Royal Commission Update – Canberra Day 31 – 13 April 2022

RSL References

Positive:

- 9:51am – Volunteering at RSL to give back
- RSL Victoria and Legacy have done a lot of work to address issues re. Case management – if we were to do survey again, we'd have a different set of results – talked about 1300MILVET – RSL VIC Veterans Centre – missing getting into wider committee through other means – 'little slow to catch on'
- Good work on case management by Mates4Mates in Queensland and also RSL Victoria through 1300MILVET and Veterans Central approach

Negative:

- Service Catalogues (generally) – misguided – Putting them online – lacks peer support – can't direct them to all services – some don't know what their actual issue is – doesn't analyse flow-on effects – 'could be very dangerous' – May be a useful adjunct – but needs some clinical supervision

ESO Discussion – Matt Schröffel

- Barriers for veterans and families accessing services offered by ESOs
    - In certain cohort (80s and 90s) have fallen through cracks because of awareness and information
    - Stigma issue with DVA, and organisations who might give them access to DVA i.e. ESOs
    - Might feel embarrassed
    - Don't feel connected to ESOs
    - Don't know how to get started
    - It seems complicated
- Young veterans losing faith in ESOs – going online for support – observation of Facebook groups – lots of informal advice – front door for veteran support is not through ESOs – peer support where RSL or other accredited person as the starting point of case management, this could make a difference, so people don't fall through the cracks – sees role for ESOs - acknowledged this situation is improving – RSL Victoria and Legacy have done a lot of work to address these issues – if we were to do survey again, we'd have a different set of results – talked about 1300MILVET – RSL VIC Veterans Centre – missing getting into wider committee through other means – 'little slow to catch on'
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- Better to focus on case management – know how to manage cases, assess people, collaboration system with other ESOs, assess good ESOs – focus on intake – need first contact and capture of some information – need social workers involved – good work on case management by Mates4Mates in Queensland and

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Recommendations

- Needs to be collaboration between ESOs – observe a lot of fragmentation, vying for grant money, prevalence, some egos, some have a club/membership environments – 'they want to be the champion' – need to collaborate with other ESOs to provide quality services
- Slow to adopt model for collaboration – accept areas where they're strong i.e RSL dealing with veterans directly, Legacy dealing with family members – should consider developing a joint case management standard, regardless of where the intake happens, they can be put in system and offer needs-based services across ESOs – this is improving a little bit
- Need a national case management system
- Governance structures – DVA, ADF, ESOs, service providers delivering services with no overarching organisations – something needs to sit above all of that – board-type situation may be best – independent, arms-length from Government
- Accreditation by Government for ESOs re. service standards

General Summary

- Lived witness testimony, which included suggestions on transition and advocacy work
- Extensive testimony re. Joint Health Command, health structures, and health approaches to suicide and suicidality in Defence
- Testimony on where veterans have identified gaps that would improve their wellbeing, including extensive testimony on the ESO landscape

9:00am – 10:15am - Ben Hofmann (Compensation Advocate, Veterans' Support Centre, Currumbin RSL)

Service

- 19 years in the Army – did recruit training – learnt from those who had been deployed and Vietnam Veterans – lots of experience – great camaraderie, large amount of responsibility
- Deployed to East Timor – toxic leadership, no support for tasks being asked to do – hierarchy fighting for medals – very frustrating – sometimes there was no purpose on the operation – no one has regard for our safety
- Did a decompression program on return – work and PT for a couple of weeks to settle back in, and then you can have leave – then after leave, back to training in Townsville
- When being away from family, wasn't tough because of shorter deployment
- Deployed to Iraq in 2006 – not many weekends at home – training was a waste, leadership was poor – concerned about safety, frustrated that commanders were ignoring experience and micromanaging
- Mental health deteriorated – affected by leadership, attacks, poor orders, no purpose, lack of safety for his team - Physical injury following incident in camp
- Op tempo was extremely high – not enough troops available – led to operational burnout
- Suicide as an option to avoid capture was floated at pre-deployment training – suicide enters toolbox of options
- Returned to Australia – tick and flick psychological screening - marriage broke down, PTSD symptoms, drinking heavily to sleep - received psychological support after seeking help – significant physical injuries
- Medical discharge – documents lost, medical review boards cancelled multiple times – decision papers lost – 13 months to discharge – still feeling unwell mentally and physically - suicidal
- DVA process – some accepted conditions – had to use DVA appointed medical professionals – DVA psychologist was poor – had to find own psychiatrist to support claims – used an advocate

Advocacy work

- Started volunteering at local RSL – thought I could give back - trained in TIP and ATDP

