mental health issues, including

- a lack of empathy in the language used during the application process
- a perceived lack of transparency or information that should be shared that would help in the management of the process
- the time for a determination to be made with a lack of certainty of funding for treatment
- the perceived or real fear that should a person get better that they will lose their benefits, have them reduced or need to reapply

The resultant stress of the claims process has the potential to worsen a veteran's mental health condition while they are awaiting a determination.

Recommendation: *The NAC supports simplifying and streamlining the claim system, ensuring support and empathy in the language used. The system needs to acknowledge the significant distress being experienced by the veteran and their family and reduce the number of bureaucratic hurdles to achieve a determination for a claim.*

Transition from the ADF

Transition from the ADF to civilian life has improved, particularly for the medical discharge process. However, there are still areas to be addressed including a “warm handover” of care and data sharing. The ADF Garrison Health medical records system does not communicate with the national Electronic Health Record or the VVCS system VERA.

Recommendation: *The NAC supports further information technology enhancements to facilitate data sharing which would expedite claims and lead to better treatment outcomes.*

Claim acceptance

Veterans consistently report frustration and difficulties with trying to prove their claim. There is a strong feeling among veterans and their families that DVA automatically adopt a position of rejecting a claim, forcing the applicant to apply for reconsideration or review.

Rather than having to prove the case for compensation, consideration could be given to automatic acceptance with issue of a DVA white card in the case of exposure to predisposing events. For example:

- deployment to an area of operations should automatically entitle recognition for mental health conditions such as post-traumatic stress disorder (PTSD)
- specific roles involving physical stress/strain (eg. Infantry soldiers) should automatically entitle veterans to recognition of any degenerative orthopaedic condition

Recommendation: *The NAC supports shifting the focus of assessing officers to a viewpoint of acceptance first, and trying to find a reason to reject it, rather than the converse. Automatic white card issue with recognition for conditions following known exposures should be considered.*

Clinician Rebates

The NAC would also like to flag concerns arising out of the Medicare (and correspondingly DVA) rebate indexation freeze affecting psychiatrists and clinical psychologists. The remuneration gap between seeing veterans versus private patients from the general community or Defence members is now so significant that clinical providers are prioritising other clients over DVA referrals. In some cases, providers are refusing to accept clients with DVA white or gold cards because of the poor remuneration offered.

The monetary disincentive for seeing DVA clients, combined with a paucity of mental health services particularly in rural or remote areas, means that DVA clients are either left with no provider choice or must travel significant distances to access care. Even in metropolitan areas, the poor remuneration attracts lower quality providers, for example junior clinicians building their practice or clinicians who can't, for whatever reason, maintain a regular client base. Either situation results in substandard care, and acts as a disincentive to build a workforce experienced in military/veteran issues or managing PTSD.

The treatment of mental health conditions should be standardised between Defence and DVA, with a focus on developing a highly skilled workforce in military mental health.

Recommendation: *The NAC supports a review of DVA rebates to make them competitive with private patient rebates, removing the disincentive to see DVA patients. Notably state and federal workers compensation bodies have realigned their fees for this reason.*

Remuneration should be indexed against stepped models of care, married to case complexity and the type of case management being introduced by DVA and VVCS.

Conclusion

While the NAC is primarily concerned with VVCS service delivery, there are significant overlaps and influences of the DVA claims process. Consideration of the recommendations above would assist with reducing the severity of mental health conditions among veterans and improve long term outcomes.

Yours sincerely,

Professor Jane Burns

Chair, VVCS NAC