INDEPENDENT REVIEW OF THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE JOINT INQUIRY INTO THE MANAGEMENT OF JESSE BIRD'S CASE

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Acknowledgements

I acknowledge with gratitude the assistance I received in the preparation of this review from many persons in the Department of Veterans' Affairs (DVA), the Department of Defence and in the Commonwealth Superannuation Corporation. This review, covering as it does, many aspects of the operations of the three agencies, but particularly of DVA, would not otherwise have been possible without the willingness of people with whom I spoke to be open about processes and laws which need rectification for the betterment of the welfare of veterans.

In particular, I would like to mention Mr Neil Bayles, Assistant Secretary, Portfolio Assurance Branch, Legal, Assurance and Governance Division, and Mr Mark Vuaran, also of that Branch. Their support has been invaluable while being scrupulous about not intruding on my independence.

In addition, I acknowledge the work of Ms Karen Bird and Ms Connie Boglis for their tireless efforts to ensure that the death of Mr Jesse Bird has been a catalyst for change.

Robin Creyke

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OVERVIEW

Following the *Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case* (*Joint Inquiry*), instituted by the former Minister for Veterans' Affairs, the Hon Dan Tehan MP, the current Minister for Veterans' Affairs, the Hon Darren Chester MP, appointed me to undertake an independent review of the implementation of the nineteen recommendations of the *Joint Inquiry*.

The terms of reference for the Independent Review are to:

- Ensure each of the recommendations has been, or is being, actioned in a timely manner;
- Ensure that the actions being undertaken for each recommendation are appropriate;
- Evaluate the progress of the implementation of the recommendations; and
- Prepare a report to Government on the findings of the Review.

The report to Government on the findings of the Review is attached. Of the nineteen recommendations I have found that:

- Appropriate action has been taken in response to fourteen of the recommendations that are either complete or substantially complete, needing only ongoing monitoring and evaluation, or consideration of ancillary changes.

Of the remaining five recommendations:

- Recommendation 4 (a priority recommendation) requires improved internal information-sharing between Open Arms and DVA, and changes to Privacy Policies are suggested to ensure that the purpose of information collection is consistent with best interests of the veteran;
- Recommendation 6 (a priority recommendation) requires further progress on initiatives to improve information-sharing, including the development of an electronic information sharing system for DVA, Defence and the Commonwealth Superannuation Corporation (CSC);
- Recommendation 10 requires completion and evaluation of the piloting of the case management approach, in particular the Wellbeing and Support Program, prior to further consideration by Government, as well as a continued focus on transition;
- Recommendation 11 highlights the need for the development of an ICT system which integrates available client information in a single client view, better supporting the ability of staff to identify and manage clients at-risk; and
- Recommendation 13 requires more progress on the significant future body of work to update DVA letters and knowledge management systems, and in the interim urgent improvement of the most commonly used template letters.

DVA is undergoing dynamic and profound changes under its program of Veteran Centric Reform, changes which benefit the veteran community as a whole, including those who are at-risk or vulnerable. These changes are being driven by the professionalism and commitment of the leaders within the agency.

My discussions with these members of the senior executive staff indicate that, subject to forthcoming final reports from parallel inquiries, including of the Productivity Commission, and appropriate funding, those remaining recommendations will be effected in due course.

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Emeritus Professor, ANU
15 March 2019

SUMMARY REPORT

The 2018 update figures from the Australian Institute of Health and Welfare (AIHW) in its annual *National suicide monitoring of serving and ex-serving Australian Defence Force personnel*[1] showed that in the 2014-2016 period the suicide rate for young (under 30) ex-serving personnel of the Australian Defence Force (ADF) was 2.2 times higher than for Australian men the same age.

The AIHW completed an initial study of suicide among serving and ex-serving ADF personnel in 2016, amid strong and increasing public concern around this issue. This concern has also been reflected in the establishment of a large number of Parliamentary and government reviews and inquiries, which have looked at the suicide of serving and ex-serving ADF personnel, their mental health more broadly, and the adequacy of the services and systems for their support, compensation, and rehabilitation. These include a parliamentary report in 2017 (*The Constant Battle: Suicide by Veterans*),[2] a report of the Auditor-General (*Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs*),[3] and the draft report of the Productivity Commission inquiry into Compensation and Rehabilitation for Veterans, to be completed in mid-2019 (*A Better Way to Support Veterans*).[4]

The significance of the findings of these reports prompt urgent attention, particularly in relation to the issue of suicide in the Australian veteran community, veteran mental health, and the need for improvements to existing services and support systems for veterans.

One such death was that of Mr Jesse Bird, who took his life in June 2017 at the age of 32. Mr Bird had voluntarily left the ADF in 2012. He had a number of accepted mental health conditions, had difficulty finding meaningful work after his discharge, and suffered financial and relationship stressors. His case has become a litmus test for the need to better understand and respond to the risk factors of suicide in serving and ex-serving ADF members.

There is a paucity of research into the causes of veterans' suicide,[5] but generally understood risk factors for suicide include issues affecting Mr Bird: mental illness, unemployment, relationship and financial problems. Another issue identified in submissions to the *Constant Battle* report is the impact of dealing with administrative delays and problems: '*delays, negative determinations or perceived maladministration in DVA* [Department of Veterans' Affairs]'.[6] These factors were at the forefront of an inquiry by DVA and Defence (*Joint Inquiry*) into Mr Bird's death instituted by the Hon Dan Tehan MP, then Minister for Veterans' Affairs, and have been the principal focus of this review.

The *Joint Inquiry* produced 19 recommendations with an emphasis on the improvement of services for veterans seeking compensation and support (Appendix 1). These recommendations were tabled in Parliament on 24 October 2017 and the Minister advised that on behalf of the government he had accepted all the recommendations.

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[1] Australian Institute of Health and Welfare (AIHW) *National suicide monitoring of serving and ex-serving Australian Defence Force personnel: update 2018* (2018.)

[2] Senate Standing Committee on Foreign Affairs, Defence and Trade *The Constant Battle: Suicide by Veterans* (2017) (*Constant Battle* report)

[3] Auditor-General Audit Report No 52 of 2016-2017 *Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs* (ANAO report).

[4] Productivity Commission Draft Report *A Better Way to Support Veterans* (2018) (Productivity Commission Draft Report).

[5] Senate *Constant Battle* report [3.25].

[6] Senate *Constant Battle* report [3.43].

On 2 November 2018, the Minister for Veterans' Affairs the Hon Darren Chester MP appointed me to undertake an independent review of the implementation of the nineteen recommendations.

The Terms of Reference for the Independent Review are to:

- Ensure each of the recommendations has been, or is being, actioned in a timely manner;
- Ensure that the actions being undertaken for each recommendation are appropriate;
- Evaluate the progress of the implementation of the recommendations; and
- Prepare a report to Government on the findings of the Review.

The context in which these recommendations are to be assessed is a period of unprecedented change within the Department. Commencing in 2016, DVA began transforming its policies, procedures and legislation to provide more targeted and improved services to veterans and their families. In particular, the changes are intended to make it easier and quicker for veterans and their families to interact with the Department and to improve their experience when interacting with the Department.

Much of this transformation is being funded year to year by Government under the Veteran Centric Reform (VCR) program, which is expected to last six years. There has also been legislative amendment to support many of the reform initiatives[7]. VCR marks a profound change to the mode of operation of the Department. From being a compensation and claims focused body it is to become one which embraces not only compensation, but the rehabilitation, financial security, mental and physical wellbeing of veterans and their families. VCR involves putting veterans at the front and centre of DVA's operations to ensure they do not get lost in the process.

The reforms reflect an acknowledgement that the complexity of the laws DVA administers, its antiquated technology systems, and manual processes are not fit to provide the kind of support veterans and their families require in the twenty-first century, and to be able to provide that support when it is needed and before it is too late.

In parallel with the transformation, there has been a wholesale reorganisation of the governance of the Department which took place over 2017-2018, including new structures and leadership. Translating these new principles into legislation, policy and procedures inevitably takes time. VCR is intended to energise that process. The change is being progressed with enthusiasm, and determination by the Department, driven by the professionalism and commitment of its senior staff.

The task should not be underestimated. The Department has been in existence for over a century. The Repatriation Department was set up in 1917 to provide for veterans of World War 1. The Department of Veterans' Affairs followed nearly half a century ago, in 1976. The successors of 'the Repat' have been responding to the needs of those who have returned from the numerous conflicts in which Australian forces have been engaged. That has meant that the functions of the agency have progressively been expanded as the nature of the war or service has changed and the needs of those who took part have evolved. VCR is the latest iteration of that evolution.

Today, these changes include tasks as large and complex as the digitisation of more than 250,000 client files, the review of more than 900 template letters to clients, the modernisation of more than 200 antiquated information technology systems, the consolidation of more than 200 public telephone lines, the revision of many thousands of documents in its Consolidated Library of Information and

[7] *Veterans' Affairs Legislation Amendment (Veteran-centric Reforms No 1 and No 2) Acts 2018* (Nos 1 & 2) (Cth).

Knowledge (CLIK) containing information used by DVA staff and clients, and managing the potential reform of three complex and overlapping pieces of legislation. None of these are tasks which should be underestimated.

Nonetheless, prioritising reform needs is critical. If attention is to be centred on the whole person's welfare, the reforms need also to take into account veterans and their families who most need that support - the at-risk, the vulnerable, and those with complex claims.

Consistent with that principle, this review was charged with assessing the degree to which the 19 recommendations made following Mr Bird's death have been completed, and the timeliness with which the responses have been undertaken.

Key findings

My examination has concluded that fourteen of the recommendations are complete or substantially complete. These issues now need only minor changes, or, in some cases, ongoing monitoring and evaluation, or legislative change.

Of the remaining five recommendations, two (recommendations 4 and 6) are among the priority recommendations listed in the *Joint Inquiry*. The first relates to improved information-sharing internally between DVA's counselling and mental health service, Open Arms, and the rest of the Department, the second concerns improved information-sharing between DVA and its partner agencies, in particular Defence.

Other hurdles faced by DVA are its complex claims legislation involving three principal Acts, the *Veterans' Entitlements Act 1986* (Cth) (VEA), the *Military Rehabilitation and Compensation Act 2004 (*Cth) (MRCA), and the *Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988* (Cth) (DRCA), and the consequential impact of this complexity on DVA's claims processes, staff capability, and client experience.[8]

The issue of inefficient administrative processes reflects survey findings from the Special Operations Forces Pilot (SOFP) which has just concluded. The worst irritant for the participants, who were transitioning from the ADF, was DVA's 'complex, slow processing', considered by 100 per cent of transitioned members surveyed as the 'most severe' of the irritants they faced in dealing with the Department, and by nearly 90 per cent of those surveyed as one of the 'most frequent'.

These areas for further work are consistent with the findings of the Productivity Commission Draft Report which identified as issues for DVA 'outdated information and communication technology (ICT) infrastructure, as well as inefficient, and poorly planned and executed administrative processes',[9] and which observed that 'DVA should also evaluate the effectiveness of its own mental health service — Open Arms … to ensure that services are … accessible'.[10]

Priority recommendations (recommendations 1-9) issues

Information-sharing between Open Arms and DVA

Information exchange between Open Arms, DVA's counselling and mental health service, and the remainder of the Department is not optimal (recommendation 4). Concerns about sharing arise due to the confidentiality underpinning the counsellor/client relationship, a reluctance on the part of

[8] Productivity Commission Draft Report, 120.
[9] Productivity Commission Draft Report *A Better Way to Support Veterans* (2018) (Productivity Commission Draft Report) Chapter 9 'Key Points'.
[10] Productivity Commission Draft Report, 34.

counselling clinicians to share information even for at-risk clients, coupled with privacy inhibitions. The current consent form needs revision to clarify when information-sharing can occur.

The *Privacy Act 1988* (Cth) restrictions can be overcome. Both Open Arms and DVA have adopted a wellbeing, whole person model of care for their clients. This model was adopted by DVA generally under VCR, and Open Arms has indicated it is taking a person-centred approach to risk formulation and intervention planning as indicated by the revision of its Risk Assessment Management Plan (RAMP) tool.

That convergence, provided the change is publicly notified, sustains an exchange and use of information collected by Open Arms or DVA in circumstances which are for the benefit or best interests of the individual concerned. Changes are required to the Privacy Policies of both Open Arms and DVA to make clear that they operate under a welfare model for the support of the individual before this barrier can be overcome.

DVA could seek authority to amend legislation to mirror an exemption found in NSW privacy legislation to overcome the inhibition. The NSW provision permits a public sector agency (Open Arms is part of DVA) to share and use information for the benefit or best interests of an individual.

Adoption of these steps would permit the interchange and use of information about clients who are presenting as 'at-risk' (not just at 'serious risk') to their life or health, with consent if appropriate, but without consent if the clinician has identified sufficient risk.

Information-sharing between Defence and DVA

In relation to information-sharing with Defence (recommendation 6), training of DVA staff more accurately to request advice has reduced the time taken to process information requests with Defence, and proof of identity issues have been simplified. In addition, direct access by DVA staff to Defence's electronic records is progressively becoming available and the numbers of staff with access will increase when security clearance backlogs are reduced.

DVA and Defence have revised their KPIs and introduced a more sophisticated framework for the categorisation and prioritisation of information requests. There has been a number of improvements to the Single Access Mechanism (SAM) for information exchange between Defence and DVA, and the average time taken to resolve information sharing requests has been reduced.

However, there is evidence that a substantial proportion of information requests are not meeting the revised KPIs. This supports the need for continued efforts to improve information-sharing, including the continuation of existing initiatives and the longer term development of an electronic information exchange system for Defence, DVA and the Commonwealth Superannuation Corporation (CSC).

VCR recommendations (recommendations 10-17) issues

Case management

A small number of DVA clients are managed by the Coordinated Client Support (CCS) team, which helps vulnerable clients and clients with complex claims to navigate DVA services and ensure their needs are met. CCS provides a level of case management for clients, as well as linkages to internal DVA supports and external community and medical supports. More holistic approaches to case management (recommendation 10) are being trialled in DVA, but there is more work to be done. That is in part due to the embryonic stage of some of the pilot programs, to case management being resource intensive, and to difficulties in locating suitable case managers in some regional areas.

The trials of case management approaches are, however, indicative of a willingness to embrace this form of support for vulnerable or at-risk veterans and their families. An example of this commitment

is the Special Operations Forces Pilot program for transitioning members through assistance of a dedicated DVA officer, and case management, if needed, for veterans and their families. Other examples are the Transition Health Assessment (THA) Project for streamlining medical assessments for use by DVA, Defence and CSC; the Wellbeing and Support Program, a case management program for clients with complex or multiple needs; and the Veteran Suicide Prevention Pilot providing support to those who have experienced a suicide crisis. No decisions have yet been made about routine adoption of any of these pilot studies and further work is required in relation to the monitoring, completion and evaluation of these trials and pilots.

Open Arms has introduced a Complex Needs Client Support program for client integrated care. The program seeks support from multiple agencies and providers to produce an appropriate outcome but needs evaluation. After a successful pilot in Townsville, Open Arms has also recently decided on a national roll-out of a Community and Peer Program to help manage complex and high-risk clients with the assistance of 'lived experience' mental health peer workers.

Defence and DVA continue to monitor and drive initiatives benefiting transitioning veterans, and both agencies have an enhanced willingness to manage and develop rehabilitation programs with the aim of ensuring veterans continue in employment. These steps are in train but need evaluation and monitoring to ensure maximum effectiveness, as well as time to implement and scale up successful programs. A parliamentary report is expected in 2019 concerning transition issues.

System support for the identifying and managing high risk clients

Considerable work has been undertaken to identify behavioural triggers which alert staff to veterans who may be at-risk, and to set up a dedicated team to manage internal assessment and referral of these veterans. Training has occurred, and a new Client Support Framework has been established. Recent recruitment for front-line staff has included consideration of their 'soft skills'. It is too soon to evaluate the success of these moves which occurred only in the latter part of 2018.

In relation to ICT changes (recommendation 11) there are some encouraging developments:

- DVA can put priority indicators on claims in the Integrated Support Hub (ISH),the DVA claims management system, including to identify if the claimant is suffering financial hardship, was medically discharged, or where the claim relates to sexual harassment, sexual or physical assault; and
- it is expected that by April 2019 there will be a flag at the client-level in ISH to identify clients with current or accepted claims for mental health conditions.

A major issue is that there is no single system which permits a complete view of the client for staff dealing with clients and their claims. Information on a veteran is contained in multiple databases, and in some cases between Departments (e.g. Defence medical and service records). There is generally no capacity for those systems to communicate with each other. Staff, too, are generally tasked with decision-making on one or a limited number of aspects of a claim, and different staff are likely to be involved for different claims by the same veteran. This fragmentation of systems, and segmentation of the claims processes, prevents the development of a holistic view of a claimant's interactions with DVA and is inimical to achievement of the goals of VCR.

More system flags are needed to allow staff to identify complex claims, homelessness, and educational, race or age-related reasons for difficulty navigating online and administratively complex processes (see recommendation 9). However, the introduction of additional functionality to the current claims system may not be feasible, and the importance of such changes supports the need for a new system which could provide a single client view.

At the same time, there is a need for caution in adopting ICT solutions to all client interactions with DVA. ICT systems can certainly improve consistency, timeliness and comprehensiveness. However, to the extent they reduce the need for interactions with DVA staff, they also remove the ability of staff to develop a relationship with a client and develop an understanding of their circumstances. In particular, a system is not able to read subtle behavioural indications of stress on the part of a user. To identify the at-risk or vulnerable requires emotional intelligence, and sensitivity. These are not qualities which can be achieved by systems.

Communications and knowledge management

Approval has been obtained by DVA management for a program to improve communications (recommendation 13) and knowledge management including CLIK, fact sheets, and manuals. Specific training on the application of behavioural insights to improve letter writing has occurred, and funding has been approved for a whole of department letters improvement program. More needs to be accomplished. There should be early revision of the most common template letters under the three Acts, and attention is needed to replace the revised templates in the ICT systems.

Conclusion

Underpinning these transformational changes has been the input from the multiple reviews and inquiries into the operation of DVA. The impetus and visions they have provided should not be underestimated, but there is no substitute for lived experience to provide impetus for change.

Two people who have helped provide that lived experience are Ms Karen Bird (Mr Bird's mother) and Ms Connie Boglis (his former partner). They have worked tirelessly to ensure that the death of Jesse Bird was not in vain. Together they have maintained the pressure for change. Their efforts have resulted in attention being given to deficits in some aspects of DVA's operations. The result, as I have perceived it during this review, has been a 'perfect storm' of improvements, as chronicled in this review, to the way in which the Department interacts with its veteran community and their families. Jesse would be proud of them.

Much has been achieved, but more change is needed. Some of those changes are matters which need routinely to occur. They include evaluation, monitoring and testing changed processes to ensure they meet their desired objectives, and that those who are responsible for their administration understand them and can refine them as necessary. Others, such as systems changes, cultural changes, and foundational principles will take longer to embed. The process is underway and with careful attention the goals can be reached.

RECOMMENDATIONS 1-19, RESPONSES AND SUGGESTED ACTIONS

Priority recommendations 1-9

Recommendation 1: The Secretary to examine the areas of potential non-compliance with current legislation and policy to provide the Minister advice regarding any redress action/s.

This recommendation has two aspects: a response specific to the circumstances relating to Mr Bird's death; and areas of legislation and policy which need updating or change generally.

The response to this recommendation in relation to Mr Bird is complete. The Department conducted an internal inquiry into the facts of Mr Bird's case, identified areas of non-compliance with legislation and policy, interviewed those involved and provided advice to the Minister. The recommendation was actioned in a timely and appropriate manner. As the deficiencies identified were generally in line

with the policies and practices at the time, and these policies and practices have been revised or clarified, and misunderstandings rectified, no further suggestions for action are required.

The response to the generic application of this recommendation is outlined in the remaining recommendations. The Department has committed to support clients at-risk or who have complex claims. Consistent with the Department's pre-existing Transformation program and VCR, it has put in place revised departmental structures, practices and procedures to better provide for the veteran community and these steps are outlined in the response to the remaining recommendations.

Legislation has been passed providing for VCR, for support to families following the death of a veteran or former veteran, and the veteran payment has been introduced for veterans who have a lodged a claim for a mental health condition and who are struggling financially.

A suggestion is that there needs to be continued focus on legislative change to the VEA, alongside that for the MRCA/DRCA, pending more wholesale legislative changes following the final report of the Productivity Commission.

Recommendation 2: Provide delegates with a clear statement of the policy and processes when considering an interim payment of compensation for permanent impairment to ensure that interim compensation payments are being provided in all cases where appropriate.

The response to this recommendation is substantially complete. There are now clear statements of policy and processes requiring consideration, where appropriate, of payment of an interim payment of compensation for permanent impairment.

One suggested action is that DVA seek authority to amend the legislation to support waiving any overpayments.

Recommendation 3: Put in place controls to ensure process of registration of claims is consistently followed when needs assessment is received and not delayed by other information that is not yet provided.

The response to this recommendation is substantially complete. Training has been delivered, and policy documents have been amended to ensure registration of claims is not dependent on lodgement of a D1360 form. The completion of a needs assessment also now results in claims automatically being registered for the appropriate benefits. These changes have contributed to significant reductions in the time taken to register claims under the MRCA or the DRCA.

Suggested actions are:

- update the Integrated Support Hub (ISH) system to remove the requirement for pre-lodgement of a D1360 form;
- ensure that future induction and refresher training emphasises there is no need to pre-lodge a D1360 form for registration to occur; and
- undertake spot checking of claims to ensure the correct position is understood.

Recommendation 4: Enhance reporting and risk factor escalation between VVCS and DVA through an offering to clients that includes an 'opt-out' model of information sharing, so that all support services are integrated for clients with diagnosed mental health issues.

The response to this recommendation needs continued attention. Open Arms (formerly VVCS) revised its consent form, and has increased its collaboration with the rest of the Department. More is needed to remove restrictions on communication between the two to enable early support to clients to avoid potential self-harm. Barriers remain due to cultural factors; confidentiality undertakings to clients; and the *Privacy Act 1988* (Cth).

Suggested actions to be taken are for Open Arms:

- to encourage all its clinicians to prepare a Risk Assessment Management Plan (RAMP) for any client at the commencement of any provision of its counselling service; and
- to further revise its consent form to support better information sharing.

Suggested steps to alleviate the legal restrictions to information exchange in the *Privacy Act 1988* (Cth) are:

- for Open Arms and DVA to revise their Privacy Policies to indicate that a purpose of their collection of information is to enable them to use that information to offer services for the benefit or welfare of their clients; and
- to seek authority to amend relevant legislation to provide that as a public sector agency, there is an exemption for DVA including Open Arms to keep confidential information it collects, where the purpose is for the benefit of the individual concerned.

Recommendation 5: Put in place controls to ensure that complex case management is initiated for complex or high risk clients.

The response to this recommendation has been substantially completed, subject to provision of consequential funding and resources.

Steps have been taken to provide at-risk client indicators, to establish the Client Support Framework, which includes the Triage and Connect team, the Coordinated Client Support (CCS) team, the Managed Access team (for clients with unreasonable behaviours) and the Wellbeing and Support Program. The Triage and Connect team better manage, if needed, the assessment and referral to appropriate services, including case management, of clients at high risk or with complex claims. Triage and Connect also manage escalations of complex cases and high risk clients for executive consideration at a Weekly Client Discussion (WCD). Further escalation is also available to the Problem Solving Forum, for exceptional or urgent cases needing the attention of subject matter experts from across the Department. New procedure manuals have been developed and training has been delivered to relevant staff on the new framework and processes.

These developments, alongside the development of a flag indicating where a client has claimed for a mental health condition (see recommendation 9), support:

- better recognition of client vulnerability; and
- allocating experienced staff to manage face-to-face interactions with clients at high risk or with complex needs or claims.

Front-line staff have been made aware of the need for sensitivity in interactions with vulnerable clients, and better understand the circumstances in which they should refer claims to Triage and Connect. This helps avoid the overburdening of front-line staff who may lack the skills to manage at-risk clients and who are already managing a high caseload.

DVA analysis indicates that around one in three veterans who deal with DVA have current or accepted claims for mental health conditions. The number of veteran clients who have mental health conditions is likely to be higher, as not all veterans will be aware they have a mental health condition, and not all mental health conditions will be service-related. These figures are significant and support the Government's decision to extend the availability of non-liability health care for all mental health conditions. They are also indicative of the need for a management focus on this cohort in relation to claims processing and determination.

VCR and the Early Engagement Model may have contributed to the recent spike in claims received by DVA. The high number of claims being received by DVA, together with the high proportion of claimants with mental health conditions, indicate that the referral and case management functions will need increased funding and personnel if these bodies are to operate effectively for the benefit of veterans at-risk or with complex needs or claims.

Recommendation 6: Revise Service Level Agreement Key Performance Indicators for information sharing with partner agencies (such as Defence and the Commonwealth Superannuation Corporation), including timeframes for DVA to request information as soon as possible after claim registration and timeframes for partner agencies to respond.