- Good working relationship with DVA – claims process has blown out – want to provide as much as possible during the claims process – provide realistic expectations to their veterans – delegates he works with are on top of things
- Where veterans are vulnerable, let DVA know to get the seen as priority – medically discharged or retiring veterans no longer given priority
- Being able to use own treating medical professionals in claims is beneficial – Non-Liability Health Care (NLHC) are really good – Veterans Payment is good – Incapacity Payments are good
- Lots of veterans don't know about what they're entitled to – no information provided in layman's terms – trauma can make it difficult to understand the information available
- Commonwealth Superannuation (CSC) is not explained well – creates a rumour mill

Recommendations

- Need proper Transition and Rehabilitation Units – proper staffing by highflyers, not has beens – collective unit for rehabilitation – peer reviewed – members from DVA, CSC etc. – transition unit in each Brigade – longer term process - eases transition and provides purpose – help reduce suicide – make it a pre-requisite for brigade command or regimental command, to show they care about their subordinates – similar to US Marine Corps Wounder Warriors Battalions
- Need to get rid of toxic leaders
- Decompression programs – maybe follow the British model

10:30am – 2:30pm Rear Admiral Sarah Sharkey AM CSC (Surgeon General, Australian Defence Force) - Daniel Morton (Director-General, Health Policy Programs and Assurance)

- Joint Health Command – 4 branches – Delivery of healthcare domestically (Garrison Health), Health Policy program and assurance branch, operational health branch (materiel, procurement, specialist areas), health business and plans

Bupa contract

- All health provided by Defence is not provided under BUPA – provides lion share of what Defence members access through BUPA contract – procurement for initial 6 years, with rolling one-year terms, to a total of 10 years – Defence's option – not exclusive when BUPA cannot provide (i.e. Open Arms) and some clinical workforce and support to operational space may also be outside BUPA
- BUPA provides around 95% of services in garrison health system
- Also deliver network of service providers in off-base system – service providers have different agreement between themselves and BUPA
- Objective of entering into contract was to provide assurance re. access to high-quality healthcare services, improvements re. governance, improve clinical governance arrangements and provide opportunities for data informed continuous improvement – Defence gets back BUPA data, which they analyse
- Demand-driven contract – didn't want to reduce costs, but just provide cost certainty
- Patient-centred care is fundamental principle -
- Does Defence have difficulty getting psychiatrists to see members – no, except where there are supply pressures in terms of broader civilian community – reflects shortages in wider health system – see 91% of clients who want to be seen – any delays are due to wider community demand – reflects wider civilian health system environment
- Incentives for BUPA to provide psychiatrists to provide care to Defence members
- Defence health care is a primary health care network – there is a prioritisation process here – clinical team determines what health needs are – BUPA will identify external provider as required, and facilitate Defence member access to service

- To ameliorate individuals not being able to access care – source alternative supplies, surge services in particular centres – re. psychiatrists, recruited and engaged uniformed psychiatrists (currently 4 operating) –
- Ongoing reporting by Bupa about performance under the contract – regular reporting and auditing –
- Some concerns with performance – including invoice management processes
- Forums for engagement – service delivery-level and higher

System

- Seek to provide health care system similar to what is provided to the Australian public – *Commissioner Kaldas:* needs to be beyond this because of the significant risks faced by members (both in service, and in terms of bullying, sexual harassment, hazing etc.) – *Adm. Sharkey*: services are comprehensive, look to support and protect ADF members and their needs – *Kaldas* Not just on the health system, this is whole of Defence *Sharkey:* Agreed. Lifetime approach to member wellbeing, whole of Defence approach is needed, that is reflecting in whole of enterprise Governance arrangements
- Sometimes members will go to a public hospital, sometimes to a private – up to the practitioner
- Some services beyond the Medical Benefits Scheme (MBS) or Pharmaceutical Benefits Scheme (PBS) may be approved on a case-by-case basis – it is a frequently exercised delegation
- 2nd opinions where members are unhappy with interaction – review can include family
- Defence accepts it is under obligation to provide mental wellbeing care to its members
- Reporting members' use of health services of Members to Chain of Command – when this affects what they can do operationally or in the work environment – no detailed clinical information about diagnosis – will not say, without members consent, any identifying information that it is a mental health concern – only restrictions are told to Chain of Command – can include people in the BUPA system who makes these decisions – members will not be pressured to consent to release in the clinical setting
- Independent Welfare Boards – panels of very senior officers according to testimony – but will take this on notice
- Elective surgery – some surgeries may require high-level approval – fee schedules a matter for BUPA- do not fund cosmetic surgery or where a surgery may have impact on specialised occupation – Chain of Command can be involved in timing of surgery
- Obligation to report any health issue that may affect safety of themselves or others – every member is aware of this, right from recruitment – discussion of treatment with Defence Medical Officer
- Barrier to accessing care is employability and deployability – Defence working to optimise trust is Defence Health System – best placed to manage it – working to build trust in the system
- 'Medical downgrading' is a flexible process – tension between ensuring safe workplace v. risk to individual safety
- Consideration of Independent Patient Advocate