The response to this recommendation is underway but is incomplete, despite being a priority recommendation. Although ambitious ICT programs inevitably take time to implement, there are also a number of non-ICT aspects to this recommendation. The ongoing failure to meet KPIs for information-sharing suggests the need for continued attention to these initiatives. A suggested action is embedding personnel from each agency in the other to improve information sharing.

The KPIs for DVA/Defence interchange of information have been revised. The Commonwealth Superannuation Corporation (CSC) does not have a formal agreement, including timeframes, for sharing information, but the communication and manual processes between CSC and the other agencies are within acceptable timeframes.

Improvements to the Single Access Mechanism (SAM) for information exchange between Defence and DVA have reduced the average time taken for information sharing, and there is a Defence / DVA Electronic Information Exchange (DDEIE) Strategy under way which includes the development of a cost-effective electronic information sharing and exchange system for Defence, DVA and the CSC. Refinements and developments to existing processes and procedures are needed and are being undertaken. These steps address delays in evidence-gathering. There is a subsidiary hurdle due to delays in obtaining security clearances from the overburdened Australian Government Security Vetting Agency to support direct access by DVA staff to electronic Defence records.

Recommendation 7: Review existing Service Coordination processes that provide coordinated, tailored and empathetic response to families, for relevancy in the case of the death of non-serving clients.

The response to this recommendation is complete. The *Veterans' Affairs Legislation Amendment (Veteran-centric Reforms No 1) Act 2018* (Cth) has amended the MRCA to insert Chapter 5A to provide

a Family Support Package. The Family Support Package provides further support to families with access to counselling, child care and home help, as well as assistance to widowed partners and spouses of eligible veterans. These supports are available where the veteran's death was a service death or was a suicide related to service. Service coordination processes have been updated and training has been undertaken to ensure that staff are able to provide an empathic response to families. Under the Client Support Framework, service coordinators form part of CCS and provide coordinated and tailored information and services to bereaved families.

Recommendation 8: Educate staff and monitor implementation of the inquiry recommendations above.

The response to this recommendation is substantially complete. Extensive training has been undertaken relating to the legislative, procedural and structural changes which have taken place in response to the *Joint Inquiry* recommendations.

Attendance at training is being monitored, and understanding of the material checked. Specialist training for dealing with clients with claims related to sexual and physical abuse has been delivered, and relevant staff are being encouraged to undertake courses relating to mental health first aid, and suicide prevention.

Training has also been delivered on the identification of clients at-risk or with complex needs or claims, and when to escalate claims.

There is a program for recruitment of staff with appropriate 'soft skills'.

Management needs to ensure that there is:

- recruitment and training that results in an appropriate balance of staff with technical and 'soft' skills;
- face-to-face training of relevant staff for dealing with clients with mental health issues, who are at-risk or vulnerable, or exhibit difficult behaviours;
- training for delegates and managers to undertake supervision and support of front-line staff following emotionally demanding interactions with clients; and
- a DVA capability to support staff who are emotionally distressed, to supplement the support provided by the Employee Assistance Program, in recognition of the number of clients with mental health or other vulnerabilities and the special character of issues facing those who are or have served in the ADF.

Recommendation 9: Identify indicators for veterans at-risk to develop best practice case management models.

The response to this recommendation is encouraging. A set of 'at risk flags' was initially developed by DVA and communicated to staff to help them identify clients at risk. It was followed by the development of an expanded set of 'triage referral and assessment indicators' to use under the Client Support Framework. Open Arms has its own approach for managing clinical risk. The triage referral and assessment indicators include client risk indicators as well as departmental risk indicators, critical response indicators, indicators of claims or entitlement complexity, and the client behaviours to be considered if referring clients to DVA's Managed Access team.

The triage referral and assessment indicators expand on and encompass the 'at risk flags', and care should be used to avoid confusing front-line staff by having multiple lists.

A system flag to identify if a client has a current or accepted claim for a mental health condition is expected to be in place by April 2019. However, further extension is needed of the ability of DVA's ICT systems to support the identification of at risk and vulnerable clients. Best practice case management would benefit from a single client view which included information indicators such as homelessness, 'complex claims', difficult behaviours, and for those having difficulty navigating DVA systems and processes for educational, race or age-related reasons.

The refinement of DVA's ICT systems and behavioural indicators to support best practice case management models for at-risk clients should continue.

VCR-related recommendations 10-17

Recommendation 10: Continue to pilot an integrated and holistic case management approach, including a whole-of-person view, a holistic care model for veterans, and an increased focus on transition support and vocational assistance. Subject to the evaluation of the trial this will require further consideration by Government.

Integrated and holistic case management approach

The response to this recommendation is partially complete, requires completion and evaluation of the current trials, and further consideration by Government.

DVA has developed and is piloting case management for veterans through the Wellbeing and Support Program. The Wellbeing and Support Program is designed to provide clinical care coordination and claims management using a single point of contact for at-risk clients. It is resource intensive and to date has only been made available to a small number of clients. The initial evaluation is due in the first half of 2019. If the evaluations of the Program are positive, the Program could be considered for expansion and ongoing funding beyond 2020.

The underlying principle of VCR is to provide a holistic care model for veterans. Two other relevant programs are Open Arms' Community Coordination pilot, and DVA's Veteran Suicide Prevention pilot. The Community Coordination pilot has been successfully evaluated and a Community and Peer Program is being rolled out nationally. The Veteran Suicide Prevention pilot will, if adopted, also assist in providing a holistic care model and support to combat suicide of veterans.

Open Arms is embracing a more whole-of-person case management approach and clinicians are being trained to refer clients to other appropriate agencies and private sector providers.

The principal barrier to DVA having an integrated and holistic decision-making approach is due to the ICT barriers outlined in recommendation 11.

Transition and Vocational Support

DVA and Defence, in conjunction with CSC, are focusing strongly on transition and vocational support for veterans exiting the ADF. This includes rehabilitating veterans to return to service, or to be gainfully employed. Under the Special Operations Forces pilot, currently being evaluated, a dedicated DVA Liaison officer is available for members and their families to assist with the transition process, and if necessary, to provide a case manager. The Transition Health Assessment pilot tested approaches to consolidate and streamline medical reports required by DVA, CSC and Defence. This program is also being evaluated.

Financial assistance to veterans who have lodged a claim for a mental health condition and who are unable to work more than eight hours per week is provided by the 'veteran payment', a recent government initiative. A number of other DVA initiatives impacting on transition and vocational support are listed in the discussion.

Suggested actions include:

- wide notification of the Early Engagement Model to encourage earlier lodgement of claims and to improve understanding by ADF members of the services offered by DVA;
- increased emphasis by Defence and DVA on the development of transition plans before discharge; and
- continuation of a joint monitoring body comprising Defence/DVA personnel to monitor existing programs and develop creative programs to assist transition and vocational support for veterans.

Recommendation 11: Implement better systems and processes to identify and alert staff in order to support high risk and vulnerable veterans.

The response to this recommendation is partially complete but needs to be ongoing given staff turnover, and there is a need for further ICT development.

Better systems and processes have been implemented with the development of the risk indicators discussed at recommendation 9 and the establishment of the Client Support Framework (including Triage and Connect, CCS, the Managed Access team, and the escalation bodies such as the Weekly Client Discussion, the Problem Solving Forum), and a Steering Committee to coordinate and oversight support for delegates. As part of the new Framework, all Security Incident Reports are also sent to the Triage and Connect team, where expert staff investigate DVA supports, at the same time that embedded social workers assess from a psychosocial perspective. These developments, coupled with a planned flag for clients with mental health claims, changes under way to the complaints management system to better manage those at-risk, and staff training on the improved systems and processes, have implemented this recommendation to help staff identify high risk and vulnerable veterans. Other initiatives are listed in the discussion, including that Open Arms has revised its risk assessment management plan (RAMP) tool to reflect best practice in clinical risk assessment.

The major ICT issue relates to claims processing. The inability of the multiple systems to talk to each other leads to fragmentation of information about a client, compounded by segmented claims processes which mean individual staff do not have a complete picture of a client or their needs. In combination these problems prevent staff having a whole-of-person or single view of the client and are currently significant barriers to the goals of VCR.

DVA ICT architecture needs urgent updating to dismantle these barriers, to reflect the changed architecture for support of those at-risk, and to avoid the potential for inconsistent practices from manual workarounds.

A suggested action is the introduction of a system which integrates relevant information and provides staff with a single client view, which would include clear and editable information on a particular client's risk indicators. At present the available 'priority indicators' are applied to claims, rather than clients, and do not cover all of the factors which would be relevant for considering a client's risk or vulnerability (see recommendation 9).

Recommendation 12: Put in place wellness checks for uncontactable clients with mental health conditions and trigger additional support mechanisms for clients with mental health conditions who repeatedly submit incomplete documentation or exceed expected response timeframes.

The response to this recommendation is substantially complete, subject to ongoing monitoring and implementation of wellness checks.

Wellness checks are conducted by DVA social workers for new clients, and can also be conducted, on request, at any stage during the claims process. The Open Arms Risk Assessment Management Plan (RAMP), to be finalised in 2019, is adopting a person-centred approach. On intake, and at any time during counselling, a client is assessed for risk of harm to self or others so protective factors can be implemented.

There have been improvements to the claims system to alert claims staff and team leaders of the need to take action if milestones are missed.

From 1 May 2018, financial support has been available in the form of the 'veteran payment' for veterans who have claimed for a mental health condition and who are unable to work more than eight hours per week.

Recommendation 13: Implement action to ensure letters and emails are accurate, easy to understand and appropriate in tone.

The response to this recommendation needs continued attention.

Approval has been obtained for a project to review and redesign fact sheets and letters. The project plan has been developed but to date there is no outcome in terms of reframed letters or fact sheets. In the interim, a manual has been developed on 'Using behavioural insights to write better letters' and training on the manual undertaken.

The blockages include:

- implementation being tied to the broader knowledge management reforms;
- the number of letters involved;
- the slowness of reform of templates in ICT systems with the resultant manual workarounds being a potential source of errors and inconsistencies in correspondence; and
- the difficulty of simplifying reasons when complex legislation is involved.

An immediate response should be that at least the three to four most common letters under the VEA, the MRCA and the DRCA should be updated as a priority to ensure clients enjoy the benefit of correspondence meeting this recommendation.

Key templates available through ISH should be reviewed and updated to reflect recent legislation and policy changes as a matter of urgency.

Recommendation 14: Implement action to ensure liability and compensation rejection or claim denial correspondence occurs only after a DVA staff member phones to discuss the outcome with a client. This discussion should detail:

a. the nature of the decision or determination;

b. opportunities for the member to appeal the decision, should they wish to;

c. alternative services that DVA can offer;

d. options to defer the decision and revisit at a later stage (e.g. once conditions have stabilised), not implications for recording times taken to process; and

e. DVA point of contact in case further explanation is desired.

The response to this recommendation is substantially complete, with two further steps suggested.

DVA has implemented new protocols for staff to phone clients in advance of an adverse decision letter. To support these protocols, face-to-face sensitivity training of relevant staff in how to provide that advice has occurred, and scripts and policy advice have been distributed.

Further steps are:

- to establish a system of supports for staff following adverse information phone calls which have been distressing for them; and
- in light of staff concerns about this process, to accept there may need to be changes to scripts, guidelines or training materials to take account of suggestions about the scheme following implementation.

Recommendation 15: Expand scope of reviewed circumstances to include services sought through other Government agencies and community services.

The response to this recommendation is complete.

DVA has links on its website to 'External Supports for At-risk Clients' and the 'Need Help Now' site, as well as information in CLIK. These sources, together with the Defence 'Engage' portal, alert veterans to multiple sources of assistance from other government agencies and community services. Staff have been advised of the sources through training and departmental communications.

A watchpoint is needed to ensure the information on the website is up-to-date. The DVA upgraded website should be tested to ensure there are no problems accessing these sites prior to the launch expected in mid-2019.

Recommendation 16: Introduce a case-response team with specified resources across public affairs, legal, strategic communications, executive and divisions to create a DVA response to emerging issues and messaging that is respectful and supportive in tone.

The response to this recommendation is complete.

DVA has undertaken a number of organisational changes, including the creation of new forums and committees, which improve its ability to identify and address emerging and systemic issues. These include the Weekly Client Discussion, comprising members of the DVA executive, the Problem Solving Forum, comprising subject matter experts, the Client Services Committee, and a Delegates Support Projects and Initiatives Steering Committee (Steering Committee) for the support of delegates. These bodies have the capacity to respond at the levels envisaged in this recommendation. As the bodies were established only recently it is too soon to judge their impact. Their establishment indicates a firm intention to respond to this recommendation.

Additional recommendations for consideration by government (recommendations 17-19)

Recommendation 17: The provision of more timely compensation payment by using a current assessment of the service-related level of permanent impairment, instead of delaying compensation payments until the service-related level of permanent impairment has stabilised.

The response to this recommendation is complete.

The encouragement of staff to consider interim permanent impairment compensation where appropriate (discussed at recommendation 2), and the requirement that it must be offered in claims for mental health conditions where the condition has not stabilised, have contributed to more timely access to compensation for veterans. Improvements to the coordination of medical assessments may also contribute to more timely payments.

It would be prudent, however, to extend the waiver power of the DVA Secretary (eg MRCA s 429) to provide that it covers deemed criteria for eligibility, to avoid potential legal challenges.

Recommendation 18: The provision of more timely incapacity compensation payments for those former members of the ADF incapacitated for service or work by a mental health conditions, without the need for a determination that those mental health conditions are related to service.

The response to this recommendation is complete to the extent possible.

Legislative change would be required to provide for incapacity payments for a client with mental health conditions not related to service. In the absence of this, the Government's introduction of the 'veteran payment' for those veterans who have lodged a claim for mental health conditions and are incapable of working more than eight hours per week indicate that the substance of this recommendation has been met. Separate to the issue of compensation, on 1 July 2017, under the expansion of non-liability health care, DVA now fully funds treatment for *all* mental health conditions, regardless of whether those conditions were service-related.

Recommendation 19: Funding for a trial of an independent legal advocacy service to assist veterans with claim preparation and lodgements to enable long-term improvement in the quality of claims and ensure that veterans receive their entitlements with minimum administrative burden.

The response to this recommendation is complete.

On 24 October 2017, the Government announced $1.7 million in funding to undertake a scoping study to professionalise veterans' advocacy, which included consideration of an independent legal advocacy service. The study was conducted by Mr Robert Cornall AO in 2018, and the report of the Veterans' Advocacy and Support Services Scoping Study was released on 13 March 2019.

Separate to the Scoping Study, draft recommendation 10.3 in the Productivity Commission Draft Report suggested that the VRB should be used only to provide 'alternative dispute resolution services'. The final report of the Productivity Commission's inquiry is expected in late June 2019.

DETAILED REPORT

BACKGROUND

Between 2001 and 2016, there were '373 suicides in serving, reserve & ex-serving Australian Defence Force (ADF) personnel'.[11] Although, overall, 'the age-adjusted suicide rate was lower for serving and reserve men, than for all Australian men', ex-serving men 'had an age adjusted suicide rate 18% higher than for all Australian men'.[12] Of greatest concern was that 'ex-serving men aged under 30 had a suicide rate 2.2 times that of Australian men the same age'.[13] This is consistent with findings of the Transition and Wellbeing Research Programme, the most comprehensive Australian study on the impact of military service on the health of transitioned and regular ADF members. The Programme's Mental Health Prevalence Report estimated that one in three transitioned ADF had high to very high psychological distress, one in five had experienced suicidal ideation, plans or attempts in the previous 12 months, and almost half had experienced a mental disorder in the same period.[14]

These are sobering statistics. An attempt to understand these issues was recently provided by the Productivity Commission with the observation that:

> *While veterans are serving, there are a range of protective factors that are likely to reduce the risk of mental ill health compared with the general population. They include a strong sense of purpose, camaraderie and easy access to health care.*
>
> *But they are also exposed to particular mental health risks, including exposure to trauma and time away from family and frequent relocations. And once veterans leave the ADF, they no longer benefit from the protective factors that supported them while serving and are at greater risk of poor mental health. Transition to civilian life can also be a risk factor in itself, as recent research into veterans' transition and wellbeing highlighted.*
>
> *Changes brought about by the transition process can lead to the development and/or exacerbation of existing service related mental and physical symptoms resulting in psycho-social adjustment issues ranging from employment difficulties and family/relationship conflict, to mental health and substance abuse problems.*[15]

There are many causes of suicide. As the Senate Standing Committee on Foreign Affairs, Defence and Trade noted in the *Constant Battle* report:

> *The reasons why a person may decide to take their own life can be very complex. In particular, not everyone who has suicidal ideation has a mental health condition … Research in this area is still continuing and at this stage it is difficult to discern any clear trend or common factor. To the committee, this indicates that the current preventative, early intervention model targeted to those*

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[11] Australian Institute of Health and Welfare (AIHW), *National suicide monitoring of serving and ex-serving Australian Defence force personnel: 2018 update* (September, 2018) (AIHW 2018 update report), 1.

[12] The AIHW 2018 update report noted in its Summary, that: 'While the proportion of women in the ADF is increasing, the number of women serving in the ADF has historically been low. For privacy and statistical reasons relating to the small number of women in the study, suicide rates and standardised mortality ratios (SMRs) for women are not reported'.

[13] In 2014-16, the most recent period for which data was available. AIHW 2018 update report, 1.

[14] Van Hooff M, Lawrence-Wood E, Hodson S, Sadler N, Benassi H, Hansen C, Grace B, Avery J, Searle A, Iannos M, Abraham M, Baur J, McFarlane A, 2018, *Mental Health Prevalence, Mental Health and Wellbeing Transition Study*, v-vi.

[15] Productivity Commission, Draft Report, *A Better Way to Support Veterans* (2018) (Productivity Commission Draft Report), 34.

at-risk, together with a holistic response to improve the overall welfare of veterans is the most appropriate approach to reduce the rate of suicide amongst veterans.[16]

More research is required on the causes of veteran suicide.[17] The large scale Transition and Wellbeing Research Programme, funded by Defence and DVA, is a welcome step in this direction.[18] In addition, the 2017-2018 Budget provided $9.8 million over three years to pilot new approaches to supporting vulnerable veterans with mental health concerns – the Mental Health Clinical Management Pilot, now known as the Veteran Suicide Prevention Pilot, delivered to the at-risk population after hospitalisation, and an expansion of the Coordinated Veterans' Care (CVC) program via a CVC Pilot to improve support for those with chronic mental and physical health problems.[19]

One of the issues identified in the submissions to the *Constant Battle* report was described as '*delays, negative determinations or perceived maladministration in DVA [in] the compensation claim processes … creating critical stress for veterans and [being] a contributing factor to suicide'*.[20] Arguably this was one of the factors which may have contributed to the suicide of Mr Bird.

The incidence of suicide has led to a growing concern about the number of serving and former members of the Australian Defence Force (ADF) who have committed suicide.[21] This heightened concern within the community about these figures has led to a number of reports.[22] It is important to remember that these statistics are made up of real people, and tragedies which have a lasting impact on their friends and families, as was made clear in the case of Mr Jesse Bird.

Mr Bird's suicide

Mr Bird was born on 1 November 1984 and joined the Australian Army as a Rifleman on 9 April 2007, at the age of 22. As a member of the 1st Battalion, Royal Australian Regiment, Mr Bird was based in Townsville, Queensland. Mr Bird was deployed to Afghanistan on Operation SLIPPER from 9 June 2009 to 12 February 2010.

Mr Bird submitted his application for discharge from the Army on 18 July 2011, to take effect in January 2012. While still serving, Mr Bird lodged a MRCA claim with DVA for liability for a shoulder injury [redacted], which was subsequently accepted by DVA.

On 29 January 2012, he was discharged from the Army. At the time of his discharge, Mr Bird had successfully completed rehabilitation for his shoulder injury and his Medical Employment Classification (MEC) was upgraded to reflect that he was considered fully employable and deployable. Mr Bird transferred to the Standby Reserve Force on 30 January 2012.

In October 2015, Mr Bird was again in contact with DVA and non-liability health care was accepted for a number of mental health conditions. DVA funded treatment for Mr Bird's mental health conditions as a DVA client and provided counselling through Open Arms.

In May 2016, Mr Bird lodged a MRCA claim for liability for his mental health conditions, which was accepted. Mr Bird subsequently sought incapacity payments for a reduced ability or inability to work,

[16] Senate Standing Committee on Foreign Affairs, Defence and Trade *The Constant Battle: Suicide by Veterans* (2017) (Senate *Constant Battle* report) [3.93].
[17] Senate *Constant Battle* report [3.25].
[18] Senate *Constant Battle* report [3.18].
[19] Senate *Constant Battle* report [3.62].
[20] Senate *Constant Battle* report [3.43].
[21] As evidenced by the number of reports in daily newspapers: see Appendix 1.
[22] See Appendix 1.

and compensation for permanent impairment arising from his shoulder injury and mental health conditions.

Based on medical reports, Mr Bird's conditions did not meet necessary criteria at the time of consideration of his claim for permanent impairment, and the claim for compensation for permanent impairment was rejected by DVA on 8 May 2017.

Mr Bird died in late June 2017, aged 32. At the time of his death, DVA was processing his claim for incapacity payments, which was approved posthumously on 5 July 2017.

Subsequent actions following Mr Bird's death

Following his death, a joint internal inquiry was established by the Department of Veterans' Affairs (DVA), Defence and Open Arms, then known as the Veterans and Veterans' Families Counselling Service (VVCS), to review the management of his case. The report of the *Joint Inquiry into the facts surrounding the management of Mr Jesse Bird's case* (30 October, 2017) (*Joint Inquiry*) was provided to the family of Mr Bird on 15 September 2017. The *Joint Inquiry* made nineteen recommendations.

On 24 October 2017 the Government accepted all of the nineteen recommendations. The Government also committed to institute an independent review of the implementation of the recommendations after twelve months. On 2 November 2018, I was appointed as an independent reviewer to conduct that review.

In the course of the review I was provided with copious material evidencing DVA's responses to the nineteen recommendations and had discussions with senior officials in charge of areas related to the *Joint Inquiry* in DVA, Defence and the Commonwealth Superannuation Corporation (CSC).

I also met with Mr Bird's mother, Ms Karen Bird, and his former partner, Ms Connie Boglis, on more than one occasion. [redacted] Ms Bird and Ms Boglis also provided me with submissions they had made to other inquiries and correspondence with DVA since Mr Bird's death in June 2017.

Ms Bird wished to reiterate the need for responses to the following issues:

(a) failing to adequately follow up or support Jesse despite clear signs of need;
(b) failing to properly consider and deal with Jesse's permanent impairment claims;
(c) failing to properly consider and deal with Jesse's incapacity payments claims; and
(d) failing to respond appropriately to Jesse's final complaint and cry for help.

These concerns are addressed in the substance of my report, and the consideration of the actions undertaken in response to the 19 recommendations of the *Joint Inquiry*.

Evidence

As part of the independent review, I have considered the report of the *Joint Inquiry*, a further internal review by DVA conducted in response to recommendation 1 of the *Joint Inquiry*, observations from interviews with senior officers of DVA, CSC and Defence, submissions made by DVA and Defence to the Senate Committee *Constant Battle* inquiry, DVA's submission to the Productivity Commission's inquiry, the Productivity Commission Draft Report, the Progress Reports DVA publishes quarterly on its website about changes it is making to address the 19 recommendations of the *Joint Inquiry*, along with other material provided to me pertaining to developments relevant to this review.

In relation to the *Joint Inquiry*, my responses to the terms of reference and the recommendations are focused on the position as at 31 December 2018. A date was chosen in light of the speed with which changes are occurring within the Department. That cut-off date has not precluded reference to subsequent developments to the date this report was finalised.

Independent Review

The independent review has examined the changes following the administrative issues which arose in Mr Bird's case and the impact on better claims administration for the future including opportunities to improve training for staff. The DVA has accepted that 'many of its policies and procedures required improvement, clarification and in some instances replacement' and has 'committed to making changes. DVA is 'genuine in [its] desire to learn from Jesse's story and to improve'.[23] The deaths of Mr Bird and other veterans who have died by suicide has had a pervasive impact on the Department.

DVA's self-examination has revealed that, although there is a willingness to change, DVA has in the past not been consistently robust at operationalising policy revision. Effective management is required to incorporate into policies, procedures and systems the changes needed due to perceived deficiencies.

Currently, DVA is undergoing profound change as evidenced by its Transformation program and its move from being a compensation-focussed, process-driven agency to one which embraces the principle of being 'veteran centric' and focusses on how best to support the wellbeing of veterans and their families. The commencement of the Transformation program predated the death of Mr Bird, but his suicide has provided a catalyst for many specific changes. Some of the redress measures reflected in the recommendations have been accomplished in the short term. Others, particularly those relating to training and change in the culture of DVA to match these developments, and the enhancement or development of new ICT systems, inevitably take longer to achieve.

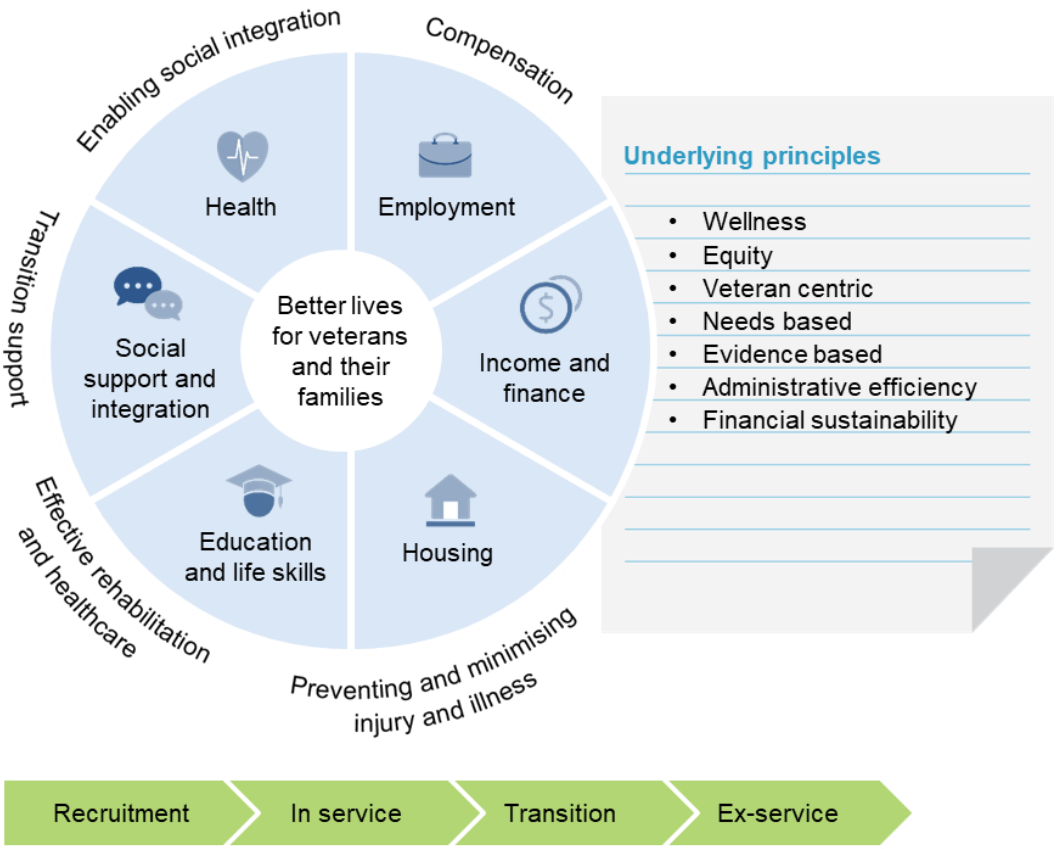
One of the key objectives of the reforms is an increased focus on the wellbeing of serving and ex-serving ADF personnel over their lifetime, including through improved rehabilitation, work health and safety, and transition support. Ultimately, as the Productivity Commission has observed, this should mean that:

- fewer veterans and families need to deal with injury, illness or death;
- when impairments do occur they are managed better and more veterans are able to return to work; and
- veterans and their families are better prepared to manage their lives post service, and veterans are provided with the skills needed to have a post-military career.[24]

[23] DVA email to Mrs Bird, 17 April 2018.
[24] Productivity Commission Draft Report, 650-651.

These aims are illustrated in the following figure, which is reproduced from the Productivity Commission Draft Report.

Figure 1 **A system that is about better lives for veterans and their families**



DVA has made remarkable efforts to make changes to legislation, policies and procedures to minimise any adverse impacts on clients who are at-risk or vulnerable. It needed to do so. When a veteran makes a claim, it is the beginning of a long and tortuous process, requiring considerable determination and documentation.

Some of the redress measures reflected in the recommendations of the *Joint Inquiry* have been accomplished, including the need to engage with clients and their communities by talking to the veteran and their family throughout the process. This is a Transformation commitment which should be maintained and an approach which must be emphasised.[25] Others, particularly those relating to training, additions to systems functionality, and change in the culture of DVA to match these developments, inevitably take longer to achieve.

Nonetheless, DVA is well on the way to becoming a veteran centric body. A decade ago responses to claims were based solely on policy which was legislation-focused. If a claimant could not fit within the strict legislative criteria, the claim would be rejected. This is no longer the case. Today the policies increasingly consider the spread of needs of the individual and take a holistic approach and if the claim falls within the broad scope of the legislation, adopting a beneficial approach, it will be granted.

[25] Discussion with DVA, 28 November 2018.

The evidence for this is the number of claims which are now being accepted. For example, 'around 91 per cent of *Military Rehabilitation and Compensation Act 2004* (Cth) (MRCA) clients have liability accepted for at least one condition'. However, the acceptance rate varies between different conditions and types of service.[26]

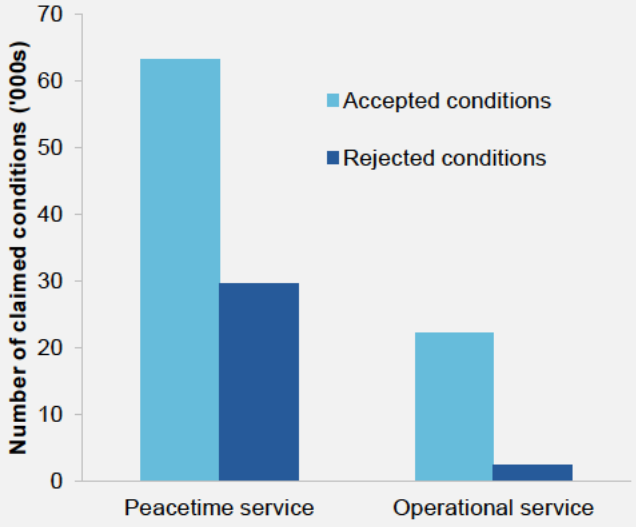
Overall, DVA administers a system which is generous to veterans, consistent with the beneficial nature of the legislation. Based on 2017-18 figures, the Productivity Commission estimated an annual spend of $47,000 on each DVA client, largely comprised of DVA's $7.4 billion expenditure on compensation and income support and $5.3 billion expenditure on healthcare[27]. This is also evidenced in the Productivity Commission's analysis of MRCA claims (see Box 1 below, reproduced from the Draft Report). In 2017-18, 79 per cent of liability determinations under the MRCA were successful; 56 per cent under the DRCA; and 61 per cent under the VEA.[28]

Box 1 **Rates of acceptance**

From the commencement of the MRCA scheme on 1 July 2004 to 30 June 2017, nearly 29 200 individual claimants had lodged claims for liability for over 117 000 determined conditions.

Around 24 400 of these conditions (21 per cent) were reported as related to operational service, including service in Afghanistan, Iraq, East Timor and various peacekeeping missions. Over 89 200 other conditions (76 per cent) were related to peacetime service, while another 3,400 conditions (3 per cent) were reported as relating to both peacetime and operational service.

For any single condition, the probability of liability being accepted under the MRCA was around 73 per cent. For conditions related to operational service only, the acceptance rate jumped to over 90 per cent. For conditions related to peacetime service (including those related to both peacetime and other types of service), the acceptance rate is around 68 per cent.



Source: Productivity Commission estimates based on unpublished DVA data.[29]

[26] Productivity Commission Draft Report, 324.
[27] Productivity Commission Draft Report, 132.
[28] Productivity Commission Draft Report, 324.
[29] Productivity Commission Draft Report, Box 8.6, 324.

Cultural issues

The community expectations are that DVA should provide health and welfare services in addition to being a compensation provider. They are a key focus of the Transformation program. These changes from a claims-based focus to a more holistic, client-centred approach are occurring, but they demand considerable cultural and system change.

The new processes and procedures outlined in this review are steps in the right direction but changing culture and attitudes takes many years to effect. In this regard, it is instructive to see how the CSC has tackled similar issues to DVA, given the agencies face some similar challenges. CSC has introduced a program of staff recruitment and training. Identification of clients at-risk or vulnerable has been aided by recruitment processes for staff in claims management roles. In particular the CSC has identified that staff need to be resilient, intuitive and good at interpreting behavioural signals. The recruitment process has been aided by a psychometric assessment containing 10 attributes needed for the roles.[30]

Even with a recruitment program for people with 'soft skills', it will take time for those staff to receive the appropriate technical training and acquire the requisite skills needed for decision-making in a more welfare-oriented body.

An example of the slowness to change is that systems and processes are still based around individual claims, rather than holistically.[31] In addition, despite a Transformation commitment to a whole-or-person care model, procedures and policies have not yet been implemented to effect the change fully. Realigning claims processing to enable a holistic view of a client's needs requires fundamental structural change and is not accomplished quickly.

At the same time, I was presented with multiple examples of rapid changes which have been made. During the several months of this review, I have seen five updates of the Department's responses to the *Joint Inquiry*, each containing significant new initiatives. In that period, there has been organisational changes and the establishment of a new structure for supporting clients, the Client Support Framework. These changes included the creation and resourcing of an internal triage function, escalation pathways such as the Weekly Client Discussion and Problem Solving Forum, and new oversight bodies such as the Client Services Committee and the Delegates Support Projects and Initiatives Steering Committee (Steering Committee).

The rapidity of these developments attest to the urgency I detected as the Department evolves from its continuing role as a claims management body to one which is taking a whole person view of the clients who seek its assistance.

Technological issues

Reasons for an absence of timeliness include the inevitable time taken to re-engineer and build complex Information and Communication Technology (ICT) systems. These reasons apply to DVA systems, and also systems managed by the Department of Human Services (DHS) and Defence. Development of ICT systems is also costly. I acknowledge that the progress of implementing the *Joint Inquiry* recommendations needs to take account of ICT limitations and delays, as well as resource constraints.

Technological improvements undoubtedly help speed up routine case management and decision-making, and the introduction of MyService for clients and the Integrated Services Hub (ISH) for DVA staff are likely to have been significant contributors to DVA's improved claims processing times.

[30] Meeting with CSC, 22 January 2019.
[31] Discussion with DVA, 3 November 2018.

However, they currently provide little assistance with the identification and management of at-risk and vulnerable veterans. This largely depends on frontline staff and person-to-person interactions.[32]

ICT will never replace the need for such interactions in relation to vulnerable clients and complex cases, but it can provide more assistance to the staff who engage with clients. DVA is faced with clients young and old, with a spread of abilities, conditions and degrees of resilience. Accordingly, their interactions with DVA vary widely and it is important to recognise there should not be a one size fits all approach.

Other key issues

Identification of those at-risk is an essential pre-requisite to effective targeting, and use of the panoply of services and other forms of assistance DVA provides to veterans in need. That is no easy task. A recent study of the literature by the *British Journal of Psychiatry Open* has found that 60 per cent of those who died by suicide did not have, or denied having, suicidal thoughts in the weeks or months prior to their death.[33] Conversely, as a standalone test, less than 2 per cent of people who did exhibit suicidal ideation died by suicide.[34]

If even trained medical practitioners cannot rely on suicidal ideation as a reliable indicator of the risk of suicide, how much harder is it for persons without that training and experience accurately to identify when individuals are at significant risk. The most that can be expected of front-line staff is that identification of vulnerability can prompt more sensitive treatment of the person and consideration of additional supports.

[32] Discussion with DVA, 28 November 2018.

[33] McHugh, CM, Corderoy, A, Ryan, CJ, Hickie, IB, & Large, MM, 'Association between suicidal ideation and suicide: meta-analyses of odds rations, sensitivity, specificity and positive predictive value' (2019) 5 *BJPsych* [*British Journal of Psychiatry] Open*, published online 31 January 2019, hard copy in March 2019.

[34] Augusson, K, 'Thoughts of death: doctors can't predict who will suicide by asking' *Sydney Morning Herald*, 2-3 February 2019, 19.

RECOMMENDATIONS

The outcomes of the *Joint Inquiry* comprise the nineteen recommendations. These are categorised as those having priority (recommendations 1-9), longer-term recommendations (recommendations 10-16), to continue as part of the Veteran Centric Reform (VCR). The remaining three recommendations (recommendations 17-19) are listed as 'additional recommendations to the Minister for Government to consider'.[35]

***Priority recommendations* (1-9)**

Recommendation 1: The Secretary to examine the areas of potential non-compliance with current legislation and policy to provide the Minister advice regarding any redress action/s.

In response to recommendation 1, DVA conducted an internal review, completed on 30 October 2017 which considered whether there had been deficient actions by officers of either agency and what redress actions should be taken.

The internal review found that the relevant legislation, policies and practices lacked the necessary detail to assist the decision-makers in making a beneficial decision in Mr Bird's case. It determined that while the staff were largely working within parameters, the intent of these policies and practices was either inconsistent with the beneficial nature of the relevant legislation, or there was an absence of policy to support the circumstance. This impeded the ability of staff to provide appropriate support.

The review identified five areas of concern:

1. a needs assessment for Mr Bird's mental health conditions should have been registered as a claim for incapacity payment when it was initially received by DVA on 27 August 2016;
2. no offer was made of interim permanent impairment compensation;
3. the request for information that was sent to DVA SAM should have been a 'high' (urgent) priority request, not a low priority/routine request;
4. the management of Mr Bird's 22 June 2017 complaint; and
5. the MRCA supplement due to Mr Bird for the period prior to July 2015 was not processed.

The Minister was briefed in April 2018 on the steps taken by the Secretary to deal with any areas of potential non-compliance with current legislation and policy and the actions taken. The issues around the first area of concern have been dealt with in recommendation 3 of the *Joint Inquiry*, and DVA's response to that recommendation. Similarly, issues around the second area of concern have been dealt with in recommendations 2 and 17 of the *Joint Inquiry*, and DVA's responses to those recommendations. Issues around the management of Mr Bird's 22 June 2017 complaint have been taken into account in the development of a new Client Feedback Management System (CFMS). The outstanding MRCA supplement has since been paid.

In addition, the review recommended a series of follow-ups with staff involved in managing Mr Bird's case. Interviews were held with these staff on 24 April 2018 and I am advised that appropriate action has been taken relating to those specific findings.

The internal review found that for the most part staff were following common practice or made decisions which were open to them based on the legislation and policies in place at the time. Given this, and evidence that staff are now particularly aware of the issues arising from these events – indeed the events have led to the expression the 'Jesse factor' as a touchstone for concern - no further action is required. Staff across DVA take seriously the need for reform.

[35] *Joint Inquiry* recommendations.

This review, accordingly, has focused on ensuring that the steps to improve the legislation, the policies, and the understanding of them by DVA staff reflect those improvements.

Conclusion

The issues identified in response to this recommendation were largely systemic issues. As the discussion indicates in the body of the review these issues had led to practices which were widespread at the time of Mr Bird's death, and the actions of individuals involved reflect those practices.

Misinterpretation of the legislative requirements and the absence of clear guidance for staff played a part. The legislative framework is not helpful, being complex and representing, as it does, an uneasy combination of veterans' entitlements and workers compensation principles, a problem highlighted by the Productivity Commission.[36]

The accepted beneficial nature of the legislation could not have alleviated these problems.[37] The courts' and tribunals' interpretation of these provisions is that they are not without effect, and if there is ambiguity in facts or the meaning of relevant legislation that ambiguity must be interpreted in the veteran's favour.[38] But the beneficial provisions cannot result in legislation affecting veterans being strained or exceeded.[39]

Recommendation 2: Provide delegates with a clear statement of the policy and processes when considering an interim payment of compensation for permanent impairment to ensure that interim compensation payments are being provided in all cases where appropriate.

Under s 68 of the MRCA, compensation for permanent impairment requires that the Commission (or its delegate) is satisfied that impairment is likely to continue indefinitely, and the person's compensable condition has stabilised. The amount of compensation is determined with reference to a 100 point scale of impairment, with the impairment generally having to constitute at least 10 impairment points to warrant compensation. Under s 75 of the MRCA, veterans may be entitled to interim compensation payments in proportion to their approximate impairment, if the delegate is satisfied that the impairment will stabilise at 10 impairment points or above.

Mr Bird lodged claims in May 2016 for initial liability for service-related medical conditions including posttraumatic stress disorder (PTSD), alcohol abuse, and major depressive disorder. He was issued with a White Card to receive mental health treatment under the non-liability health care scheme. The claims were accepted as service-related in August 2016.

Following his initial application Mr Bird was also advised that he could seek an incapacity payment for loss of earnings, as well as permanent impairment compensation for non-economic loss. In November 2016 he sought permanent impairment compensation, but the claim was unsuccessful. Based on Mr Bird's medical reports, his mental health conditions were assessed as not stable, and a review was recommended in six months once Mr Bird had completed further treatment. As a result, the assessment of Mr Bird's permanent impairment at that time was based only on his shoulder injury,

[36] Draft Report *Compensation and Rehabilitation for Veterans - A Better Way to Support Veterans* (December 2018) 121.
[37] The relevant provisions are found in the VEA s 119; MRCA s 334; DRCA s 142.
[38] *Minister for Immigration & Multicultural Affairs v Eshetu* (1999) 197 CLR 611; confirmed in *Minister for Immigration and Citizenship v Li* (2013) 249 CLR 332; *Bull v Attorney-General* (NSW) (1913) 17 CLR 370 at 384 per Isaacs J; *Repatriation Commission v Hayes* (1982) 43 ALR 216 at 219.
[39] *Repatriation Commission v Hayes* (1982) 43 ALR 216 at 219.

which was assessed as stable and permanent. The assessment did not meet the minimum 10 point threshold required for eligibility for compensation.

This claims history revealed several administrative problems. First Mr Bird was not offered interim permanent impairment payments ahead of a final determination while waiting for his mental health conditions to stabilise. The requirement for a condition to stabilise is contained in the MRCA and relevant provision states that one of the criteria for permanent impairment compensation is that 'the person's compensable condition has stabilised'.[40]

That provision is qualified by a later provision which notes that: 'Interim compensation can be payable to a person whose condition has not stabilised'.[41]

The qualification is authorised by section 75 of the *Military Rehabilitation and Compensation Act 2004* (Cth) (MRCA) which states, as relevant:

> *(1) The Commonwealth is liable to pay interim compensation to a person if:*
>
> *(a) the Commission is satisfied that the person will be entitled to compensation under section 68 or 71; and*
>
> *(b) the Commission is not able to determine the degree of impairment suffered by the person because one or more service injuries or diseases concerned have not stabilised; and*
>
> *(c) the Commission is satisfied that the impairment suffered by the person as a result of the injuries or diseases constitutes at least the number of impairment points required for the person to become entitled to compensation under section 68 or 71* [that is, 10 impairment points]*; and*
>
> *(d) a claim for compensation in respect of the person has been made under section 319*.

At the time of Mr Bird's death DVA policies had inadequate explanation for staff of these requirements. The Consolidated Library of Information and Knowledge (CLIK), available to staff and to the public, merely replicated section 75 without explanation. The inadequate explanation was an example of the concerns more generally about the usefulness of CLIK (see recommendation 13).[42]

As interim compensation can be payable as a lump sum,[43] and staff were reluctant to approve interim compensation in circumstances where there was a possibility the final assessment would be lower than the interim assessment, or where it might fall below the 10 impairment point threshold entirely. Staff practices also varied between DVA offices, and at times were inconsistent with the legislation or policy. As a consequence, the numbers of such payments were lower than they could have been.

Training and education since Mr Bird's death have corrected these misunderstandings. On 14 September 2017, DVA issued a *Businessline,* DVA's principal form of communication for policy change, to provide additional guidance to staff on the appropriate use of interim compensation for permanent impairment,[44] and updated information was placed on CLIK. Where an impairment is permanent but not yet stable, staff are advised that payment of interim compensation should be considered.[45]

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[40] MRCA ss 68(1)(a)(iii), 71(1)(b)(iv); DRCA ss 24(2).
[41] MRCA s 66 – simplified outline of the relevant part. See also DRCA s 25(1)(b).
[42] Productivity Commission Draft Report, 374.
[43] MRCA s 78(1).
[44] *Businessline*, 14 September 2017 'Interim Permanent Impairment Compensation'.
[45] *Businessline*, 14 September 2017 'Interim Permanent Impairment Compensation'.

The guidance also clarified that 'stable' means unlikely to improve to any major degree, and 'permanent' means the condition is not likely to resolve.[46] Where the stability of an impairment is unclear, delegates should seek an opinion from a DVA Contracted Medical Advisor (CMA) or the client's medical practitioner.

Subsequently, a decision by the Military Rehabilitation and Compensation Commission (MRCC) on 10 November 2017 approved changes to the policy for payment of interim permanent impairment compensation (see recommendation 17). The revised policy requires that where clients are seeking permanent impairment compensation for certain mental health conditions,[47] and they have a level of impairment of 10 points or more, which is not yet stable, interim compensation *must* be offered. Mr Bird had a number of mental health conditions accepted by DVA and would have qualified under this revised policy.

The policy is supported by information resources and training for all existing and future claims staff.[48] Guidelines have been expanded and updated in CLIK,[49] and details of the revised policy have been promulgated in a *Businessline* of 23 November 2017 (see recommendation 13).[50]

A training package on the updated approach including the revised policy was developed and administered to existing staff throughout 2018, for completion by 28 February 2019.[51] A training package for Income Support staff, those who assess claims for interim permanent impairment payments, was delivered face-to-face.[52] The revised information is included in the induction training for new staff and in refresher training. New staff also work under the supervision of a senior officer until competent. Attendance at training sessions is recorded. As at 31 December 2018, the number of staff who have completed the training was 235 and it was expected that a further 95 would be trained by early 2019.[53]

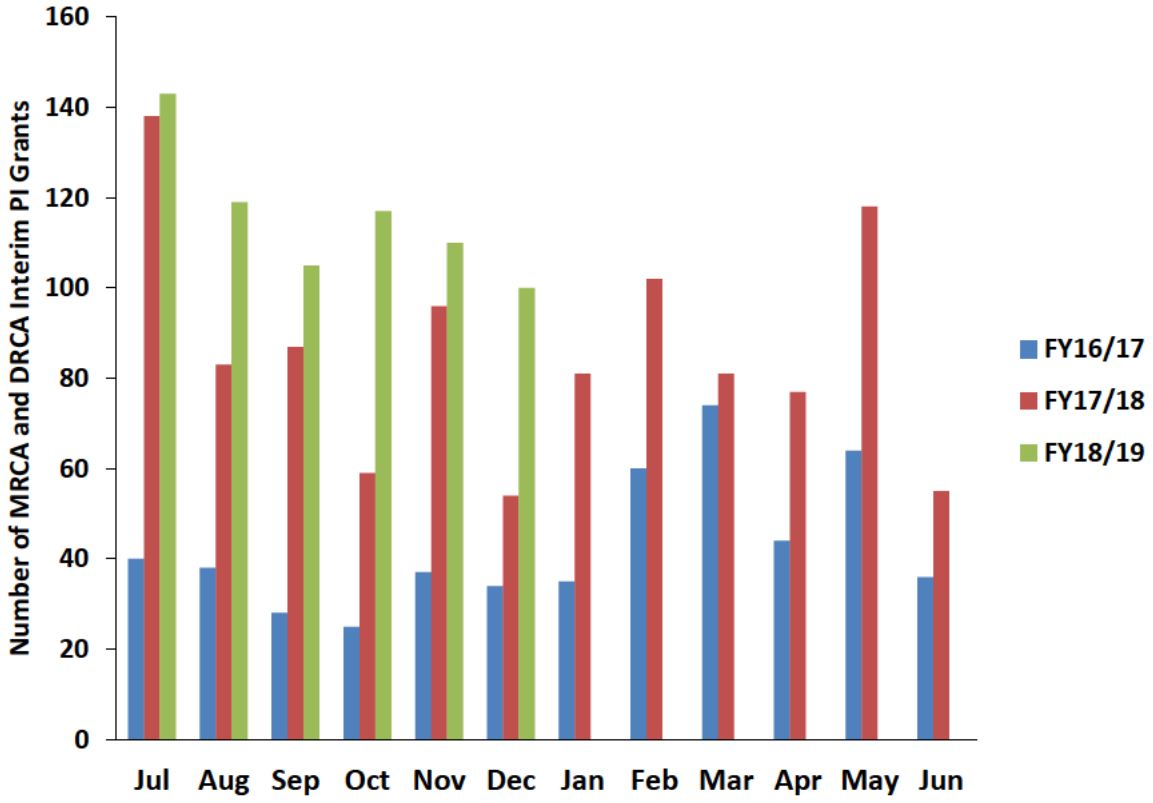
Not only have relevant staff been trained but their understanding has been tested. A sample review of permanent impairment cases under the MRCA that were declined in 2018/2019 – 15 cases each in WA and Queensland – identified that interim payments would not have been appropriate in any of the 30 cases.[54]

As at 31 December 2018, DVA had made 1,262 interim permanent impairment payments under the MRCA and the DRCA since December 2017, and 2,276 such payments since July 2016. The number of payments doubled between the FY 2016/2017 to the FY 2017/2018 year (515 to 1031).[55] For the most recent July-December 2018 period, the number of payments more than trebled in comparison to July-

[46] CBD training presentation 'Complex Claims Management: Support for staff interaction with complex or at-risk clients 2018'.
[47] Specifically, posttraumatic stress disorder, depressive disorder, anxiety disorder, substance use disorder or alcohol use disorder. See also recommendation 17.
[48] *Businessline* 14 September 2014 'Interim Permanent Impairment Compensation'; 2.04: 'Permanent Impairment Workshop Agenda'; PowerPoint presentation 'Interim Compensation: MRCA Permanent Impairment'; Team Leader and Assistant Director Forum *Minutes* 10 November 2017.
[49] CBD training presentation 'Complex Case Management: Support for staff interaction with complex or at-risk clients' (2018).
[50] Interim Permanent Impairment (PI) compensation for clients with certain mental health conditions under the *Military Rehabilitation and Compensation Act 2004* (Cth) (MRCA).
[51] CBD training presentation 'Complex Case Management: Support for staff interaction with complex or at-risk clients' (2018).
[52] DVA *Progress Report*, 15 January 2019, 53; 'Interim Compensation: MRCA Permanent Impairment'.
[53] DVA Progress Report, 15 January 2019, 4.
[54] DVA Progress Report, 15 January 2019, 4.
[55] MRCA Interim PI payments granted by month. This includes both 'Interim Lump Sum' and 'Interim Periodic Payments'.