ADF Centre for Mental Health

- Around 40 FTE at the Centre – HMAS Penguin as centre – and then regional teams aligned with the 8 Joint Health Unit in each region, looking after 49 health care points
- Provides awareness, mental health promotion activities, workshops, training programs, consultancy services including to command and clinicians

Data

- Current systems can collect data – committed to better measure health outcomes among members and services – working with BUPA to do this
- Suicidality data has flagged serious problem in the transitioned ADF – what outcome metrics are Defence analysing to address this issue? – progress made on ability to access healthcare at the point of suicidality – ideation is higher in ADF members that general community – data has been good in recognising pattern of suicidality and being able to address it

- Also, good data that healthcare is being accessed – so services must be offering something that are being used by members – also Defence is microcosm of national health system
- Defence can now examine suicide and suicidality in a lot more detail, and design better strategies to address them
- Examining other areas of information outside health information – other data from other sources – 86% who have presented to garrison health with ideation do not go on to an attempt

Suicide and suicidality

- 2011 – 3,358 people self-reported suicidal ideation out 50,000 members
- Have audited deaths by suicide and are examining risk factors for suicide and suicidality – analysing patterns to design strategies
- Work needs to be done about identifying holistic information on patterns – stop siloing other sources of info i.e. IGADF, chaplains, Chain of Command etc. – this needs to be a whole of Defence force approach
- Some resources in Joint Health Command have had to be redirected to address other priorities as well
- Senior leadership committed to approach beyond just a health approach – Governance looking to sit in Defence People Group – would facilitate a whole-of-organisation approach

Continuity of Care

- Healthcare coordination forums – formalised system of multi-disciplinary team around a member's clinical management to ensure it's well coordinated and communicated
- No measure of continuity of care
- Habitual relationships – ensuring to the extent possible that is the same group of clinicians that have effective relationship with particular units where Defence members are posted

2:45pm – 4:00pm - Mark Schröffel (Director, Australian Veteran News)

Shout Out

- Led and designed the program for Melbourne Legacy – trying to engage with Younger Veterans (post-1992) – struggling to collect data – turned it into an engagement campaign – wanted to present stories in way that would encourage others to do so as well
- Lifecourse and Wellbeing Model – Design principles of storytelling, journey mapping and social network analysis – can help to identify issues or patterns, and therefore, appropriate solutions and how they affect the person
- Transition of own volition – initial elation and planning – delayed effect of struggles or realisations – can be a turning point and readjust (often a peer or someone they knew suggesting something)
- Tougher for those who leave involuntarily – can be at a low point for a long time – turning point when they get triggered into a proactive mode – 5-6 year transition
- Barriers for veterans and families accessing services offered by ESOs
    - In certain cohort (80s and 90s) have fallen through cracks because of awareness and information
    - Stigma issue with DVA, and organisations who might give them access to DVA i.e. ESOs
    - Might feel embarrassed
    - Don't feel connected to ESOs
    - Don't know how to get started
    - It seems complicated
- 6 key insights
    - former NCOs are key influences (connection, rapport, trust) – ESOs may not be the best way to do this as that they don't feel that they trust them – most veterans who are members of ESOs don't want to be
    - families bearing the hidden burdens of service life – posting cycles, missing parents, burden of care, health care, hidden costs
    - Young veterans losing faith in ESOs – going online for support – observation of Facebook groups –

lots of informal advice – front door for veteran support is not through ESOs – peer support where RSL or other accredited person as the starting point of case management, this could make a difference, so people don't fall through the cracks – sees role for ESOs - acknowledged this situation is improving
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    - Transition is an ongoing process with complicated twists and turns
    - DVA need better surveys to engage with Veterans and then obtain insights
    - Important for reservists to control their stories and see the future – better attention needs to be paid to reservists – ADF has failed reservists for a long time

<u>Recommendations</u>

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<u>Australian Veterans News (AVN)</u>

- Conduct a Veterans Wellbeing Survey – sacrifice some scientific rigour for engagement and speed – good representation from all age groups – designed around Australian Institute of Health and Welfare (AIHW0 model
- Surveys not necessarily for data analysis – more about engagement