December 2016 (from 202 to 694), indicating the education changes and revised policy have had a significant effect[56] (see Figure 3 below).

Figure 3 **Monthly interim permanent impairment payments - financial year comparison**



Source: Unpublished DVA data.

Risks

There is a risk that under the final assessment of the level of a veteran's permanent impairment, the threshold of 10 impairment points may not be reached, or the condition may 'stabilise' at a level lower than the level at which the permanent impairment compensation has usually been paid In those circumstances the veteran has received compensation (generally as a lump sum) to which they were not entitled.

DVA has adopted a generous approach to such cases. As the evidence indicates that a high proportion of applicants stabilise above the threshold requirement, DVA has assessed the risk of not meeting the statutory requirements as low. Consequently, the current practice is not to seek to recover any overpayment.[57] A suggestion is made in recommendation 17 for a legislative change which would sanction such an approach.

Conclusion and suggested actions

This recommendation is complete. There are now clear statements of the policies and processes to be followed during consideration of a claim for permanent impairment. The policies state that an interim

[56] MRCA Interim PI payments granted by month. This includes both "Interim Lump Sum" and "Interim Periodic Payments".
[57] MRCC Submission, No MRCC 48/2017 'Streamlining Interim Permanent Impairment Compensation' 20 October 2017.

payment must be considered for all claims for mental health conditions and should be considered in all other appropriate cases. If the claim ultimately is not successful because the condition has not stabilised, or does not reach the minimum 10 impairment points, the overpayment will not be pursued. Provided the training continues, and is monitored, and the risk of overpayment is also monitored to ensure the volume of payments of interim permanent impairment payments remains at an appropriate level, this recommendation is complete subject to the next observation.

DVA could consider seeking legislative support for waiving the recovery of any overpayments. This would avoid any adverse comment by the courts, tribunals or the Auditor-General (see recommendation 17).

Recommendation 3: Put in place controls to ensure process or registration of claims is consistently followed when needs assessment is received and not delayed.

Delay in processing claims is one of the most consistent complaints about the Department's processes. Delay exacerbates negative effects on veterans, particularly those with mental health problems, and may contribute to financial stress.[58] It is significant that a survey of special operations forces participating in the Special Operations Forces Pilot (see recommendation 10) rated 'complex, slow processing' as the 'the worst issues and irritants' with DVA.[59] This finding was the highest result for transitioned members under 'severity' (nearly 100 per cent), and was third highest result under 'frequency' (nearly 90 per cent).[60] For transitioning members, 'complicated process and no single point of contact' was second highest result of those responding.[61]

On 27 August 2016, Mr Bird emailed DVA with his needs assessment, the first step in an application, indicating he was seeking compensation for his incapacity to work. This should have been registered at the time as a claim for incapacity payments, but instead Mr Bird was asked to complete the claim form D1360: 'Claim for Incapacity for Service/Work'. Registration did not occur in Mr Bird's case until his advocate provided the completed D1360 form to DVA on 1 June 2017. This was 278 days after Mr Bird made his initial inquiry. The claim was then decided in 34 days. Partially as a consequence of this delay, his claim for incapacity payments was not finalised until after his death.

A needs assessment can be completed by the veteran or by DVA staff in response to a claim made by a client. The needs assessment process is required under the MRCA, but is in practice used for the VEA and the DRCA as well.[62] The needs assessment identifies what services and benefits a client may be eligible for following acceptance of initial liability for a service-related injury or disease. These services may be any of the following:

- incapacity payment;
- permanent impairment compensation;
- rehabilitation;
- Repatriation Health (Treatment) Card;
- household services;
- attendant care services;
- vehicle modifications; and

[58] Productivity Commission Draft Report, 366.
[59] *Special Operations Transition Pilot: Initial Project Plan*, 8 June 2018, v0.1, 22.
[60] *Special Operations Transition Pilot: Initial Project Plan*, 8 June 2018, v0.1, 22.
[61] *Special Operations Transition Pilot: Initial Project Plan*, 8 June 2018, v0.1, 22.
[62] *R&C ISH Rehabilitation and Compensation – Needs Assessment R&C ISH Step-by-Step Guide.*

- income support.

The practices and systems at the time of Mr Bird's death which delayed the registration and determination of his claim for an incapacity payment were:

- claims not being registered in the absence of the completion of a D1360 claim form due to business processes; and
- delays in obtaining a client's service and health records from the Department of Defence.

The second of these issues is dealt with at recommendation 6.

Form D1360

The failure to register Mr Bird's claim when he first applied arose due to a mistaken understanding that a client needed to complete a D1360 form before a claim for incapacity payments could be registered. The misperception had arisen as a matter of operational practice and reflected the form's administrative purpose to collect information which DVA needed to process a claim, such as the medical certification of incapacity.

That understanding did not accord with the legislation. The MRCA s 319 states that for a valid claim to be made it must be in writing, provided to the MRCC, and be couched in the prescribed form.

However, no such form was ever prescribed.[63] Consistent with this, the *MRCA Policy Manual* stated that no form was required to be completed before a claim could be registered.

The DVA website now reflects this position. The relevant entry states:

> *In order to meet the requirement for claims for compensation pursuant to section 319 [2] a client will be able to verbally confirm during a telephone conversation for the needs assessment they are seeking compensation under MRCA. The client will still be able to return a signed copy of the needs assessment, but this is not mandatory. A client's claim for compensation is also valid if they have ticked the appropriate box at question 23 [3] of the MRCA claim form (D2051), or submitted a written request for compensation, then a signature on the needs assessment is not mandatory.*
>
> *Note: Recent changes to section 319 of MRCA allows for a client to make an oral statement during a needs assessment telephone call either before or after liability has been determined that they are seeking benefits such as Permanent Impairment compensation or Incapacity Payments, and for that statement to be treated as a valid claim for compensation*.

The website indicates that the misunderstanding has been rectified. The practice now adopted is that a verbal or written indication that a client is seeking compensation as part of a needs assessment is treated as a claim for compensation under MRCA, including incapacity payments. There is no requirement for the needs assessment to be accompanied by the D1360 form for the claim to be registered. DVA can directly request the information collected by the D1360 form, such as the medical certification of incapacity.

Training

Training of the relevant staff on this issue was completed in November 2018, with 159 staff trained. These were staff located in DVA offices in Melbourne, Sydney, Perth and Brisbane. The training involved two sessions: a general overview; and specific processing training. The 10 staff trained in Brisbane were considered to be 100 per cent of staff who required the specific training. Training was

[63] MRCA ss 319(2)(c).

also provided via video conference for general Income Support staff and Veterans Access Network (VAN) staff.[64] Face-to-face local education sessions continue to be held to ensure staff understand that Form D1360 is not a requirement for the registration of a claim for incapacity payments.

Information management

A hard copy information resource *Rehabilitation and Compensation – Needs Assessment R&C* [Rehabilitation & Compensation] *ISH Step-by-step Guide,*[65] advising the correct position, has been published. Training materials were developed for staff in the Clients' Benefits Division (CBD) to mirror the changes in the relevant systems (see following).

CBD's Primary Claims and Benefits: *Claims for Compensation: Registration and withdrawal protocols 2018* now states:

> *There is no requirement for a specific form to be completed for registration of a benefit claim (eg form D1360 – claim for Incapacity).*

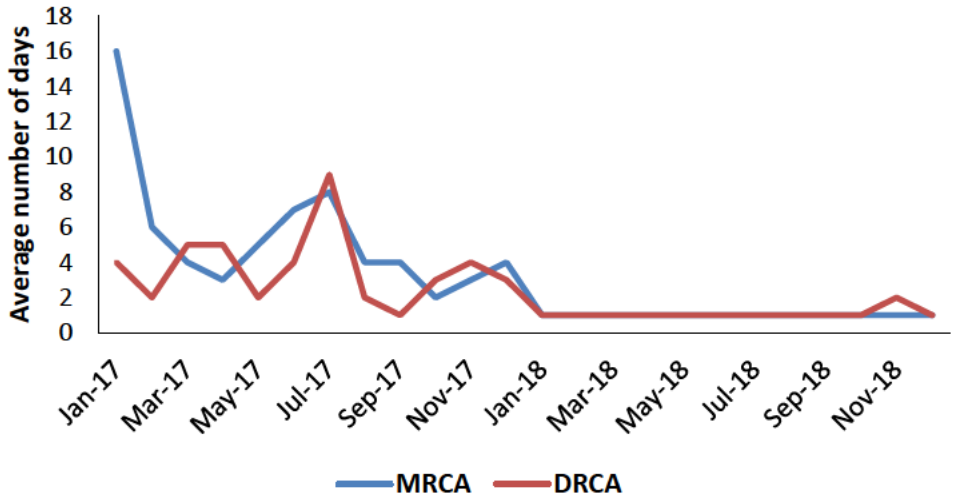
and further that:

> *If incapacity payment is selected and a **D1360 – Claim for Incapacity for Service/Work** claim form was received, select '**Yes**'. If the client has specified they would like to claim for Incapacity Payments and has not returned a D1360 ... the delegate should still select **'Yes'** to 'D1360 claim form received.* [66]

Systems changes and timeliness

Changes to systems have been made to reflect the correct position and figures obtained from ISH suggest an improvement in the time taken to register a claim to an average of one day for new MRCA and DRCA claims (see Figure 4 below).

Figure 4 **Average time taken to register new claims under MRCA and DRCA in 2017 and 2018**



Source: Unpublished DVA data.

[64] The Veterans' Access Network (VAN) staff offer general enquiry services through email, telephone calls and face-to-face visits.

[65] *R&C ISH Rehabilitation and Compensation – Needs Assessment R&C ISH Step-by-Step Guide*; and 'R&C ISH - Needs Assessment - FAQs'.

[66] 'CBD Primary Claims and Benefits - Claims for Compensation: Registration and withdrawal protocols 2018'.

MyService has been established to be the principal online claims processing portal for use by clients. At present MyService includes an online Needs Assessment form that is completed during the claim, or which can be completed as a separate activity.[67] The form does not contain any reference to the need for completion of form D1360.[68]

MyService is presently being used for needs assessment, initial liability claims, and from January 2019, for lodgement of an incapacity payment claim. DVA aims to develop the system so that it is capable of accepting online lodgement of claims for compensation for permanent impairment claims by the end of 2018-19.[69]

In time, MyService will be able to accept online applications for claims under all three Acts administered by DVA. The forward work plan includes bringing the full suite of claiming applications into the one portal.

As this discussion has indicated, the MyService system is still under development and is progressively acquiring functionality, a process not due to be complete until 2019-2020.[70] The development of MyService is only part way through a planned six year program. Although initially funded for two years, it is hoped that further funding will be provided for the balance of four years. Implementation by 2019-2020 is subject to delivery time frames and prioritisations in the Shared Services ICT delivery schedule.[71]

The importance of these changes on timeliness is evidenced in figures in the Productivity Commission Draft Report.[72] These figures indicate that the MyService development has made significant inroads on the claims-processes delays. DVA figures provide evidence for the ongoing uptake and expansion of MyService. By 7 February 2019, MyService had 53,305 users and a total of 21,146 claims by registered users had been lodged through MyService. Though formal evaluation has not taken place, informal feedback on MyService has been positive.

The Productivity Commission Draft Report contained a chart on time taken to process initial liability and permanent impairment claims (excerpted at Figure 7 below). The figures are unpublished and only cover periods to September 2017. Nonetheless, they show a sharp drop in time taken for all types of claims under the MRCA and the DRCA in the 2016-2017 year, and that 'permanent impairment processing times have been cut by more than 50 per cent'.[73] Based on unpublished DVA data, the Productivity Commission's draft report records that:

> *On timeliness – the average time taken to process a MyService initial liability claim is 33 days, compared to an average across all MRCA initial liability claims of 84 days in 2017-18.*[74]

Conclusion and any suggested actions

This recommendation has been implemented subject to one ICT change and the continued training and monitoring of claims assessments to ensure changes are understood and registration occurs promptly. The results of the information, training and systems changes on this issue are designed to ensure that registration of an incapacity payments claim occurs promptly upon completion of a needs assessment and that claims are automatically registered for the benefits case types and incapacity

[67] DVA *Progress Report,* 15 January 2019, 53.
[68] R&C ISH 'PAMT changes in a nutshell'.
[69] Productivity Commission Draft Report, 358.
[70] DVA *Progress Report,* 15 January 2019, 16.
[71] DVA *Progress Report,* 15 January 2019, 18; Timeline Release 1 December 2018.
[72] Productivity Commission Draft Report, 358.
[73] Productivity Commission Draft Report figure 9.2, 367.
[74] Productivity Commission Draft Report, 359.

claims identified in the needs assessment. The effects of these changes are shown in the significantly reduced time taken to register claims under the MRCA or the DRCA (see Figure 4 above).

There are several suggested actions: the ISH system, as at 31 December 2018, still referred to the need for a D1360 form and this needs correction; the second is a generic one, namely, that induction and refresher training should reinforce the correct understanding of the limited role of D1360 and that if the form is not completed, that does not mean registration cannot take place. The third is that claims should be spot-checked to ensure that training relating to changes to legislation, policies or procedures has been understood and applied.

Recommendation 4: Enhance reporting and risk factor escalation between VVCS [now Open Arms] and DVA through an offering to clients that includes an 'opt-out' model of information sharing so all support services are integrated for clients with diagnosed mental health issues.

Recommendation 4 is advocating improved sharing of information between Open Arms and DVA in relation to clients facing circumstances which cause them stress.

An issue affecting Mr Bird was that there was a disconnect between the information known to Open Arms[75] and information held by DVA. Open Arms was informed by Mr Bird about Mr Bird's relationship and personal issues; DVA had information about his claims' history, employment and financial difficulties. Neither Open Arms nor DVA had a full picture of Mr Bird's circumstances, and neither was able to take a holistic view of the factors affecting his wellbeing and vulnerability. The primary reasons for the disconnect were privacy laws and professional confidentiality principles which inhibit the sharing of information.

Open Arms is a counselling service provided by DVA under section 92 of the *Veterans' Entitlements Act 1986* (Cth). Open Arms is part of DVA. The counsellors are either psychologists or mental health accredited social workers.[76] Open Arms also provides a Complex Needs Support service.[77] As clients may seek access to Open Arms for life, it is recognised that there is a need to create a strong and respectful relationship between the counsellors and their clients. Historically maintaining the privacy and confidentiality of Open Arms records has been a longstanding commitment of Open Arms.[78] As Open Arms observed 'routine sharing of information about veteran's mental health issues without consent is not conducive to effective counselling'.[79] Open Arms sees some 16,000 clients each year, but since one client may have several sessions in a year, the total of client contacts for a year is around 25,000.[80]

I was advised that Open Arms works well with DVA cases managers operating under the Coordinated Client Support (CCS) and that the communication with DVA is better than it was historically and that there is a more collegial focus when issues arise.[81] For example, Open Arms has a case management approach under review and may seek the assistance of CCS if this is necessary as part of its approach to case management and that this collaboration can happen daily. This approach is being used for more complex cases. I was provided with little information about the number of referrals from Open

[75] Formerly known as Veterans and Veterans' Families Counselling Service (VVCS).
[76] *Open Arms – Veterans & Families Counselling: Summary*, 2.
[77] Open Arms response to the reviewer's questions, February 2019, 5.
[78] *Open Arms – Veterans & Families Counselling: Summary*, 2.
[79] Open Arms response to the reviewer's questions, February 2019, 1.
[80] Discussion with Open Arms, February 2019.
[81] Discussion with Open Arms, 29 November 2018.

Arms to DVA to back up this assertion. Open Arms indicated no current reliable statistics on this matter are kept, but work is under way to rectify this.

Some senior DVA officers to whom I spoke indicated there continue to be barriers to the exchange of information from Open Arms.[82] The principal barrier is the confidentiality inherent in the therapeutic relationship concerning disclosure of communications with a client during a counselling session. At law there has always been an exemption if the disclosures reveal a serious risk to the health or life of the client or another person and this exemption is relied on, if appropriate, by Open Arms.

Open Arms has indicated that it now intends to share information with DVA if requested by, or with the consent of, the client, or 'in the case of risk'. I was also assured that Open Arms clinical policy is being updated to include collaboration with DVA for veterans identified as vulnerable or at-risk. This update to policy is to be finalised by mid-2019. So despite the historical firewall between Open Arms and DVA, the indications are that the firewall is being dismantled. 'Risk' rather than 'serious risk' is to become the test for exchange of information. That information can always be exchanged with consent, but the changes permit an exchange without consent if sufficient risk is identified.

The other major barrier to the exchange of information is the *Privacy Act 1988* (Cth) which requires government to keep confidential 'personal information' disclosed to it.[83] A higher standard of protection applies to 'sensitive information' which includes 'health information'.[84] An exception is permitted under the Act in order to 'lessen or prevent a serious threat to life, health or safety'.[85] These principles are reflected in the Privacy Policies of Open Arms and of DVA. For example, the DVA Privacy Policy states that it complies with the *Privacy Act 1988* (Cth) including the Act's restrictions on the collection, use, amendment and disclosure of personal information about a client. Open Arms privacy policy is likewise so constrained. Information may always be shared between Open Arms and DVA if clients consent.

Open Arms consent form

The previous Open Arms consent form expressly stated that Open Arms will not share information with DVA. After the recommendations of the *Joint Inquiry*, changes to the Open Arms informed consent form were endorsed by the Open Arms National Advisory Committee in October 2017,[86] and have been implemented. The revised consent process has been described as allowing for communication between Open Arms and DVA in the event of the client's consent, or in the 'best interests of your clinical care'.[87]

Open Arms asserts that:

> *Implementation of the amended consent form has contributed to a cultural shift, where Open Arms Clinicians in the past were operating on the understanding that a firewall between the two agencies prevented them sharing information, the amended consent form is providing permission to collaborate with DVA where it is in the best interests of the client and consent has been provided*.[88]

[82] In discussions with the reviewer.
[83] *Privacy Act 1988* (Cth) s 13.
[84] *Privacy Act 1988* (Cth) s 6(b).
[85] *Privacy Act 1988* (Cth) s 16B; *Privacy Act Guidelines*.
[86] Open Arms 'Minister for Veterans' Affairs National Advisory Committee on the Veterans and Veterans Families Counselling Service' Canberra, Act 26-27 October 2017.
[87] 'Consent for the Veterans and Veterans Families Counselling Service (VVCS) to Provide Services' (Open Arms consent form).
[88] Open Arms comment on recommendation 4, February 2019.

It is also not clear whether the changed consent form has made a difference to past practice. No data was available to the reviewer to demonstrate how information-sharing may have changed the practices concerning sharing of information with DVA since the implementation of the revised form. Nonetheless, Open Arms maintains that it 'can provide multiple examples of where it has reached into DVA to assist a veteran client' and that this 'practice is happening on a daily basis'.[89]

There are also criticisms which can be made of the terms of the revised consent form. The deficiencies relate to the coverage of the form, to its description of when the consent to exchange information is permitted, and the absence of terms suggesting the client can opt out. The result is that the circumstances in which information can be exchanged without consent are unclear.

Extent of notion of 'clinical care'

The revised form refers to sharing 'relevant information where it is in the best interests of your clinical care'. 'Clinical care' may not cover the disclosure of information on issues such as relationship or financial problems which may contribute to a veteran being vulnerable or at-risk. Both kinds of information are likely to be disclosed during counselling sessions but they do not fall easily within the notion of 'clinical care'.

In Mr Bird's case, there was no single piece of evidence which on its own indicated he was a serious risk to himself. There were, however, multiple factors which may, in combination, have contributed to an assessment of risk. These included the rejection of Mr Bird's permanent impairment claim, his complaint to DVA about delays in processing his incapacity claim (discussed at recommendation 11), his serious financial difficulties, his mental health conditions, and his unemployed status. It is unclear whether there was information available to Open Arms which would have permitted a disclosure to DVA of relevant information under the Open Arms revised consent form.

Terms of the consent form

The second criticism is the lack of clarity about the circumstances which permit exchange of information without consent. The language in the revised consent form contributes to that lack of clarity.

The consent form in Part A affirms the principle of confidentiality, subject to certain exceptions. In the introduction to the '*exceptions to confidentiality*' segment of Part A of the form, the test of when an exception to confidentiality arises is described as '*where the sharing of that information is considered appropriate or necessary*'. The description is broadly expressed and is less stringent than the general law test of the exemption, namely, when there is a serious risk to, life or health of the person or another. For general clients, the exception to confidentiality is expressed as where '*you or another person is at serious risk of harm'*, and for current members of the ADF, where there is '*a serious risk to yourself or to others, and where this serious risk is likely to impact on your ability to perform ADF duties or raises ongoing safety concerns'*.[90]

The problem with the '*serious risk of harm'* test is that it reflects the existing common law test and has not changed the previous, unsatisfactory position with respect to DVA/Open Arms information-sharing, nor the less demanding 'at-risk' test.

Further, the client's 'Confirmation of Informed Consent' segment in Part B of the form, merely requires the client to give consent to the sharing of information where there is '*[a] risk to my, or others, health or safety'* (emphasis added). The consent in Part B is to share information in circumstances which may not be '*serious*'.

These inconsistencies in the description of when information exchange can occur may be confusing for clinicians. Although Open Arms assured me that it has received no complaints about the form, a

[89] Open Arms response to the reviewer's questions, February 2019, 1.
[90] Open Arms Consent Form.

client may also be unsure about the circumstances in which their privacy and confidentiality can be breached.[91] This in turn may affect their willingness to agree to sign the consent form.

The less demanding tests – '*best interests of your clinical care'*; the '*appropriate or necessary'* test, or even the '*a risk to my, or others, health or safety' test* may be sufficient for Open Arms to warn DVA that a client is vulnerable but not yet a '*serious risk to self or others'*, and that special care should be taken by staff when dealing with this person. If these tests were adopted, they would permit an exchange of information about a client with mental health problems in advance of any crisis as they have been identified as 'at-risk'. This would demonstrate an approach which is apt to prevent potential threats to life or health.

Opting-out

It is unclear how clients are able easily to opt out of this arrangement. Only one confirmation option is provided on the form and that is to consent to receiving services from Open Arms, along with consenting to the disclosure of personal information if Open Arms has identified a risk to health or safety, or as required by law. Nor were figures available to indicate how many clients had opted out of the revised consent form.[92]

Summary

The form needs clarification as to which of the inconsistent statements is intended to be the applicable test, preferably a simple 'at-risk' test, and to state clearly that there is a right to refuse to give consent to information exchange. The current draft remains a barrier to more open communications between DVA and Open Arms.

That is to be regretted. Open Arms clinicians are uniquely able to assess the state of mind of those who use its services and to provide early identification of 'at-risk' clients. The skills and training of DVA staff means they are not so equipped. That means the onus is on Open Arms to take the initiative in cases where a client is exhibiting behaviours or disclosing information which is an indicator of vulnerability. The absence of timely referrals by Open Arms to DVA creates a risk that a DVA staff member may inadvertently interact with a client with sensitivities in a manner that enhances a risk of self-harm on the part of the client. This exchange should occur prior to the person being '*at serious risk of harm'*.

Open Arms has indicated that a change to the Australian Psychological Society code of ethics now permits clinicians to report risk whether or not it is imminent. Consequently, Open Arms' clinicians 'are moving from a categorical approach to risk management to adopting a person-centred formulation based approach that ensures a comprehensive assessment and intervention plan is implemented for clients.'[93] However, the indication from Open Arms is that the change of approach is likely to take time to be fully embraced.[94] In the meantime, the lines of communication need to be as open as possible if both agencies are to be able to operate to maximum effectiveness to assist those clients who need their care.

Privacy Act issues

The consent forms and collection notices of both DVA and Open Arms need amendment to make it clear to clients the circumstances where information is shared by DVA and Open Arms for referral and counselling purposes, and the role that DVA plays in monitoring progress to facilitate access to other services. The wording of any consent to disclosure of information between DVA and Open Arms should be similar, or complementary, and would need to be publicised on their websites. At present the

[91] Open Arms' response to the reviewer's questions, February 2019, 2.
[92] Discussion with Open Arms, 29 November 2018.
[93] Comments on reviewer's draft response to recommendation 4, February 2019.
[94] Discussion with Open Arms, 26 February, 2019.

notification of confidentiality and privacy on the DVA website and the consent provisions or forms of either Open Arms or DVA do not refer to consent to use of information about potential risks.

As both Open Arms and DVA are one agency, there is no inhibition on either disclosing personal information they hold to the other. But that disclosure cannot lead to use by the other. That is because the use must relate to the primary purpose for which the information was collected. The advice is that DVA collects information primarily for the provision of its compensation services and other benefits, while Open Arms collects information for the primary purpose of providing counselling. So even if sensitive personal information indicating a client was at-risk was disclosed by Open Arms to DVA, the claims assessment divisions of the Department could not use the information since they do not offer a counselling service. The converse also applies. Open Arms could not, without explicit consent, provide counselling services to a client referred by DVA since the information was provided to DVA for the primary purpose of the provision of services other than counselling.

If the collection of personal and sensitive information is for a secondary purpose, for example, risk assessment, there must be explicit consent to use for that purpose or one or more of the exceptions in the Privacy Act must apply. One such exception would to lessen or prevent a serious threat to any person or another. This would apply only in exceptional circumstances. Any regular or routine exchange could not rely on that exception.[95] The result is that without explicit consent DVA could not use information from Open Arms to provide mental health, rehabilitation or financial support to a client at-risk.

One solution to this dilemma is for both Open Arms and DVA to advise on their websites that the personal information they collect is to be used to provide services for the wellbeing of veterans and their families. That purpose is consistent with VCR (for DVA) and the provision of whole-of-person care, progressively being adopted by Open Arms. To do so would be consistent with *Privacy Act s 95 Guidelines* that note that an agency '*should carefully consider their obligations under NPP1 [National Privacy Principle 1] to advise individuals from whom they are collecting personal information of any regular disclosures that will be made'*. The disclosure by either DVA or Open Arms would then be a primary purpose for both arms of the agency and the exchange and use of the personal information would not breach NPP1.

Another solution, although not in the short-term, is for legislative change. DVA could adopt the approach to exemption for personal information held by a public sector agency found in the *Privacy and Personal Information Act 1998* (NSW). Section 26 of that Act states:

26 Other exemptions where non-compliance would benefit the individual concerned

(1) A public sector agency is not required to comply with section 9[96]or 10[97]if compliance by the agency would, in the circumstances, prejudice the interests of the individual to whom the information relates.

This provision permits exchange of information within different elements of a public sector agency which would 'benefit the individual' or enhance the person's 'interests'. The exemption would be sufficient to cover those 'at-risk' but not yet at 'serious risk'.

A legislative amendment could be sought to the *Privacy Act 1988* (Cth) along the lines of the New South Wales provision. Alternatively, since that could be an uncertain and lengthy process, a provision

[95] *Open Arms response to the reviewer's questions*, February 2019, 1.

[96] *Privacy and Personal Information Act 1998* (NSW) s 9 relates to the collection of personal information directly from an individual.

[97] *Privacy and Personal Information Act 1998* (NSW) s 10 relates to the requirements to disclose the purposes for which personal information is being collected.

to this effect could be inserted in the VEA, the MRCA and the DRCA. This would be effective in accordance with the statutory interpretation principle that the specific provision (in the three Acts) takes precedence over the more general provision in the Privacy Act.[98]

The Productivity Commission Draft Report observed that '*Open Arms could significantly contribute to both the provision of high-quality mental health care and the coordination of care for veterans with complex problems'*[99] which suggests there is need for more open communications between Open Arms and DVA, an interaction which at present does not appear to be optimal.

Conclusion and suggested actions

It is clear that the revised consent form was an attempt to improve information exchange between DVA and Open Arms. Despite the attempt, it is not clear that the form is fully effective as a mechanism to share information about a veteran who may be at-risk or vulnerable in advance of serious risk to that person's life or health. Clarification is required if the revised form is to be effective to enable sharing of information with DVA to avoid the escalation of stress which may lead to a serious risk to life or health.

Unless Open Arms takes an expansive view of the exceptions to its privacy and confidentiality obligations to enable it to breach its confidentiality obligation, there remains a significant blockage in the Open Arms willingness to share information with DVA. As DVA and Open Arms have different purposes for the collection of personal information, the consequence is that information disclosed to one cannot be shared with the other unless an exception applies. That exception is met only if there is consent (discussed above) or there is serious danger to life or health of the veteran or another person. The blockage is reinforced by the traditional adherence by Open Arms to keep private the substance of information exchanged during counselling.

Two solutions to this blockage are:

- Open Arms and the other elements of DVA should revise their Privacy Statements to indicate that a purpose of collecting information is to enable a holistic veteran centric approach to ensure a client's wellbeing. That step would open the way not only to exchange of information but also to use it for the benefit of the veteran;
- DVA should seek to introduce to either the *Privacy Act 1988* (Cth), or to each of the *Veterans' Entitlements Act 1986* (Cth) (VEA), the *Military Rehabilitation and Compensation Act 2004* (Cth) (MRCA) or the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (Cth) (DRCA) a provision that an exception to privacy arises when an exchange of information by a public sector agency would benefit the individual concerned. The provision would mirror the provision in the *Privacy and Personal Information Act 1998* (NSW) s 26 and is consistent with the holistic approach to the wellbeing of veterans adopted by DVA and being implemented by Open Arms.

There is a need to clarify the inconsistencies in the consent form to ensure that an appropriate balance between privacy and disclosure is resolved. Adoption is also recommended of either of the two suggestions to meet the restriction on exchanging information about at-risk clients. This will involve changes to policy, training and culture to ensure this more beneficial approach is adopted.

[98] The *generalia specialibus non derogant* principle: and see *Perpetual Executors and Trustees Association of Australia v Federal Commission of Taxation* (1948) 77 CLR 1 at 29.
[99] Productivity Commission Draft Report, 596.

Recommendation 5: Put in place controls to ensure that complex case management is initiated for complex or high risk clients.

A system deficiency highlighted by Mr Bird's case was the absence of processes to alert staff to two categories of clients: those having difficulty navigating the complex DVA claims system; and those with mental health or other problems which placed them in the high risk category. These deficiencies are being addressed. Discussion also focuses on the need to simplify the claims processes, case management initiatives, and the committees which oversight claims by those with complex claims or who are at high risk.

There have been many complaints concerning the complex nature of the legislation DVA administers and the frustrations experienced by veterans at the administrative processes. All these issues have the potential to impact adversely on a veteran's mental health and wellbeing.[100] As the Productivity Commission commented in its Draft Report, '*a complex system does not need to be complex for users*.[101] And as the Productivity Commission also pointed out these issues are not new.

In 2013 the Australian Public Service Commission in its Capability Review of DVA observed:

> *the benevolent philosophy that has been much promulgated throughout the department, and actively looks to provide veterans with their entitlements, needs to be matched by benevolent design.*[102]

Clients with claims that are complex have been described as including those who:

- have been designated as 'priority' by Defence as part of the Early Engagement Model;
- are making mental health claims; or
- are in financial hardship.[103]

Mr Bird fell into the last two of these three categories.

The major steps taken in response to these problems are the VCR program, the updating of ICT systems (MyService and ISH are discussed at recommendation 2), the Early Engagement Model (see recommendation 6) to provide information on medical issues of ADF members to DVA as early as possible, and Open Arms Complex Needs Client Support.[104] Other steps involve simplification of the processing of claims for commonly claimed conditions; a revision to the DVA committee structure to offer a single entry point for high risk and complex claims clients; training for staff to identify and better support clients in the high risk or complex claims groups; and a targeted systems update to include indicator flags for high risk and vulnerable clients (see recommendation 11).

Simplification of claims processing

DVA has introduced multiple changes to simplify claims processing and advance the access to treatment and compensation for veterans. Those steps include the extension of non-liability health care to all mental health conditions[105] (see recommendation 12), the changed policy concerning payment of interim compensation for permanent impairment under the MRCA (see

[100] Productivity Commission Draft Report, eg Key Points, 387.
[101] Productivity Commission Draft Report Overview, Key points, 1.
[102] Australian Public Service Commission *Capability Review: Department of Veterans' Affairs* (2013), 11.
[103] Productivity Commission Draft Report, Box 9.5, 363.
[104] Productivity Commission Draft Report, Chapter 9.
[105] Factsheet HSV109 – Non-Liability Health Care; Factsheet HSV61- DVA Health Card – Specific Conditions (White); Factsheet HSV14 – Osteopathic Services.

recommendations 2 and 17), and the streamlining or straight-through processing of claims for certain conditions (see recommendation 17).

The segmentation of the claims process remains a potential barrier to obtaining a clear overview of the needs of a client. DVA does not provide a holistic care model. As the Productivity Commission Draft Report observed:

> *Under the DVA's current segmented approach to processing DRCA and MRCA claims, separate assessors undertake each step of the claims process (and potentially each injury under the DRCA). As such, it would be difficult for a single case manager to determine an entire claim from beginning to end, except in the simplest of cases (such as non-liability healthcare applications). The 'super delegates' who can do this — DVA staff members familiar with the length and breadth of the entire claims process and with decades of experience across the agency — do not exist in sufficient numbers to handle all cases*.[106]

At present, an inhibitor of claims management is the siloed system under which different aspects of a claim are decided by different divisions or teams within DVA. The process involves 4 stages: registration and needs assessment; initial liability; permanent impairment; incapacity and other permanent compensation claims.[107] The Department does not have a holistic claims assessment model.

In response to a recommendation of the Australian National Audit Office (ANAO) that DVA review its current approach to processing claims, DVA has agreed to investigate the possibility of managing 'the claim and client through a single point of contact for all initial liability claims'.[108]

As evidence of DVA's efforts to improve these issues, Combined Benefits Processing (CBP) trials have been running since August 2018 in Brisbane and Perth, whereby delegates undertake CBP for MRCA-only claims. The processing of the Initial Liability claim, the conducting of the consequent Needs Assessment and the processing of any resultant Permanent Impairment (PI) claim is now being undertaken within a single process and by a single delegate rather than three.

The observed benefits derived to date are:

- Greatly improved client satisfaction rates.
- Improved staff satisfaction and professional development.
- Significantly reduced overall Time Taken to Process (TTTP) the claims had they been processed in three parts. [109]

Additionally, where a client qualifies for Incapacity Payments and or Rehabilitation Services a warm referral by the CBP delegates occurs for the client, providing a more personalised experience for the client. The trials are initially of claims under the MRCA and will progress to claims under the DRCA. More complex claims with eligibility across MRCA, DRCA and/or the VEA will continue to be done separately.[110]

Another advantage of an end-to-end approach and a holistic client perspective is that it would avoid the present fragmentation of requests to Defence for information about a client's claims using DVA

[106] Productivity Commission Draft Report, 365.
[107] Meeting with DVA, 21 February 2019.
[108] Auditor-General Audit Report No 52 of 2016-2017 *Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs*, 35.
[109] Meeting with DVA, 21 February 2019.
[110] Meeting with DVA, 21 February 2019.

SAM. At present there is no single, end-to-end information management system, which means transfers between DVA and Defence can be time consuming and may include unnecessary or duplicated requests. Developments under way seek to streamline and simplify the information exchange between Defence, DVA and CSC (see recommendation 6 below).

Structural improvements

Additional sources of frustration are the numerous areas within DVA from which clients can seek help. Attempting to navigate this complexity can contribute to the stress a client may be experiencing. The DVA has restructured its architecture to better assist clients with complex circumstances or high needs, through establishing the Client Support Framework (CSF) (see following).

Under the CSF, the Triage and Connect team functions as a central point to quickly assess and appropriately refer or escalate high risk or complex claims, including to Coordinated Client Support (CCS), the Wellbeing and Support Program, a Problem Solving Forum (PSF), or the Weekly Client Discussion (WCD), and consideration, following an escalation process, by senior staff.[111] In addition, referral can be to a Managed Access team which deals with interactions with clients whose behaviours are unreasonable, seeking to address issues and support return of these clients to business as usual. An Improving Processing Systems (IPS) team manages and coordinates improvements to ICT systems (see recommendation 11).

A brief description of some elements of the revised structures follows. The PSF and escalation service are discussed under recommendation 16.

Triage and Connect

A key feature of the improvements is the development of a triage or allocation process exercised through the Triage and Connect team. Triage is a single internal point of referral for clients at-risk or with complex needs. The Triage process is specifically designed to provide for the assessment and resolution of complex client matters.[112] The small Triage and Connect team (some 5 members), following an internal referral from DVA staff, assesses the client's needs, and decides which services or forms of assistance are required. The process is still in the implementation phase.

Initially the Triage and Connect team had two 'embedded' Open Arms staff members, but these were withdrawn when they were not being used as intended.[113] There is a need for the Open Arms expertise and the increasing volume of cases means the small team is stretched. Alternatively, the team needs its own clinician. [114]

Due to DVA's current 'siloed' structure, Triage and Connect often encounter issues because no particular area or individual officer has ownership of a client's case, or there is no-one taking a holistic view of the client's circumstances or issues. Triage and Connect can refer or escalate complex cases where issues are unresolved, and effectively coordinate actions to ensure resolution. Actions include arranging referral to the CCS, the Open Arms, the Wellbeing and Support Program, Problem Solving Forum, the Steering Committee (provides support to delegates), and to DVA social workers.[115]

Referrals to Triage and Connect are also made for each client where a security incident report is raised. This is an advance on previous security incident management procedures (see recommendation 11).

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[111] Client Support Framework – The Right Support at the Right Time; National Training Materials for Client and Support Services Division.
[112] R&C ISH 'Perform Needs Assessment.
[113] Discussion with Open Arms, 8 February 2019.
[114] Discussion with DVA, 30 November 2018.
[115] *Triage Team Policy Documentation – June 2018,* 4.

The revised procedure provides greater support to clients and ensures more comprehensive management of risk beyond a single incident. These referrals usually result in follow-up contact by one of the Open Arms clinicians, as well as an in-depth review of the client's DVA circumstances and claims.

The intention is that a coordinated, collaborative approach is taken to each of these cases, with the clinical and non-clinical staff working together, with client consent, to find solutions to the client's specific problems and to communicate these to the client. Many complex case matters have been resolved via coordination by the Triage and Connect Team working with relevant business areas or with Open Arms. The collaboration has identified underlying issues requiring escalation of the client's claim, thus preventing future escalations or incidents. Triage is being rolled out in a staged approach.

Escalation can also lead to case conferencing of high risk or complex cases by senior staff, including the Weekly Client Discussion (WCD) attended by the First Assistant Secretaries of Client Engagement & Support Services, Clients' Benefits Division and Legal, Assurance and Governance Division, representatives from Triage and Connect, Coordinated Client Support, DVA Security, Open Arms and the Secretary's Office.

Since implementation in August 2018, a total of 368 client cases have been referred to Triage and Connect.[116] Referrals have primarily been complex or high risk clients with mental health issues, high profile clients, and clients with complex entitlements matters, such as complex claims, errors or other issues.[117] It is anticipated that more in-depth data analysis of the impacts of Triage and Connect will be undertaken in 2019 once further data is available.

Coordinated Client Support (CCS)

A key element of the program for better managing clients' needs is CCS. CCS commenced in 2016, and initially included an Intake team and a Client Liaison Unit (CLU), together with case coordinators from Case Coordination and Service Coordination services. With the establishment of the Client Support Framework, intake has been combined with Triage and Connect, and CLU is now Managed Access.

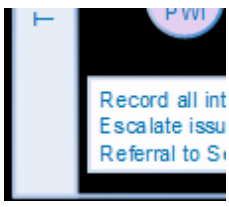
A key feature of the CCS is that it is intended to be the principal vehicle for the provision of tailored services (see Figure 5 below). Case coordinators may be designated as the single point of contact with DVA when required, for example: for complex cases, at risk clients, high profile clients or in the case of the death of a serving member. In cases where the client has exhibited difficult behaviours, the clients are referred to the Managed Access team.

CCS assesses the client's needs, assigning one of three levels of support. Those requiring additional support because of their complex and multiple needs are classified as Levels 2 (Guided Support) and Level 3 (Comprehensive Support). If appropriate, CCS will appoint a CCS case coordinator who then assists these clients to access benefits and other services. A client can be referred to CSS at any point in the claims process.

CCS has recently recruited a mental health professional to be part of the team. It is anticipated that this person will provide support and guidance to the service coordinators (see recommendation 7) in working effectively with clients. The person may also provide direct support to bereaved clients where required.

[116] DVA Progress Report, 31 December 2018, 44.
[117] CLIK 'External Supports for Clients At-risk'.

Figure 5 **Overview of Coordinated Client Support**



Source: Coordinated Client Support Guidelines (draft), p9.

There are, however, limitations to the support provided. CCS is not a crisis intervention service, does not deliver adverse decisions or claim outcomes, provide clinical case management, or assessment of entitlement to benefits. Nor does it undertake any processing or calculation role under the VEA, MRCA or DRCA.[118]

An evaluation of the CCS program is being conducted by the University of New South Wales in conjunction with DVA for completion in early 2019. There has been a noticeable increase of use of CCS. For the two years from July 2016 the figures indicate a 20 per cent increase in referrals. [119]

Problem Solving Forum (PSF)

The PSF is designed to resolve specific client issues including complex eligibility and policy decisions. The PSF comprises high level policy staff, and holds weekly conferences on high risk or complex cases. PSF meets weekly and, as at 31 December 2018, it had convened 14 times and conferenced 20 client cases since the first meeting on 10 July 2018.[120] This is a relatively small number of cases but the evidence is that many complex case matters are often resolved with relevant business areas by the Triage and Connect Team.

Wellbeing and Support Program – case management

The Wellbeing and Support Program is a two year program for the trial of a case management model, operating under the Client Support Framework (see recommendation 10).

Open Arms

As part of the assistance for at-risk individuals, Open Arms has engaged more clinicians who can deliver mental health case management. Open Arms has also taken steps to increase its ability to track the use of mental health case management in its client management system. Policies have been updated to include a process for contacting clients identified as high risk, referred to as 'reach out calls' (see recommendation 9). These moves are part of the Open Arms program to build its ability to provide crisis intervention when needed.

Open Arms also offers a service - Complex Needs Client Support – to ensure coordinated and targeted care for a client with complex and/or multiple needs. This support aims to provide coordinated, timely and integrated care for a client across multiple agencies and providers.

Training

Relevant training on how to identify, and to communicate with clients classified as 'high risk' or with complex cases is discussed at recommendation 8.

To ensure case management is initiated for all clients in the 'at-risk' or 'complex claim' categories there needs to be effective training of claims assessors. At present, under the segmented administrative processes, claims assessors' training and operation is largely focussed on the process for which they have responsibility. It would be unrealistic to expect a single claims assessor to have sufficient technical knowledge to manage a complex claim (see quote earlier under 'Simplification of Claims Processes'). Nonetheless, all claims assessors can be trained to be good listeners and to use the risk indicators to identify a client at-risk and then suggest a referral. Care needs to be taken to avoid overburdening front-line staff with responsibilities. There is further discussion of these issues under recommendation 8.

[118] Coordinated Client Support National Policy Issue Number 01/16 8-10, 12.
[119] DVA unpublished data – number of referrals of clients to CCS.
[120] DVA Progress Report, 31 December 2018.

Complex cases and at-risk triggers: ICT upgrade

The Department is exploring ICT changes to provide a better system of alerts to staff about a client's vulnerabilities or their complex circumstances. These developments are discussed at recommendation 11.

Conclusion and suggested actions

Implementation of this recommendation requires a multi-faceted approach. Steps have been taken to develop most facets but more is needed.

DVA has developed and disseminated at-risk client indicators, established the Client Support Framework, comprising the Coordinated Client Support team, the Triage and Connect team, the Managed Access team (for clients with unreasonable behaviours), the Wellbeing and Support Program (for case management), as well as referrals to Open Arms, and to DVA social workers. These bodies and trained individuals better manage, if needed, the assessment and referral to appropriate services, including case management, of clients at high risk or with complex claims. Escalations are also now possible to a Weekly Client Discussion undertaken by senior DVA executives, and to the Problem Solving Forum for consideration by subject matter experts from across the Department.

Training has been undertaken on the new processes and procedures manuals developed.

These steps indicate that DVA architecture has evolved rapidly in response to this recommendation. Care is needed to avoid confusion with the multiplicity of bodies offering coordination or social supports remains a concern. It is too soon to judge if that confusion will be experienced, but close monitoring is required if that is not to occur.

The MyService development will not help directly with case management, and in fact may run counter to it as it is about high speed, low interaction services. MyService may assist by enabling DVA to increase its services to clients who are high risk or have complex claims since it will free up experienced staff to focus on such clients.

At the same time, management needs to take care to avoid making unrealistic demands on front-line staff facing these additional demands on their assessment of claimants as well as claims. The most that should be expected is to sensitise them to the possible need for a referral, so that assessment can be undertaken by others of whether a single case coordinator is needed.

The number of CCS case coordinators and the small size of the Triage and Connect team needs to be increased. That is due to the increasing demand for their services. One indicator of vulnerability and complexity is mental health, and DVA analysis indicates that as at June 2018, some 53,202 veterans, or 32 per cent of veterans who are clients of DVA, have current or accepted claims for mental health conditions.[121]

Recommendation 6: Revise Service Level Agreement Key Performance Indicators for information sharing with partner agencies (such as Defence and the Commonwealth Superannuation Corporation), including timeframes for DVA to request information as soon as possible after claim registration and timeframes for partner agencies to respond.

The context for this recommendation was receipt of Mr Bird's application for incapacity payments on 1 June 2017. DVA did not submit the request to its internal DVA SAM team to action until 13 June 2017. The request was classified as 'low priority'. DVA SAM team sent the request for Mr Bird's service

[121] Discussion with DVA, 21 February 2019.

and health details to Defence on 21 June 2017. On the evening of 22 June 2017, Mr Bird lodged a complaint about the delay in processing his application.

On 23 June 2017, the request was upgraded by DVA to 'high priority', and Defence was contacted on 26 June 2017 to escalate the request. Defence provided the information on 28 June 2017, after the death of Mr Bird.

Administrative delays in compensation processes can exacerbate existing stress and have a negative impact on mental health. It is in this context that attention is drawn in this recommendation to the timeliness of the exchange of information within the relevant government agencies.

There are signs that initiatives are improving exchange of information between those involved, that the speed of exchange is increasing, and that training and documentation is under way that will educate users on the processes.

DEFENCE

Background to systems and processes

The process for seeking an applicant's service history and health records from Defence is an essential element for many DVA processes and is imposed on DVA under the VEA and the MRCA.[122] No such obligation is imposed under the DRCA.

Single Access Mechanism

The exchange of information between DVA and Defence is managed by two dedicated teams in each Department as part of the Single Access Mechanism (SAM). The exchange is authorised by a *Memorandum of Understanding* (MOU) between Defence and DVA.[123] The MOU is designed to ensure the two Departments work together to deliver care and support for serving and former members of the ADF. Included in the MOU is a commitment to share information in the most effective manner, principally electronically.[124] There is also an Information Management Working Group involving Defence, DVA and the Commonwealth Superannuation Corporation (CSC).[125]

There is a Defence SAM team and a DVA SAM team.[126] The aim is for the two teams to centralise the management of information requests and communicate effectively to provide requested information.[127] The Defence SAM team manages access to a member's service and health records,[128] whether paper or electronic. Some of the improvements described later go to either DVA system to Defence system extraction (eg MyService validating service via PMKeyS), or to DVA person to Defence system extraction (direct access). With Defence's program of digitisation these opportunities will increase, and it is likely the Defence SAM team will be relied on mostly for older and more complex requests relying on paper-based records. There is a three year timeline for a number of SAM system improvements.

One of the issues which had impacted on Mr Bird in June 2017 was the categorisation by DVA of his request as non-urgent. Under the MOU, requests to Defence could be designated as urgent, medium,

[122] VEA s 17; MRCA s 324.
[123] Schedule 17, MOU between Defence and DVA, 28 February 2017.
[124] Schedule 17, MOU between Defence and DVA, 28 February 2017; MOU between Defence and DVA, 28 February 2017, Attachment A, 'Defence DVA CSC Information Management Working Group (IMWG)'.
[125] MOU between Defence and DVA, 28 February 2017, Attachment A, 'Defence DVA CSC Information Management Working Group (IMWG)'.
[126] *DVA SAM Procedure Guide*.
[127] *Single Access Mechanism Request Handing Guide.*
[128] Action Plan v1.

routine research requests, or a request related to Boards of Inquiry pre-1985.[129] DVA only sought to upgrade the request for Mr Bird's information from 'medium' to 'urgent' after his complaint and not long before his death. The KPIs for Defence were 20 calendar days for a medium request and five calendar days for an urgent request.

At the time, there was a significant backlog of urgent cases which meant staff were reluctant to classify a request as urgent unless necessary and, in June 2017, there was a spike in referrals due to a large increase in requests.[130] Although Defence's response to the revised category was prompt, the delays by DVA may have contributed to the pressures Mr Bird was experiencing.

Mr Bird was, at that time, experiencing financial hardship and mental health issues but these issues do not appear to have been appreciated by the Department in its management of the information request. After Mr Bird made his complaint, DVA contacted Defence to escalate the request on 26 June 2017. In the event, Defence's response on 28 June 2017 was within its KPIs, whether measured from the original request (seven calendar days), or DVA's contact on 26 June 2017 (two calendar days).

Despite a thorough enquiry by DVA no evidence was found to explain why the request was not dealt with by DVA as urgent from the outset. This mis-categorisation was dealt with in the DVA internal inquiry. Mr Bird's case, however, has drawn attention to the need for greater care by DVA to characterise a request appropriately (see following).

In August 2017, a more nuanced categorisation system was introduced with the agreement of the Defence/DVA Links Steering Committee.[131] There are now four priority categories – Urgent (General), Urgent (Complex), Medium and Routine, and three service categories – within 12 month of separation or currently serving, between one to three years from separation, and greater than three years of separation. The relevant KPI for Defence increases with time since separation, ranging from five business days for an Urgent (General) request for a client within 12 months of separation, to 35 business days for a Routine request for a client greater than three years since separation.[132] All requests related to incapacity claims are now classified as Medium at a minimum.[133] This recognises that these claims, by their very nature, involve a degree of financial hardship and should not be treated as Routine.[134] Defence has also indicated that information-sharing initiatives related to the Defence/DVA Electronic Information Exchange (DDEIE) Strategy (see following) should significantly reduce the volume of requests from Defence SAM.

Other improvements to information exchange

A facilitator group, Enzyme, was engaged to conduct workshops between Defence and DVA on identifying and overcoming the barriers to better communication.[135]

Enzyme facilitated separate workshops with DVA and Defence in March and April 2018[136], followed by a combined agency workshop on 1 May 2018.[137] The purpose of these workshops was to develop an action plan to rectify issues in the SAM process. A further workshop with DVA was held on 18 May

[129] Schedule 17, MOU between Defence and DVA, 28 February 2017.
[130] Discussions with representatives from Defence, 20 December 2018.
[131] *SAM Request Volume and End to End Process Improvement Plan*, 1.
[132] *DVA SAM Team Guide.*
[133] *SAM Request Volume and End to End Process Improvement Plan*, 3; *SAM Priority Categories*, 6.
[134] *Action Plan v1*, 3.
[135] *DVA SAM Procedure Guide.*
[136] *Defence SAM Issues and Opportunities Report FINAL*, 5 April 2018; *Defence SAM Issues and Opportunities Report,* 20 March 2018.
[137] *Single Access Mechanism Process Improvement Report*, May 2018.

2018 to discuss and agree priorities and immediate next steps.[138] An Action Plan is in place[139] for next steps.[140]

A regular complaint made by Defence was that requests from DVA were often poorly expressed. In response to site visits and staff engagement, the Action Plan noted that the quality of DVA requests has since improved and backlogs in DVA are being brought under control.[141] The DVA SAM procedures guide has been updated[142] and training packages are being developed to address this problem.[143]

Issues which have not yet been fully solved include the inherent difficulties which result from incomplete or inaccurate information in a request, lack of knowledge about SAM, need for better training by staff, and the inability to edit information once it is in the DVA ISH system.[144]

DDEIE Strategy

DVA are working with Defence and CSC on the implementation of the Defence/DVA Electronic Information Exchange (DDEIE) Strategy.[145] The aim of the DDEIE Strategy is to establish a cost-effective electronic information sharing and exchange system. This includes support for system to system automation and DVA direct access. As at December 2018, the Strategy was halfway through the first year of a three year plan.[146]

The DDEIE Strategy involves a number of staged ICT improvements and projects, including records digitisation, improvements to the SAM Request Management System, and the Early Engagement Model (discussed below).[147]

DVA and CSC are each to appoint a Project Manager and team to carry out the next phase for the DDEIE.[148] When DDEIE comes into operation, it will further reduce the time taken as the number of claims relying on the SAM system will be reduced, confined as it will be to older veterans where the service records are historical and paper-based.[149] CSC has had little involvement with the DDEIE Strategy, as it is principally managed by DVA and Defence.

In addition, Defence has a long-term project to have a new eHealth system by 2022. It is intended that this system would be capable of exchanging information with the Department of Human Services' (DHS) MyHealth Record and DVA's systems.

Early Engagement Model

The Early Engagement Model seeks to establish a relationship between DVA and serving members as early in their career as practicable. The model includes Defence providing information to DVA on ADF members from the time of enlistment, and providing information to members about DVA support and

[138] *Single Access Mechanism IDR Workshop Report*, 18 May 2018.
[139] *Single Access Mechanism Process Improvement Report*, May 2018.
[140] *SAM Request Volume and End to End Process Improvement Plan*, 1.
[141] *SAM Request Volume and End to End Process Improvement Plan*, 1.
[142] *DVA SAM Team Guide*.
[143] *SAM Request Volume and End to End Process Improvement Plan*, 1.
[143] *DVA SAM Team Guide*.
[143] *DVA SAM Team Guide*, 1.
[144] *Single Access Mechanism IDR Workshop Report*, 18 May 2018, 12-14.
[145] *Defence/DVA Electronic Information Exchange Strategy*.
[146] Discussions with representatives from Defence, 20 December 2018
[147] Discussions with representatives from Defence, 20 December 2018.
[148] Defence Chief Information Officer Group *Business Requirements Documents – Defence DVA Electronic Information Exchange (DDEIE).*
[149] Discussions with representatives from Defence, 20 December 2018.

services while they are serving. The purpose of the model is to assist with early intervention and preventative care, where appropriate, and to organise ongoing consent to the sharing of information between Defence and DVA.[150] All members who joined the ADF from 1 January 2016, and those who separated from the ADF after 27 July 2016, are now registered with DVA.[151]

This exchange of information relates to personal information concerning health, rehabilitation and veterans' services, and management of the welfare of defence members and their dependants.

The information shared with DVA for the purposes of the Early Engagement Model relates to:

- the date of enlistment or appointment;
- any involvement of the member in a 'serious incident' (where the member is classified as 'Very Seriously Ill, or Very Seriously Injured' or 'Seriously Ill or Seriously Injured');
- that the member has commenced or completed transition from the ADF; and
- whether the member had qualifying service as defined in the VEA.

The exchange is subject to Defence's Privacy Policy, and the 'personal information' which is disclosable relates to termination of service on medical grounds, or for any reason that involves the use of misuse of drugs or alcohol, except where the termination is only for possession or supply.

For CSC, disclosure of 'personal information' can occur if service is to be terminated on medical grounds.[152] The disclosable information only refers to injury or disease which is 'serious'. This neglects all of those injuries which, while not classified as serious at the time, may have longer term harmful effects.

Access by DVA staff to Defence records

In November 2018, the DVA SAM team commenced a self-service trial of post-2014 Defence medical information through the Defence system DeHS. Access to DeHS allows DVA to retrieve medical information, case notes and diagnostic imagery in real time and negates the need for DVA to approach Defence.

This trial proved very successful and system access has been extended to a number of claims assessors who were also involved in the Special Operations Forces Pilot (SOFP) at Holsworthy. As part of this trial the DVA SAM team are now also self-servicing all requests for post-2014 medical evidence through DeHS (noting that the electronic self-servicing of pre-2014 medical information is not possible).

Improvements to processing times

As a result of the initiatives, there has been an improvement in the average processing times for information requests within DVA and Defence. Figures from DVA suggest that monthly response times in SAM to complete requests for information between July 2017 and December 2018 reduced from an average of 33.8 days in July 2017 to 11.3 days in December 2018.[153]

These processing times are regularly monitored by the Defence/DVA Links Steering Committee (DLSC), which comprises senior officers from DVA and Defence. A higher level of oversight is provided by the

[150] *Defence/DVA Electronic Information Exchange Strategy;* Attachment A, 5.
[151] Productivity Commission Draft report, 266.
[152] MILSPERSMAN Part 007, Ch 9 *Disclosure of Certain Personal Information in Relation to the Department of Veterans' Affairs and the Commonwealth Superannuation Corporation* [9.5], [9.6], [9.9], [9.11.b], [9.12] – [9.14].
[153] Unpublished DVA data –Performance against SAM KPIs.

Defence/DVA Executive Committee (DDEC), which comprises the Chief of the Defence Force, the Secretaries of DVA and Defence, and relevant Deputy Secretaries.

Nonetheless, there are continuing issues. The performance report for DLSC for the July to September quarter in 2018 reported that only 32 per cent of SAM requests were completed within the KPI benchmark, with a high percentage of requests overdue. Although the number of urgent requests by DVA had halved compared with the March-June quarter in 2018, only 50 per cent were completed within the KPI timeframe, a 13 per cent decrease in completions compared to the previous quarter.[154]

Service history

The central issue for timeliness is obtaining information relating to service history, and the opportunity to reduce the need for, and time taken to complete, information requests.

Since the launch of MyService in early 2017, DVA has implemented changes to reduce the need for manual information requests to Defence for service history information. Initially, access to MyService was limited to clients who had a PMKeyS (Personnel Management Key System) number, and who had enlisted after 30 June 2004. For these clients, MyService was able automatically to verify their service history with Defence systems. Implemented between September 1997 and December 2002, the PMKeyS system has become Defence's core system for personnel management. MyService was expanded to all PMKeyS number holders from 31 October 2017.

For clients with service prior to the introduction of PMKeyS, there was no similar opportunity to electronically verify service history with the older and often paper-based Defence systems for these records.

That barrier has been dismantled with MyService now accepting a self-declared service history. A release in September 2018 provided functionality for MyService to 'trust' self-declared service history. This followed approval of this approach by the MRCC, effective in August 2018,[155] and formally ratified on 13 December 2018. DVA is sampling claims with self-declared service history to ensure the integrity of the system is being maintained and that any relevant timeframes are being met.

DVA accepts the service history stated by the member, processes the claim and later pursues the necessary supporting paperwork.[156] Use of either a verified or self-declared service history can then permit automatic acceptance of liability for some conditions. However, other cases still require DVA to access Defence information through the SAM process.

Digitisation of health records by Defence

A further significant innovation is the progressive digitisation by Defence of its health records. This would extend digital coverage to all current permanent ADF and reservists, as well as pre-PMKeyS hard copy records (the DHS program). These records, when combined with the Defence eHealth System, will create a complete electronic health record for ADF members, improving accessibility and speed of information exchange for the purpose of claims applications.[157]

From 2018, CSC has had access to those Defence health records held on eHealth and this has enhanced the timeliness of information exchange.[158] Digitisation of Defence's health records is scheduled for

[154] Excerpt – Defence Links Steering Committee Quarterly report – Period 1 July – 30 September 2018.
[155] *Defence/DVA Electronic Information Exchange Strategy*.
[156] Defence DVA CSC Information Management Working Group (IMWG), Attachment A.
[157] Department of Defence and Department of Veterans' Affairs 2018, *Submission to the Inquiry into Transition from the Australian Defence Force,* Terms of Reference 2 [69]-[70]; *Defence/DVA Electronic Information Exchange Strategy*, Attachment A, 5.
[158] Discussions with CSC, 22 January 2019.

completion in 2020, and a new version of the eHealth system is planned for 2022. The access to eHealth by CSC has already led to an estimated 65 per cent reduction in the number of CSC information requests to Defence.[159]

Suicide prevention

Evidence from Defence was that to anticipate and prevent suicide it is important to get help early. That has involved working to remove the stigma associated with mental health issues, and the viewing as a punishment by a member of a downgraded Medical Employment Classification (MEC). Encouragement of rehabilitation is another step which lessens the likelihood of suicide. The increased emphasis on rehabilitation in Defence has had an impact, with at least half of those who attend rehabilitation returning to service.[160] Defence, like Open Arms, is trialling a peer support program using peers with lived experience and the family to assist those with suicide ideation.[161]

COMMONWEALTH SUPERANNUATION CORPORATION (CSC)

A submission to the 2017 Senate inquiry into suicide by veterans and ex-service personnel by Mr Bird's former, partner, Ms Boglis, stated that his financial difficulties led him to seek a superannuation payment from CSC to meet his immediate bills until his DVA claim was finalised. He was advised he needed reports from his medical psychiatrist and psychologist in support of his claim. [redacted] However, eight months after he had made the initial claim, CSC contacted Mr Bird to ask if he wished to pursue the claim as no medical reports had been provided. [redacted]

The story was provided as an instance of administrative red tape and the complexity of the processes that pose particular issues for vulnerable clients.[162] That complexity can also be seen in the offsetting arrangements that apply to a veteran eligible for both incapacity payments from DVA and invalidity pensions administered by CSC.[163] Apart from the consideration of improved information-sharing, the *Joint Inquiry* did not examine Mr Bird's interactions with the CSC.

Electronic information exchange and information management

There is no service level agreement between DVA and CSC. Response priorities and turnaround times – currently two to three days - are maintained through agency communication and manual processes. Enhancements to ICT systems in 2019 to automate existing manual processes are expected to realise a further reduction in time taken for information exchanges.

In relation to the recovery of overpayments to persons receiving a Commonwealth superannuation benefit, DVA is required by the MRCA to respond to CSC in two business days to advise if there has been an overpayment of compensation for offsetting purposes.[164]

Requests for information from Defence are channelled through a single shared email address, and access to eHealth means CSC can obtain Defence health information more directly. Privacy implications do not inhibit exchange of information, unless security restrictions apply, for example in

[159] Discussions with CSC, 22 January 2019.
[160] Discussion with representatives of Defence, 20 December 2018.
[161] Discussion with representatives of Defence, 20 December 2018.
[162] Submission 317, p 3, from Connie Boglis to the Senate *Constant Battle* report.
[163] Productivity Commission Draft Report, 507.
[164] MRCA s 420(2); Information provided by CSC, 8 February 2019.

the case of Special Forces Operations personnel. CSC does not receive information from Defence or DVA in relation to information about mental health conditions of ADF members held by Defence.[165]

Conclusion and suggested actions

The emphasis in this recommendation is on improving information exchange to speed up the evidence-gathering processes and to increase its accuracy, thus benefiting veterans. There has been a change to the KPIs in the Service Level Agreement between Defence and DVA. There is no service level agreement between DVA and CSC. Improvements in information sharing between DVA, Defence and CSC have occurred generally, aided by the increased efficiency from existing and proposed ICT developments, however there is evidence that KPIs for DVA/Defence information-sharing are still not being met. CSC has manual processes in place to achieve information exchange within acceptable limits.

DVA's ICT goal is that more automation of claims processes will lead to more consistent, accurate and timely compensation decisions. However, many of these decisions still rely upon DVA obtaining information from third parties, in particular Defence and health professionals.

The Productivity Commission Draft Report commented frequently on DVA's antiquated ICT systems, numbering over 200.[166] Ambitious IT programs inevitably take time to be developed and the planned development of an electronic information-sharing system for DVA, Defence and the CSC is no exception.

It is premature to criticise the lack of progress. To combat the slow progress due to complexity of systems development and interactions, there is a need for strong coordination and watchful oversight of the processes to ensure the programs are implemented. Evidence gathering has been improved; perseverance is needed to dismantle the current segmented claims management process and to move to a more digitised one which furthers the holistic aim. This is a priority recommendation, but speed of implementation needs to take account of the magnitude of the task. Indications of steps to be followed in this process, and the accountability monitoring required are found in the Productivity Commission Draft Report.[167]

Despite improved timelines for interchange of information between DVA, CSC and Defence, there is room for better coordination between the three. One method would be to embed staff from each agency in the other agencies to identify ways to improve the goal of seamless interactions and interchanges of information.

In order for DVA to obtain direct access to Defence systems, DVA staff need to hold appropriate security clearances. As at 12 March 2019, 163 claims assessors have been granted a Baseline clearance, out of a total of 342 staff who have been identified as needing a clearance. This means almost 50 per cent of staff who have been identified as needing a clearance have been granted a Baseline clearance. It is anticipated that all Initial Liability claims assessors (who are the primary users of medical information from Defence) will hold Baseline clearance by March-April 2019, and all Permanent Impairment and Incapacity claims assessors will have Baseline clearance by June 2019.

[165] Discussions with CSC, 22 January 2019.
[166] Productivity Commission Draft Report, 21, 120, 351, 356, 609.
[167] Productivity Commission Draft Report, Box 16.3, 621

Recommendation 7: Review existing Service Coordination processes that provide coordinated, tailored and empathetic response to families, for relevancy in the case of the death of non-serving clients.

The recommendation relates to DVA's Service Coordination process, developed prior to Mr Bird's death. The responses in the following discussion indicate that the call for 'coordinated, tailored and empathetic response for families' has received attention.

That attention has led to structural changes to provide better coordinated assistance to families following the death of a member or former member of the ADF, the introduction of a Family Support Package, and training for those in contact with clients who have suffered the bereavement of a veteran.

Service Coordination Program

The Service Coordination program was set up to provide support to the partners and families of members killed on deployment. The process now applies to all deaths that are service-related, thus meeting the terms of recommendation 7.

The Service Coordination or case management team, are responsible for identifying families who may be eligible for support through the Family Support Package, helping streamline claims processes, ensuring entitlements are received, and connecting the client and other family members with support options tailored to the client's circumstances. The options include the early engagement with Open Arms to provide support for families, Indigenous Sorry Business and Family Support Package information.[168] Service Coordinators make early contact with the dependants where a death of a former member of the ADF occurs post-discharge and there may be involvement of clinical staff in initial contacts.

These processes are set out in the *Coordinated Client Support Service Coordination Guidelines* (*SC Guidelines*), updated in 2018 to cover the extension to deaths of former members of the ADF and to take account of the Family Support Package.

Family Support Package

The Family Support Package is a significant legislative change. The *Veterans' Affairs Legislation Amendment (Veteran-centric Reforms No 1) Act 2018* (Cth) inserted a new Chapter 5A – Family Support - into the MRCA to establish the legislative framework for targeted support to eligible members, former members and their families. The Family Support Package is able to be accessed by widow(er)s where their partner rendered warlike service on or after 1 July 2004, and the partner has died as a result of service or suicide related to service. The new measures, introduced on 1 May 2018, are budgeted for over the next four years to provide support to families in the form of counselling, child care and home help.

Specifically, veterans and their nominated family members may access:

- Additional child care support for pre and primary school aged children to reduce barriers to a veteran's rehabilitation.
- Counselling support to enable the family unit to maintain its connections to community, employment and social interaction and manage within its budget. A family can access four counselling services each year for a consecutive five year period while the veteran is participating in a rehabilitation plan. Over the course of a five year rehabilitation plan, a family can access up to 20 counselling sessions.

[168] *Service Coordination Guidelines*.

Widowed partners may also be able to access:

- Home help within and around the home to assist the proper functioning or maintenance of the environment of the residence for a 2 year period from the date of death of the veteran.
- Counselling support to assist widowed partners in managing challenging life circumstances following the death of their partner. 4 sessions per year for a 2 year period following the death of the veteran may be accessed.
- Additional childcare support for pre and primary school aged children to assist widowed partners.

These measures are additional supports for MRCA veterans who have rendered warlike service post 1 July 2004, and for the partners of veterans with post 1 July 2004 warlike service who may have died while rendering such service, or whose death was a death by suicide and is related to their service.

Other Supports for the bereaved

The supports are to be provided through several bodies under the oversight of the Client Support Framework and are listed in the *SC [Service Coordination] Guidelines*, updated in November 2018.[169] Service Coordinators, Coordinated Client Support and the Triage and Connect Team are available to frontline staff for advice as to management of bereaved clients by calling the dedicated inbound line. CCS has also developed *Coordinated Client Support Guidelines* (*CCS Guidelines*) for staff, a comprehensive document updated in November 2018 (see recommendation 5).[170]

Management of clients following notification of death

Training as to the management of notifications of death received over the phone is incorporated in the training materials developed under the Client Support Framework. A *Notification of Death* document has been developed to assist front-line staff in these circumstances.[171] Scripts have been provided for those handling calls involving clients at-risk, in an emotional state, or in need of immediate support.[172]A handout has been provided to participants which provides clear instructions.[173] This has been circulated to staff via a *Businessline*.[174] As at 31 December 2018, 437 staff from across all client-facing areas have attended the training, with more sessions scheduled for delivery in January and February 2019.

Conclusion and suggested actions

The Service Coordination (part of CCS) process provided a coordinated, tailored and empathic response to families of serving members; the introduction of Chapter 5A into the MRCA - the Family Support Package - extended this response to families of non-serving members in the event of the former member's death. That means, subject to the following suggestions, that this recommendation is complete.

[169] *Service Coordination Guidelines.*
[170] *Coordinated Client Support Guidelines* 10.
[171] *Businessline* 'Tools to support the identification of, and staff interactions with, at-risk clients', 14 February 2018; 'Notification of Death – General Business Handout', 1 February 2018.
[172] *Businessline* 'Tools to support the identification of, and staff interactions with, at-risk clients', 14 February 2018.
[173] 'Notification of Death – General Business Handout', 1 February 2018.
[174] *Businessline* 'Tools to support the identification of, and staff interactions with, at-risk clients', 14 February 2018.

Recommendation 8: Educate staff and monitor implementation of the inquiry recommendations

This recommendation supports the other recommendations and is to provide assurance as to completion of them.[175]

EDUCATION

Training

The Productivity Commission noted in its draft recommendation 9.2 in the Draft Report that frontline staff who interact with clients in person should 'undertake specific training to deal with vulnerable people and in particular those experiencing the impacts of trauma'.[176] Such training needs to provide guides to achieving good listening skills and voice awareness for detection of stress.

The Productivity Commission's observations may have predated recent DVA initiatives in relation to staff training on handling vulnerable and at-risk clients, including those who are bereaved (see recommendation 7), and the Healthcare Management Advisors review discussed below. Nonetheless, it is undeniable that training of staff to identify and manage at-risk or vulnerable clients is essential if referrals to available services are to assist these clients.

In lieu of comprehensive training for *all* staff who interact with clients, DVA has in place a suite of programs and protocols that set out how staff likely to interact with claimants classified as vulnerable, or as having complex or multiple needs can assist them to navigate the claims process. It does this by directing clients towards specially trained staff or diverting them into external services, such as counselling.[177]

General training developments

General educational processes include forums for DVA R&C managers and all staff. These are held regularly. Seven forums for team leaders and two for all staff have been held since the *Joint Inquiry*. The forums reinforce changes to policy and process and the need for staff to develop relationships with clients at the start of the claims process and to maintain good and regular communication. These forums are now standard business practice.

The Clients' Benefits Division (CBD) has adopted an approach to education and training of staff under which key changes to policies and procedures are disseminated regularly and will be incorporated into face-to-face training, an example of CBD's rigorous training for its front-line staff.[178]

A new suite of training tools, materials, and governance requirements has also been implemented. These changes, which include updated PowerPoint packs, will better support team leaders to deliver critical training around process/policy changes. Staff attendance is also now being monitored and recorded through attendance sheets (held centrally), and staff are required to sign off that they have understood the training provided to them, enabling management to measure the impact of training from the staff member's perspective.

The Department has acknowledged that to work within the revised veteran centric model, the skill set of some of its staff needs to be upgraded.[179] As a consequence, a recently concluded round of

[175] 'Notification of Death – General Business Handout', 1 February 2018.
[176] Productivity Commission Draft Report, 365.
[177] Productivity Commission Draft Report, 363.
[178] Discussion with DVA, 28 November 2018.
[179] EMB Meeting 28 August 2018, 'Tactical Engagement and Communication Plan' 2; Minutes of People and culture Committee Meeting 28 November 2018 - Excerpt; discussion with DVA, 28 November 2018.

recruitment has focused on recruiting those possessing the soft skills required for a more holistic approach to its clients.[180]

In late 2017, the Secretary of the Department triggered an exercise to ascertain the number of delegates in the Department, who were not able to be separately identified in the Department's systems. The exercise established that the Department has over 500 staff exercising delegations on a daily basis, operating across four branches and three divisions, based on the structure at the time.[181]

This work has been followed by a large number of initiatives which are being undertaken to enhance the performance and decision-making of delegates. A Tactical Communication and Engagement Steering Committee (Steering Committee) has been established to coordinate these initiatives (further discussed at recommendation 16) and to monitor the implementation of the *Tactical Engagement and Communications Plan for Delegates' Support (Plan).*[182][183] The Steering Committee held its first meeting on 8 February 2019.

In addition to generic training of delegates, a leadership program, based on the Transformation Leadership Pilot conducted in 2018, was delivered for R&C team leaders and managers to ensure ongoing leadership in relation to the implementation of change in the R&C workplace.[184] A subsequent initiative, following the Pilot, was the development of a Mentoring and Coaching program to develop leadership skills at the APS 6 and EL levels.

Job training workbooks are to be introduced. The workbooks are to structure and record on-the-job learning, particularly for use with new staff, by identifying key tasks and learning goals. The prototype of the job training workbooks, which are to include Workplace Experience Logs, was released for comment in December 2018 with a final version scheduled for use in early 2019.[185]

Implementation of recommendations of the *Joint Inquiry*

A second package of national training for DVA staff on compensation-related policy and process changes as a result of the *Joint Inquiry* was delivered in December 2018, with an expected completion date of 7 February 2019.[186] This training was to educate staff on complex case management and verbal withdrawal of claims. The training alerts staff to the behavioural triggers for the high risk or complex claims cohort,[187] the sources of assistance and advice, including Open Arms, the Triage and Connect referral process, DVA social workers, external sources of assistance, and the need to alert Security in cases of immediate threat or concern. How to respond when notified of a death was also a topic covered (see recommendation 7).[188] Documentation identifying external services was provided to staff by the end of 2017, was included in a *Businessline* in December 2017, and has been uploaded to CLIK.

[180] Discussion with DVA, 28 November 2018.
[181] *Veteran Centric Reform – Delegate Mapping*, 28 January 2018.
[182] EMB Meeting 28 August 2018, 'Tactical Engagement and Communication Plan'.
[183] *Veteran Centric Reform – Delegate Mapping*, 28 January 2018; *Veteran Centric reform- Supporting delegates – Communications Approach and plan: Background and Supplementary Information,* 26 April 2018; *Veteran centric Reform Supporting delegates – Engagement& Communications Plan,* 26 April 2018.
[184] Portfolio Reviews: Governance Approach 'Terms of Reference'; Clients' Benefits Team Leader & Assistant Director Forum *Minutes* 15 November 2018.
[185] DVA Progress Report, 31 December 2018, 23.
[186] DVA Progress Report, 31 December 2018, 5.
[187] *Triage and Connect Policy Documentation – June 2018,* 25.
[188] *Department of Veterans Affairs National education and Communication Proposal* Attachment B(3).

As at 31 December 2018, 235 staff had completed the training. Training on the registration of claims was covered in a previous national round of training in November 2018.[189]

Specific training was held for improving R&C communication with clients to address recommendation 14 of the *Joint Inquiry*. The materials covered related to prior contact between staff and a client when an adverse decision is pending.[190] Between 30 April 2018 and 14 June 2018, eighteen face-to-face training sessions were conducted with 233 R&C and Income Support staff attending.[191]

From October 2018 the first package of national training on the new Client Support Framework was held. The package was designed assist staff to identify and support high risk and vulnerable clients and it was delivered to Veterans Benefits and frontline Veterans Access Network (VAN) staff. As at 31 December 2018, the training program had been completed by 437 staff, with final coverage expected to be around 520 staff by February 2019.[192]

A workshop was held for delegates on identifying and resolving issues that related to recommendation 3 of the *Joint Inquiry*. Changes to policy and process that came from that workshop were included in the training package on registration of claims for delegates delivered in November 2018.[193]

Implementation of the *Joint Inquiry* recommendations is discussed at the Open Arms National Manager Team meetings. Open Arms directors routinely update staff on these issues.

Mental health training and training related to high risk and complex cases

There is a noticeable increase in the number of clients with mental health conditions (see recommendation 5), with mental health being one of the two most common conditions leading to medical discharge.[194] Defence now notifies DVA of all medically discharged members. This is improving the early identification of such clients within DVA. There is a commensurate increase in DVA staff contact with people who have psychiatric problems. Such contact requires sensitive management and DVA has recognised that training in the skills entailed is important.

In 2018, 117 staff members attended the Mental Health First Aid Course. In addition, an external provider, Phoenix Australia, delivered training in 2017 and 2018 for 109 staff around understanding sexual and physical abuse, including self-care for delegates.[195]

Training is needed not only to help staff to manage clients with mental health conditions, but also cover other causes of client vulnerability, and on the management of a claim with complex elements. Staff are being trained to identify the behaviours which indicate those who are experiencing problems responding to DVA's processes, who are suffering stressful circumstances, or are at high risk.

As at February 2019, the Department is in negotiations with the University of South Australia to refine and deliver the 'Care · Collaborate · Connect' Psychological First Aid training program for the Department, as a proof of concept evaluation.

[189] DVA Progress Report, 31 December 2018, 6.
[190] Clients' Benefits Team Leader & Assistant Director Forum *Minutes* 15 November 2018.
[191] DVA Progress Report, 31 December 2018, 23.
[192] DVA Progress Report, 31 December 2018, 23; *Triage and Connect Policy Documentation – June 2018.*
[193] Clients' Benefits Team Leader & Assistant Director Forum *Minutes* 15 November 2018.
[194] Eg Productivity Commission Draft Report, 34, 94, 96-97, 100-101.
[195] 'Summary of Phoenix Australia training, primarily for delegates, in 2017 and 2018.

The aims of this training program are to:

- increase knowledge, skills and confidence of staff to identify, understand, and assist veterans with coping problems; and
- enhance staff coping skills and coping self-efficacy.

Healthcare Management Advisors (HMA) review of training

Following the Senate inquiry into suicides of veterans, in October 2018 DVA commissioned Healthcare Management Advisors (HMA) to review DVA training programs.[196] The review plan and an action plan proposed by HMA were accepted by DVA on 28 November 2018.[197] A project plan is being developed to prioritise the recommendations and assess resources, and will be presented in 2019 to the DVA Executive Management Board for implementation.[198]

Overall, the review found that the content of the client service programs was of high quality, and the training programs provided good coverage of necessary client services skill sets. HMA identified some well-regarded courses, notably *Applied Suicide Intervention Skills Training* and *Managing Communications and Relationships with DVA Clients*, which focus on vulnerable clients and self-care or resilience.

At the same time, the report also identified some deficiencies in aspects of the training relevant to DVA's efforts to improve its handling of high risk and vulnerable clients. These gaps were noted in the following recommendations:

- There should be more provision of face-to-face courses, particularly for interpersonal skills training. Sixty per cent of staff surveyed preferred this form of training, while acknowledging that e-learning was useful for refresher courses, and for those unable to attend. [199]
- There was a lack of a unified approach to, and prioritisation of, developing client service skills.[200]
- Induction training over the first three months of service was of variable quality, not always able to be completed within the timeframe. The opportunities to observe more experienced team members prior to undertaking initial calls was patchy and the coaching and mentoring including feedback and debriefing provided was of variable quality. These deficiencies were particularly noticeable for staff interacting with vulnerable clients. There was also limited coverage of mental health and developing client service skills during induction.[201]
- Performance management was poorly linked to learning and development programs and this requires a clear articulation of the learning objectives or skills from each course.[202]
- Performance management processes are poorly linked to available programs, although work on developing skills maturity assessments for particular business units may assist, especially in monitoring client service skills.[203]

[196] Healthcare Management Advisors (HMA) *DVA Review of Client Service Training Project Plan No 1*, 18 May 2018; HMA *DVA Review of Client Service Training Programs Situation Analysis*, 26 June 2018.
[197] People and Culture Committee Meeting, 28 November 2018, *Minutes*.
[198] DVA Progress Report, 31 December 2018, 24.
[199] HMA *Client Services Training Review: Final Report* (Oct 2018) (HMA *Final Report*) 25.
[200] HMA *Client Services Training Review: Final Report* (Oct 2018) 33.
[201] HMA *Final Report*, 27.
[202] HMA *Final Report*, 29.
[203] HMA *Final Report*, 29.

- Scheduling of face-to-face training needs to balance frequency with over-burden to avoid 'burn-out'.[204]
- More consistent coaching and mentoring is needed for staff to embed the learnings from formal training.[205]
- Relevant training material is difficult to access due to the volume of available resources and inconsistent file storage, and the complexity and length of available written reference materials.[206]

Management will need to assess and take account of these findings. Senior officers interviewed for the purpose of this review emphasised the importance of face-to-face training for clients needing emotional support.

Evaluations of the outcomes and effectiveness of training are important. This has been identified by the Productivity Commission draft report as a gap in information and its implementation as a way to improve claims administration for trauma affected clients.[207] This recommendation aligns with recommendations in the HMA report.

Departmental communications

Training alone is insufficient to instil knowledge and skills. Being able to access appropriate material when needed is also essential. Accordingly, the review has examined information resources to assess their suitability for this purpose.

At a time of significant change within DVA, it is essential that there be effective communication of new policies and procedures if these are to be implemented effectively. The *Businessline* is the principal form of communication of changed policy and practice within DVA. The evidence is that there are issues with this source of information. DVA is a large department and there are indications that staff are often too busy to read the volume of material received, including the *Businessline,*[208] with the result that important policy and procedural changes are not necessarily read, much less put into effect.

Senior DVA staff observed that the *Businessline* needs rigour to ensure it is more regular, refined and professional, and that there is a need for a broader communication vehicle. A minor irritation is that the *Businessline* is not always dated. It would be helpful in identifying the currency of the information for the date to be included on each edition.

Management is considering how best to disseminate information as part of the broader communication and engagement strategy for delegates. The aim of the strategy is to clarify the respective categories of information to be allocated to internal communications such as newsletters, staff emails, Secretary messages, online publishing (Intranet) and the *Businessline.*[209]

On 28 November 2018, DVA's People and Culture Committee accepted that 'dissemination and implementation of policy/procedural changes needs a more regular, structured and disciplined approach',[210] and said there was need for a more targeted use of the *Businessline.* The Committee noted a need for alternative means of communicating with staff, particularly delegates.[211] The

[204]HMA *Final Report*, 30.
[205] HMA *Final Report*, 31-32.
[206] HMA *Final Report*, 32.
[207] Productivity Commission Draft Report, 25, 232, 612, 649.
[208] People and Culture Committee 'Use of Departmental *Businesslines*' 28 November 2018, 1.
[209] People and Culture Committee 'Use of Departmental *Businessline'* 28 November 2018, 2.
[210] People and Culture Committee 'Use of Departmental *Businessline'* 28 November 2018, 4.
[211] People and Culture Committee 'Use of Departmental *Businessline'* 28 November 2018, 1.

Committee also agreed that Divisions need to use the *Businessline* selectively. This initiative is to be part of the broader work underway to address knowledge content management in DVA more generally.[212]

MONITORING

Portfolio Reviews Progress Reports

Implementation of the *Joint Inquiry* recommendations is monitored monthly under the oversight of the Deputy Secretary, Policy and Programs, and through Portfolio Reviews meetings with First Assistant Secretaries.[213] The November 2018 Portfolio Review meeting focused on the *Joint Inquiry* recommendations. A Progress Report on the implementation of the recommendations of the *Joint Inquiry* is published on the DVA website quarterly. The 31 December 2018 progress update was published on the DVA website in February 2019.

Summary

Training is an important aspect of DVA's response to the *Joint Inquiry*. There is a growing proportion of clients with mental health issues or complex cases (see recommendation 5). The anecdotal evidence is that there are now more clients who are vulnerable and lack resilience. Careful handling is needed to avoid exacerbation of their conditions, a skill which requires targeted training of staff.

In devising its education program DVA needs to take account of the strong preference evident from the findings of the HMA review for face-to-face training for courses relating to interactions between staff and vulnerable clients. For DVA to meet its goal of becoming a veteran centric agency, inculcating the social skills needed for effective communication with its clients should be a priority focus.

A central issue for those seeking to remedy problems illustrated by the events relating to Mr Bird's death is how to identify people who are at-risk or vulnerable. It may not be possible to identify high risk or vulnerable clients, such as those with PTSD, particularly over the phone. It is especially hard to identify those at-risk of suicide, or even those with a high level of anxiety. This perception is borne out by international research indicating that even suicidal ideation is not a reliable predictor for suicide[214] (see **Detailed Report, Background** earlier). The indicators are inadequate since they may not encompass behaviours which with hindsight could be seen as an alert, such as multiple phone calls about a claim over a relatively short time. Training can, however, sensitise staff to pick up that a client has a possible morbid condition which should trigger a referral to a social worker or other clinician.

There is also an issue about which staff should be responsible for identifying high risk and vulnerable clients. How much can be expected of front-line staff is not easy to assess. The cost alone means it is not feasible to provide specialist skills training to them all. Sensitivity training alone can cost 'a few hundreds of dollars per person'.[215] There should also be a limit to the responsibilities placed on front-line staff. They already have to administer technical issues under legislation. To expect that they also manage to identify clients at-risk is adding to that burden and requires qualities not necessarily possessed by those with good technical knowledge and skills.

Handling clients with vulnerabilities requires courtesy, emotional intelligence and sensitivity. Not all staff have or can acquire these qualities. At the least, all staff do need to be sensitised to behaviours which warrant attention from those better equipped to assess the needs of such persons. That may be sufficient identification for many. Referral can then be made to the panoply of bodies designed for

[212] DVA *Knowledge management Kick-off Meeting*, 8 November 2018.
[213] Quarterly DVA Progress Reports since 24 May 2017.
[214] See Overview 'Other key issues'.
[215] Productivity Commission Draft Report, 361.

the assessment and assistance purposes, including social workers, the Triage and Connect process, Open Arms services, and the CCS assessment and case management procedures.

Early advice from Defence, Open Arms, and medical advisers that the client has mental issues avoids front-line staff having to undertake that assessment. By April 2019 there should also be a flag to alert staff where a claimant has a current or previously accepted claim for a mental health condition. As front-line staff are generally the first point of contact with a client, there remains a need for them to be alive to possible mental health or other stresses in the client's life so that they do not inadvertently interact with the person in a way which exacerbates that stress.

At the same time, these 'soft skills' are hard to instil and time is needed to develop the skills for handling at-risk or vulnerable clients. Ensuring there is an appropriate balance of staff with soft skills and those with technical skills is a challenge for management. The increased number of clients with mental health conditions or complex circumstances must be a key consideration in determining where that balance should be set.

In this context, there are potential learnings for DVA from the approach to the identification issues adopted by CSC (see following). That agency has managed to recruit appropriate front-line staff and to train them to develop the sensitivities required for the identification role. But where more complex cases or more vulnerable clients are identified, the practice is to escalate to managers or others who have higher level training to equip them to manage the additional challenges. This is a model which could be adopted by DVA, even allowing for the significantly greater number of staff in DVA.

There are also additional time constraints on DVA staff due to workload goals. Phone calls can be time consuming which means staff miss their performance targets. This needs to be factored in to assessments of staff capability.

The HMA report suggested there were insufficient training materials and courses for the key issues of identification of those at-risk or with complex claims, and to inculcate skills in sensitively handling clients at-risk or who are vulnerable. That criticism has been attended to with the present suite of training materials, provided there is refresher training and induction training focuses on these issues.

In addition, support needs to be provided for staff who face emotionally demanding contacts with clients. Although the APS-wide Employment Assistance Program is available there should be a DVA team in addition or as an alternative to provide this support.

These steps are a recognition that identification is a function of business areas. It is staff in these areas who notify Triage and Connect. But care is needed to avoid overburdening already pressured front-line staff.

Commonwealth Superannuation Corporation (CSC)

In addition to careful attention to appointment of staff, CSC has used an external provider to train staff to read and understand behavioural signals when dealing with customers. Training includes information about Defence service, PTSD and suicide of veterans. If signs of distress are evident a claim is escalated to more senior staff. That has been a focus of training as there has been an increase in complex claims and claims from those with mental health conditions.

Conclusion and any suggested actions

DVA is making a concerted effort to train or retrain its staff. Productivity Commission figures provided by DVA indicate that in 2017-2018 the Department spent $437 million on services, including workplace training and information technology.[216]

The training has focused on improving staff understanding of the Veteran Centric Reforms (VCR) and the Transformation program, the findings of the *Joint Inquiry,* and changes to legislation, policies and processes to meet deficiencies identified in the *Joint Inquiry* report. DVA has also recognised that iterative training is essential to implement the significant number of changes with which DVA is grappling. Attendance at training is being monitored and understanding of training messages tested. In addition, closer supervision of frontline staff by managers and delegates is being encouraged.

DVA is addressing the issue of identification of at-risk and vulnerable clients with its training on dealing with clients who have mental health conditions and there is encouragement for them to undertake courses relating to suicides and other causes of death.

Training involving personal interactions by DVA staff with clients, on dealing with those with mental health issues, complex claims, or other causes of vulnerabilities should, whenever feasible, be conducted face-to-face.

Continued training is needed on when front-line staff should escalate a client at-risk. That training should clearly identify the appropriate referral channels among the options now available. Management must also emphasise to staff generally the importance of being empathic in their response to clients or families facing bereavement.

Recruitment of staff needs to balance the numbers needed with the technical skills for complex decision-making with those possessing the soft skills suitable for handling clients at-risk or exhibiting behaviours of concern. There also needs to be training for delegates and managers so they are capable of supervising and supporting staff in both categories. Training for existing staff with these skills may need to be refreshed.

DVA should consider providing supervision and support of staff who are faced with these demands. The Employee Assistance Program is available but a DVA focused program is appropriate given the specialist concerns attending those who deal with members or former members of the military forces. Attracting, training and retaining sufficient staff for these roles remains a significant policy question for management.

Recommendation 9: Identify indicators for veterans at-risk to develop best practice case management models.

A precondition to accessing DVA supports and services is the identification of veterans at-risk or vulnerable, or with cases more complex than the norm. That identification must be undertaken by individuals. External sources such as medical or other health practitioners, advocates, Defence and other government agencies, and families can be informants. By far the most common source of identification are DVA staff who have interactions with clients.

Difficulties attend assessment of risk by DVA staff. Not only have current staff generally not been trained to pick up, often subtle, indications of distress, but the client is frequently able to disguise such signals, particularly over the telephone.

[216] Productivity Commission Draft Report, 132.

These problems were present in the last contacts Mr Bird had with the Department. With hindsight, his complaint on 22 June 2017 about delays in processing his incapacity claim could have been picked up as an indicator of risk. In the complaint, Mr Bird commented that if he had not had the support of the RSL and his friends, he would have, and had, come close to becoming another suicide statistic. However, when contacted by a DVA staff member on 23 June 2017 in response to the complaint, Mr Bird had expressed his thanks for an explanation given of DVA's process for assessing an incapacity claim and indicated his satisfaction with the reply. In other words, his subsequent contact with DVA did not suggest he was suffering any particular stress at that time.

Despite these difficulties, since the events affecting Mr Bird, DVA and Open Arms have made a concerted effort to define appropriate indicators,[217] to train front-line staff to identify the behaviours which can be an indicator of stress, to implement escalation and referral processes for such clients, and to ensure from conversations with clients that the issues have been understood and acted on.[218] The aim is to support and promote veteran wellbeing, particularly through early identification and intervention for at-risk and vulnerable veterans. There is further discussion of these moves at recommendation 11.

Indicators for identification of clients 'at-risk'

DVA developed client 'at-risk flags' in response to this recommendation to help staff identify when clients may need additional supports. These were released by *Businessline* on 14 February 2018, and included guidance on when clients might need to be referred to Coordinated Client Support or DVA Security.

An expanded list of Triage risk indicators was developed subsequently as part of the triage process. These expanded triage risk indicators cover the range of matters from those requiring a critical response, to departmental risk indicators, client behaviours, indicators of complex claims, as well as client risk indicators, 48 in total.[219] The client 'at-risk flags' number only 20, and are largely reproduced under the subset of 'client risk indicators'.

The triage indicators, accordingly, are significantly more comprehensive than the 'at-risk flags'.[220] They have been modelled from risk assessment tools developed for the Special Operations Forces Pilot (see recommendation 5), and were developed by DVA in consultation with Open Arms. The information in the triage indicators material provides contact points for further information and referral.[221]

Process following identification of at-risk clients

The staff refer clients who appear to fit the client at-risk flags, and can seek advice if they are uncertain about the categorisation. If a client's characteristics or behaviours fall within those listed this is a signal to refer the client to Triage and Connect, for expert assessment and consideration for Coordinated Client Support, the Wellbeing and Support Program or other support services or programs (see recommendation 5 and Figure 6 below). Clients are also referred to Open Arms for further support. Clients who make threats of harm to self, others or property are to be referred to DVA Security, and if their behaviours meet the requirements of the Unreasonable Complainant Conduct Framework, they are assisted by the Managed Access team.

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[217] 'At-Risk flags'; PowerPoint 'Triage Referral Indicators'& 'Triage Workflow'.
[218] *Businessline* 'Tools to support the identification of, and staff interactions with at-risk clients' (undated).
[219] PowerPoint 'Triage Referral Indicators' & 'Triage Workflow'.
[220] For triage risk indicators see *Triage and Connect Policy Documentation – June* 2018 Attachment E; and *DVA National Education and Communication Project Proposal*, Attachment B(2).
[221] 'At-Risk Flags'; 'Client Support Framework: the Right Support at the Right Time'.

Figure 6 **Potential referral pathways based on indicators.**

	Critical Response Matters requiring immediate/urgent intervention to manage serious risk or respond to significant issues.	**Departmental Risk Indicators** Matters impacting upon the reputation or operations of the Department requiring high-level oversight.	**Client Risk Indicators** Factors impacting on the health, safety and wellbeing of DVA clients and families.	**Client Behaviours** Behaviours or actions consistent with the Unreasonable Complainant Conduct (UCC) Framework.	**Claims / Entitlement Complexity** Complex claims or eligibility imposing barriers to meeting needs.
DVA Security	X			X	
Triage & Connect	X	X			X
- **Coordinated Client Support**	X		X		X
- **Wellbeing & Support Program**	X		X		
- **Managed Access**				X	
Open Arms	X		X		

Source: Client Support Framework Training Documentation, 14.

In relation to the identification of at-risk clients in Open Arms, between 19 January 2018 and 31 December 2018, 4,742 Open Arms' clients were flagged with elevated risk in Open Arms' client management system. This figure represents 26.2 per cent of the total number of Open Arms' clients in that period. Even with the expectation that Open Arms would be managing a large number of at-risk and vulnerable clients as a result of referrals from DVA, alongside clients seeking help themselves, a quarter of clients represents a significant proportion and highlights the attention needed to this recommendation. The effectiveness of the alert 'triggers' is discussed further at recommendation 5.

In the same period, 101 Open Arms' clients with high risk flags were in complex case management. This compares with the 212 clients in complex case management during the 2017-2018 financial year. That suggests a potential reduction in the number of high risk cases needing complex case management, but Open Arms has also indicated that there are issues with data collection which may explain the difference. These figures on their own do not indicate a more effective system has been introduced, although it is acknowledged that changes within Open Arms are only recent (see process initiatives below and recommendation 11).

Training and information

Educating staff to ensure they understand the triage risk indicators is important if identification and assistance to at-risk or vulnerable clients is to be improved. The training sensitises staff to the importance of identifying and responding to complex, high risk and high needs clients.

The risk indicators were included in the national Client Support Framework training to be completed in February 2019.[222] The list of indicators used in the training was a combination of the client 'at-risk flags' and the triage risk indicators.[223] The national training was conducted by video conference to all the state capitals, as well as Darwin and Townsville.[224] The training comprised thirty-six sessions with further sessions possible if required. As at 31 December 2018, 437 staff had attended this training.[225] Learnings from the training session and an evaluation of its success are to be made in the first half of 2019. Consideration is being given to filming modules from the training to make these available online for staff who have been unable to attend, for new staff commencing with DVA, or as a refresher for existing staff.

Information about behaviours that raise concerns has been provided to DVA staff to help them identify clients who should be referred, and a script to assist staff to identify such clients has been developed and distributed. The risk indicators are published on the Intranet. On 14 February 2018, DVA issued a *Businessline* to notify staff about the 'at-risk' flags, the scripts to use if an 'at-risk' client is identified, the appropriate referrals for staff in that event, including external supports and where to find them on the website.[226]

Best practice case management

The benefits of case management are widely recognised, particularly for those with complex situations or who are at-risk.[227] In the survey conducted as part of the SOF Pilot, 'Lack of individualised case management' was the *second highest* irritant with DVA for transitioned members at about 85 per cent.[228] Case management is resource intensive. No comprehensive system of case management has yet been implemented although the CCS program has implemented a modified form of case management, and Open Arms, in conjunction with CCS do collaborate in relation to some clients (see recommendation 5).

Best management practices require initiation by identifying clients at-risk, followed by assessment, assistance and appropriate support. New initiatives and bodies have been established which, together with those already in existence, provide support or oversight of issues for 'at-risk' clients. These include Triage and Connect and the Wellbeing and Support Program, discussed at recommendation 10, and identified as pathways at Figure 6 above.

Veterans and their Families First Design Pilot

An initiative which aligns with this recommendation is the Veterans and their Families First Design Pilot commenced in May 2018. The Pilot has been endorsed by DVA management and is to become standard practice in business areas in 2019.[229] The program was developed in response to the *Joint*

[222] *Triage and Connect Policy Documentation – June* 2018; *DVA National Education and Communication Project Proposal*.
[223] *DVA National Education and Communication Project Proposal*, Attachment B(2).
[224] *Triage and Connect Policy Documentation – June* 2018.
[225] *Triage and Connect Policy Documentation – June* 2018; *DVA National Education and Communication Project Proposal*.
[226] *Businessline* 'Tools to support the identification of, and staff interactions with at-risk clients'; 'At-Risk flags'; 'Emergency or Critical Phone Call'; 'External Supports for At-Risk Clients'; *Businessline* 'External Support for at-risk Clients'.
[227] *Minister for Veterans' Affairs National Advisory Committee on the Veterans and Veterans Families Counselling Service*, 26-27 October 2017, Items 8 & 11.
[228] *Special Operations Transition Pilot: Initial Project Plan*, 8 June 2018, v0.1, 22.
[229] *Veterans and their Families First – Design Pilot* (May 2018); 'VCR Transformation Program Board Paper 'Putting Veterans and Their Families First Process Redesign' 27 September 2018'; 'VCR Process Redesign: Putting Veterans and Their Families First - Workshop/Meetings, August 2018-February 2019'.

Inquiry and the 2017 Senate inquiry into suicide by veterans and ex-service personnel – *The Constant Battle: Suicide by veterans*.[230] The program provides a single point of contact for a veteran during the claims process and extends to family members.[231]

Process initiatives of Open Arms

The Open Arms Client Management System (VERA) provides clinicians with the ability to make notes on the front page of a client's Individual Profile. This function is used to communicate information about risk status, specific needs of the individual, and details regarding client management plans.

If a client's record is allocated a high risk flag in a DVA ICT system, the case can be raised with Open Arms for a client assessment. The assessment in Open Arms is undertaken by a clinician who is either a registered psychologist or an accredited mental health social worker. The escalation is reviewed by Open Arms immediately upon receipt and a risk assessment undertaken and appropriate assistance provided. This may include the counsellor reaching out to the client by telephone ('reach out calls'). This initiative is different to welfare checks, which have been undertaken by Open Arms since inception. Reach out calls are a softer approach, aimed at ensuring support and building on Open Arms' ability to provide crisis intervention where necessary. In such circumstances, clients are asked by Open Arms for their consent to share information with DVA regarding their current circumstances so a collaborative approach can be taken to manage any issues.

Subject to privacy concerns (see recommendation 4), if a trigger in Open Arms indicates a client is high risk, Open Arms may escalate a case to the DVA Triage and Connect team for an internal review of the client's matters. The information exchange is to identify opportunities for increased assistance or support by DVA services. The support can include streamlining outstanding claims matters, resolving issues with claims, or implementing further assistance such as appointment of a Coordinated Client Support officer (see recommendation 5).

Conclusion and suggested actions

The ability to identify at-risk or vulnerable clients depends on the effectiveness of the flags or triggers which are used as alerts by staff. DVA has given particular attention to development of flags and indicators since the events relating to Mr Bird.

Indicators to assist staff in identifying 'at-risk' clients have been developed. These were followed by an expanded list (the triage indicators) for use in the assessment by the Triage and Connect team for assessment and referral purposes. Training has been provided on the use of these indicators.

Departmental communications like training materials, *Businesslines* and policy documents should be clear on how the 'at risk' flags and triage indicators are to be applied to avoid potential confusion.

These moves support the development of best practice case management approaches (see recommendation 10).

Priority indicators can be flagged on the claims of clients in ISH, and a system flag to identify those clients who have an accepted or current claim for a mental health condition is intended to be implemented from April 2019.

[230] Senate Standing Committees on Foreign Affairs Defence and Trade *The Constant Battle: Suicide by Veterans* (2017).

[231] 'VCR Transformation Program Board Paper 'Putting Veterans and Their Families First Process Redesign' 27 September 2018'; 'VCR Process Redesign: Putting Veterans and Their Families First - Workshop/Meetings, August 2018-February 2019'.

There is a need to develop further system flags to add to client files. These include flags for homelessness, complex claims, for those who exhibit behavioural difficulties, and for educational, race or age-related navigation problems. The refinement of the flags system should continue.

To the extent that indicators have been identified and will support the development of best practice case management this recommendation is complete. At the same time, further flags, such as one for complex claims, should be added, and system support and the refinement of indicators will be an ongoing process.

RECOMMENDATIONS FOR DVA TO FOLLOW AS PART OF ITS VETERAN CENTRIC REFORM (VCR) (10-19).

Recommendation 10: Continue to pilot an integrated and holistic case management approach, including a whole-of-person view, a holistic care model for veterans, and an increased focus on transition support and vocational assistance. The evaluation of this trial will require further consideration by Government.

VCR is intended to be a six year program of transformation to improve current business practices. A key design principle is to enhance digital capacity. This recommendation involves the introduction of a case management approach to clients who are at-risk or vulnerable, ideally to be managed by a single DVA officer. That objective is designed to enable the building up of trust between the client and the officer. An example of the approach is being trialled in the SOF pilot which is currently being evaluated. Where the case manager is unable to continue as the contact point, careful attention is needed to a sensitive handover process to minimise stress to the client. An example of the breakdown of that trust arose in the case of Mr Bird. Nonetheless, it is a resource intensive model and roll-out will need to target those who most need the service. Case management is also discussed at recommendations 5 and 9.

[redacted]

There was strong support in the Productivity Commission Draft Report for taking a holistic approach to veterans and their families, particularly during transition.[232] Draft Recommendation 7.1 proposed that there should be a Joint Transition Command (JTC) to improve coordination between DVA and Defence. The JTC would be designed so that 'transitioning veterans receive holistic services that meet their individual needs, including information about, and access to, Department of Veterans' Affairs' processes and services, and maintaining continuity of rehabilitation supports'.[233]

PILOT PROGRAMS FOR 'INTEGRATED AND HOLISTIC CASE MANAGEMENT APPROACH'

DVA has begun the journey recommended in this recommendation. A large number of pilot or research programs involving case management are in train, some of which are connected to the VCR program. DVA, in some cases together with Open Arms or Defence, are involved in pilots and trial programs designed to explore how best to provide holistic care to veterans. These include: the Wellbeing and Support Program, which commenced in August 2018 (formerly the Case Management Pilot), a trial of a case management model involving clients at high risk or with complex claims and

[232] Eg Productivity Commission Draft Report, 150, 167, 283, 613.
[233] Productivity Commission Draft Report, 291.

their families; the Special Operation Forces Pilot; the Transition Health Assessment Project; the Community Coordination Pilot; and the Veteran Suicide Prevention Pilot.

Wellbeing and Support Program – case management

The Wellbeing and Support Program is a two year program for the trial of a case management model, and operates under the Client Support Framework. The Program involves intensive and coordinated support to meet the needs of clients with complex or multiple needs, or their families. [234]

The program is being trialled in response to calls for case management for clients at high risk or with complex claims (see recommendation 10). The aim is to provide clinical care coordination and claims management using a single point of contact for at-risk clients. Case management providers must meet capability, qualifications, experience and professional registration requirements as well as the Department's standards if they are to be appointed for the program. Resourcing has been provided for the inclusion of up to 100 clients in 2018-19 and up to 200 clients in 2019-20, however, uptake has been slow.

The Program commenced in August 2018. As at 19 February 2019, there have been 93 referrals to the Program. 39 clients have been accepted on to the Program and are receiving case management services, while the remaining 54 are receiving support via CCS, Open Arms, and/or DVA rehabilitation providers. A tender has been let for identification of service providers in the Northern Territory, South Australia and Tasmania, states not included in the earlier roll-out of the Program. The Program will then operate for clients Australia-wide.

Referrals for potential participants can come from Defence (transitioning members), Triage and Connect, Coordinated Client Support and DVA Rehabilitation. An initial evaluation is expected in early 2019, with the final evaluation in 2020. If the program continues to be funded beyond 2020, the number of case managers involved will need to be increased in proportion with the client load.

Community Coordination Pilot

The Community Coordination Pilot was recently conducted by Open Arms in Townsville. The Pilot was designed to explore whether a new model of community-coordinated care would improve the service experience and care for clients with complex issues, or who are considered to be at risk of suicide.

The Pilot utilised a Care Coordination team comprised a skilled Open Arms clinician and a 'lived experience' peer or peer mentor, who worked together to support more comprehensive and integrated community care for clients.

After a successful evaluation of the pilot, the national roll-out of the Community and Peer program was announced by the Minister for Veterans' Affairs, The Hon Darren Chester MP on 23 February 2019.[235]

Veteran Suicide Prevention Pilot

The Veteran Suicide Prevention Pilot (also known as the Mental Health Clinical Management Pilot) is conducted by DVA in conjunction with Beyond Blue, the organisation set up to support those dealing with anxiety and depression who have been hospitalised. In other words, the triggers are identified by medical or other health practitioners. The Pilot is supported by legislation, the *Veterans' Entitlements (Veteran Suicide Prevention Pilot) Determination 2018* (Cth) which came into effect on 1 July 2018.

[234] 'Wellbeing and Support Program (formerly the Case Management Pilot)'.
[235] Media Release 'Community and Peer program to Help Vulnerable Australian Veterans', 23 February 2019.

The Pilot is to be run initially in Brisbane, with the cooperation of nominated hospitals, both public and private. Funding has been provided by the Government ($6.2m) to provide intensive treatment and management for veterans to improve their mental health and reduce any future risk of suicide and enable them to re-engage with the community.[236] .

VOCATIONAL ASSISTANCE AND TRANSITION

Employment services

Recommendation 10 also refers to an increased focus on transition support and vocational assistance. Issues for Mr Bird included his fragmented employment history after leaving the ADF and, from March 2016, which he was unemployed. This led to financial pressures which arguably contributed to his distress at the time of his death. His experience is not uncommon.

Being employed post-service is critical for the long-term health and wellbeing of a veteran. Although DVA traditionally has been a compensation-focused agency, the veteran centric philosophy with its focus on holistic support for a client brings with it a need to assist, where it can, in the rehabilitation and the re-skilling of members of the ADF who leave defence service.

The Productivity Commission Draft Report considers these issues in Chapter 7. Information on sources of support and various programs offered by DVA and Defence is included in the *Joint Submission by the Department of Defence and Department of Veterans' Affairs to the Joint Standing Committee on Foreign Affairs, Defence and Trade Inquiry into transition from the Australian Defence Force* (July 2018) (*Inquiry into Transition* report) and the DVA *Submission to the Productivity Commission Inquiry into Compensation and Rehabilitation for Veterans* (July 2018) at [4.6]).

DVA and Defence are now focused on improving the transition phase for veterans and of their promotion of employment services.[237] The need for the two agencies to improve their collaboration in this area was highlighted in the DVA/Defence joint submission for the *Inquiry into transition* report.[238] The consequence of the lack of coordination, as the report noted:

> *… resulted in a lack of information sharing and collaboration with each agency focusing on their own processes and systems, rather than ensuring the member's needs were considered more holistically. It was also borne out in a lack of focus on the families.*[239]

The submission conceded that historically the two agencies had divided their support: Defence was responsible for members of the ADF during service; DVA's responsibilities commenced after the member had left the ADF. DVA and Defence have agreed that their programs should be better coordinated and are taking steps to assist with transition and post-service employment designed to transition veterans into civilian jobs. A positive step in this direction is the concession by Defence to support transitioning members for up to 12 months after transition.[240]

[236] Productivity Commission Draft Report, 593.
[237] Department of Defence and Department of Veterans' Affairs 2018, *Submission to the Inquiry into Transition from the Australian Defence Force*, Introduction [11].
[238] Department of Defence and Department of Veterans' Affairs 2018, *Submission to the Inquiry into Transition from the Australian Defence Force*.
[239] Department of Defence and Department of Veterans' Affairs 2018, *Submission to the Inquiry into Transition from the Australian Defence Force*, Introduction [14].
[240] Discussion with representatives of Defence, 20 December 2018.

A key initiative of Defence is its Transition for Employment (T4E) program discussed in the *Inquiry into transition* report,[241] and the Defence Career Transition Assistance Scheme.[242] There are also joint programs by DVA and Open Arms in relation to those who are at-risk or vulnerable due to transition.

Awareness of the problem has led government to take steps to assist transitioning veterans into alternative employment. This was an election promise of the current Coalition Government, and has been a catalyst for change. Chief among the policy responses is the Prime Minister's Veterans' Employment Program.

Launched towards the end of 2016, the program is designed to raise awareness that most veterans can bring to the civilian workplace 'valuable leadership, management and individual attributes'[243] but to take advantage of these skills, there is a need to promote greater employment opportunities for veterans.

The Program provides a website, the establishment of an Industry Advisory Committee on Veterans' Employment, annual awards to recognise the creation of employment opportunities for veterans, and a Veterans' Employment Commitment for business to publicly commit to supporting veteran employment.

The Government provided $2.7 million in the 2017–18 Budget to implement the Prime Minister's Veterans' Employment Program, and further funding of $4.0 million in the 2018-19 Budget for the ongoing implementation of the Program. The 2018-19 budget also provided DVA with $4.3 million to fund additional services to help veterans enter the broader workforce, including mentoring and resume and interview preparation.

Special Operation Forces Pilot (SOFP)

The Special Operation Forces Pilot (SOFP) is a joint DVA/Defence project designed to manage a veteran's and their family's needs during transition. The Pilot is designed to ensure a whole-of-person, veteran-centric method of providing Defence/DVA services. Defence is separately trialling a single medical assessment for DVA, CSC and Defence purposes (see THA Project below). The Pilot covers Defence/DVA services while the member is serving; during transition from the ADF with support from Defence, DVA and CSC; and after transition, primarily by DVA with Defence as an adjunct.[244]

The Pilot provided a dedicated DVA Liaison officer (an advice case manager) for participant members and their families, a streamlined claims process for the transitioning member and family, and an Early Engagement Model to encourage earlier lodgement of claims and to improve understanding of DVA services. The Pilot was intended to provide a model which can be used across the ADF and by DVA.

The Pilot case managed some 450 veterans and formally concluded in November 2018, although the service continues to be provided while evaluation and next steps are being considered. The final report is expected in early 2019. Positive steps taken as a result of SOFP include significant improvements in audio testing for hearing loss, now incorporated into the Transition Health Assessment (THA) processes, and positive feedback from transitioning members and from CSC customers for the system of DVA on-base advisors.[245]

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[241] Department of Defence and Department of Veterans' Affairs 2018, *Submission to the Inquiry into Transition from the Australian Defence Force (Joint Submission to Parliamentary Inquiry into Transition),* Terms of Reference 2 [160]-[163] and Terms of Reference 3 at [57]-[71].
[242] Discussion with representatives of Defence, 20 December 2018.
[243] *Joint Submission to Parliamentary Inquiry into Transition*, [24].
[244] Special Operations Forces Pilot, Process Diagram 'Holistic, Wellbeing, Tailored Service'.
[245] Special Operations Forces 'Key Learning Outcomes: Social Media Pilot'.

A related but privately organised project is being undertaken by the Remembrance Foundation. The project was designed to assist younger veterans and their families during transition through better use of social media. Participants were drawn from the SOFP, and the communications being trialled are confined to a closed group from that cohort. The project commenced in March 2018 and is to be evaluated and reported on by early February 2019.[246]

Transition Health Assessment (THA) Project

The Transition Health Assessment (THA) Project at Holsworthy Barracks was completed on 3 May 2018 and as at 31 December 2018, the THA evaluation report was being considered by Defence.

The Project is to test ways in which medical assessments by DVA, Defence and CSC can be consolidated and streamlined, particularly during transition, with a view to speed up the claims process and to provide greater certainty about entitlements and support. A regular complaint has been that multiple medical assessments, often with the same or similar information, are required across Defence, DVA and CSC. The aim of the project is 'to introduce a single medical assessment for DVA, CSC and Defence' by a specialist occupational physician, [247] preferably prior to the member leaving the ADF.[248]

A problem identified during the status update of the project in May 2018 was that 22 of 75 claims had not been finalised prior to transition due to SAM access limitations. Generally, however, the anecdotal feedback has been positive. DVA must now decide whether to bring the project into regular use in the Department and which section will be responsible for its development and expansion. The program has not yet been adopted as routine practice.

DVA initiatives

Specific steps in the transition space in which DVA is involved are the assistance with health treatments and care with particular attention to mental health, and its prevention of suicide programs referred to in this and other sections of this review. Being mentally resilient is a key factor in transitioning into the civilian workforce.

These initiatives include:

- the extension of non-liability health care (NLHC) arrangements to *all* mental health conditions, giving veterans automatic assistance to treatment without having to show a causal link with service. Prior to 1 July 2017, NLHC was available for posttraumatic stress disorder, depression, anxiety, alcohol use disorder and substance use disorder;
- improvements to ICT communication between DVA and Defence, thus streamlining the process of making an initial liability claim online (recommendation 6);[249]
- straight-through or streamlined processing for initial liability for some 40 claimed conditions both mental health and physical (see recommendation 17);[250]
- the Next Generation Health Services project, in which DVA is a key stakeholder, to include better contacts between medical professionals and DVA to aid in the transition of ADF members;[251] and
- the Wellbeing and Support Program (see recommendation 10).

[246] Remembrance Foundation – Project Plan 'Military Families Social Media Project'.
[247] *Joint Submission to Parliamentary Inquiry into Transition* [53].
[248] Productivity Commission Draft Report, 507.
[249] *Joint Submission to Parliamentary Inquiry into Transition,* Introduction [16].
[250] *Joint Submission to Parliamentary Inquiry into Transition,* Introduction [17].
[251] *Joint Submission to Parliamentary Inquiry into Transition*, Terms of Reference 2 [76]-[78].

Other relevant programs

These include:

- e-learning programs to strengthen mental health capabilities of clinicians[252]
- Open Arms two-day S*tepping Out (Transition)* program for members and the partners[253]
- The SOFP (see earlier)
- The Early Engagement Model (see recommendation 6)
- The On Base Advisory Service (OBAS) that provides information and advice on DVA entitlements on transition, notably the incapacity payment for members unable to work, on more than 40 ADF bases nationally[254]
- The CCS program (see recommendation 5)[255]
- The Joint Defence/DVA Transition Taskforce designed to identify barriers to successful transition and address those barriers[256]
- Rehabilitation programs including vocational rehabilitation provided initially by Defence, and then if continuity is needed, by DVA.[257]

Commonwealth Superannuation Corporation (CSC)

CSC is emphasising the importance of engaging early with veterans seeking superannuation payments from CSC. Early engagement has been aided by information from Defence on a fortnightly basis about ADF members who are transitioning. If the information is obtained in advance, CSC can start work on the file ahead of transition and this can lead to payments being available on date of discharge. Recent statistics indicated that the time taken to process benefits for ADF members has significantly reduced over the last two years. The average time in January 2019 was four days. Improvement of this performance indicator is in line with draft recommendations in the Productivity Commission Draft Report.[258] The evidence is that Defence are also starting to prepare for a member's transition 6 months in advance.

There has been a reduction in the need to seek and interpret medical assessments for invalidity claims. That is due to the current practice, where possible, of relying on documentation provided by Defence. This has reduced the stress on customers and the time taken to process claims, and has led to a significant reduction in the CSC budget for medical reports. The move is consistent with Draft Recommendation 12.2 in the Productivity Commission Draft Report for 'a single front door' for those seeking invalidity pension and veteran compensation, and a single medical assessment process for invalidity pensions and veteran compensation. The suggested benefits are the reduction of the burden on veterans of obtaining separate medical reports and more consistent decision-making.[259]

[252] *Joint Submission to Parliamentary Inquiry into Transition*, Terms of Reference 2 [131].
[253] *Joint Submission to Parliamentary Inquiry into Transition*, Terms of Reference 2 [135].
[254] *Joint Submission to Parliamentary Inquiry into Transition*, Terms of Reference 4 [26].
[255] *Joint Submission to Parliamentary Inquiry into Transition*, Terms of Reference 4 [[33]-[35].
[256] *Joint Submission to Parliamentary Inquiry into Transition*, Introduction [21]-[25].
[257] *Joint Submission to Parliamentary Inquiry into Transition*, Terms of Reference 2 [59]-[61].
[258] Productivity Commission Draft Report, 275.
[259] Productivity Commission Draft Report, 508.

Conclusion and any suggested actions

Work is underway to develop a case management approach and steps are being taken to enhance the focus on transition support and vocational assistance. These developments are at an embryonic stage and will need to be carefully monitored, evaluated and funded to ensure the goals of an integrated and holistic case management approach and the increased focus on transition and post service employment are achieved.

Case management

DVA has developed bodies capable of providing a more integrated and holistic case management approach. The Triage and Connect system, CCS, and the Wellbeing and Support Program all offer services which are moving in the direction of a case management model. A form of case management occurs when Open Arms and DVA collaborate to assist a client who has been identified as at-risk.

The Open Arms program of 'reach out' calls to determine a client's well-being; the practice of DVA social workers making contact with clients with a mental health condition when a claim under the MRCA is registered;[260] and the notification by Defence to DVA when an ADF member is medically discharged are moves to increase understanding of and enable a more whole person view of a client.

Mental health and other training by DVA in relation to the at-risk group, is also a proactive step to ensure DVA staff are aware as early as possible of any vulnerabilities of a client during the claims process. The training also emphasises entitlement to non-liability health care and the receipt of other available DVA treatment, assistance and services. Overall, these developments indicate that DVA recognises that alerting staff from an early stage to all the circumstances impacting on a veteran is vital if improved and veteran centric care is to be offered to those who become DVA clients.[261]

Adoption of a comprehensive case management approach will require significant staffing increases and additional financial support.

Transition and vocational assistance

As a compensation-focused agency DVA has traditionally paid not given the same attention to transition, rehabilitation and employment matters. An approach which is veteran centric, and holistic requires an attitudinal change on these issues.

Impetus for change is provided by the Parliamentary *Inquiry into transition from the Australian Defence Force.* The Inquiry has yet to report, however, a joint submission has been provided by DVA and Defence.[262] There is also extensive discussion of assistance with transition,[263] and with post-service employment[264] in the Productivity Commission Draft Report. These can guide DVA in its steps to enhance its transition and vocational assistance to veterans.

The ultimate goal is for transition to become a non-event, with DVA, CSC and Defence working seamlessly to ensure their processes do not inhibit but assist with a productive transition into civilian life. This review suggests DVA and the related agencies are taking steps towards this goal.

There is a renewed focus on rehabilitation with a vocational focus, and on transition more generally. Consistent and continuous contact is needed between Defence and DVA. A step in the right direction

[260] Productivity Commission Draft Report, 363.
[261] *Businessline* 'Tools to support the identification of, and staff interactions with at-risk clients', 14 February 2018.
[262] *Joint Submission to Parliamentary Inquiry into Transition*, July 2018.
[263] Eg Productivity Commission Draft Report, chapter 7.
[264] Eg Productivity Commission Draft Report 303, 305.

has been taken with Defence agreeing that the same rehabilitation provider can be used by both agencies to give stability to the veteran. Defence has also agreed that it is prepared to extend its support of a member for up to 12 months post-discharge. A key part of achieving these aims is for Defence and DVA to ensure that transition plans are developed well before discharge.

The Early Engagement Model needs to be emphasised.

These steps need to be maintained and the continuation of the developments has been assigned to the Joint Defence/DVA Transition Taskforce. The work of the Taskforce is essential to drive initiatives if there are to be significant improvements in support and processes focusing on transition and employment. Close monitoring is required to ensure appropriate departmental areas are designated with the additional responsibilities, that they are funded, and built into DVA's regular program.

Recommendation 11: Implement better systems and processes to identify and alert staff in order to support high risk and vulnerable veterans.

On 1 June 2017 Mr Bird's claim for incapacity payments was lodged by his advocate. On 22 June 2017 at 9.09pm Mr Bird made a complaint (Complaint CFMS-34251) that the claim was not being processed sufficiently quickly. As discussed at Recommendation 6, his complaint was actioned by a call to him from a DVA staff member at 4.43pm on 23 June 2017. Mr Bird expressed gratitude for the advice provided, and appeared satisfied with the response (see recommendation 9). In relation to the processing of Mr Bird's claim for incapacity payments, following the complaint, DVA prioritised his case and sought to also upgrade the urgency of the request to Defence for Mr Bird's rank and pay at discharge.

Nonetheless, the events surrounding his death focused DVA's attention not only on the categorisation of requests for service and health records from Defence, but on other issues such as the complaints processes, risk indicators, the need to improve ICT systems to reflect process initiatives by DVA and Open Arms, and training.

Client feedback system

The events affecting Mr Bird raised questions about the effectiveness of DVA's complaint management system. One of those issues was that DVA's Client Feedback Management System (CFMS) at the time did not have alerts to warn people that a person might be undergoing stress. DVA has since conceded that the complaints system is 'end of life'.[265] A *Businessline* of 3 October 2018 noted that the 'ageing CFMS does not have appropriate capabilities to provide a suite of accurate managerial reports, or the ability to track, link and then analyse feedback data that has been captured in records'.[266]

As a consequence, two initiatives have taken place. In the first, DVA conducted a pilot to assess whether a centrally managed approach to feedback provided an improved service to DVA clients. The pilot was designed to meet best practice standards as developed by the Commonwealth Ombudsman, and to operate in accordance with veteran centric principles.[267] The trial took place between October and December 2018. The system includes timeframes for acknowledging complaints, the standard being 2 days.[268] However, if a complaint is made using the DVA feedback number, staff will call back within one working day. The response to Mr Bird's complaint would have met either of these KPIs. An

[265] *Businessline* 'Changes to Feedback Management within DVA'. 3 October 2018.
[266] *Businessline* 'Changes to Feedback Management within DVA'. 3 October 2018.
[267] *Businessline* 'Changes to Feedback Management within DVA'. 3 October 2018.
[268] *Businessline* 'Changes to Feedback Management within DVA'. 3 October 2018, Attachment A.

evaluation was to be held in December 2018 and the results (71 per cent of those surveyed were satisfied) indicate increased client satisfaction with the centrally managed approach.[269] Despite client approval, the implementation of the revised system is, at time of this review, further delayed while more work is undertaken on how to manage complaints indicating a client is at-risk.[270]

Second, in conjunction with DHS, as a longer term measure, DVA is working with IBM to implement a new case management feedback system to replace the current system. This system will be able to record specific information about vulnerable clients including those at-risk or in crisis and will be integrated within the existing IT platform. Clients will be able to lodge feedback direct on the system. The new system is scheduled for deployment by mid-2019.[271]

Another outcome was that a Feedback Management Team introduced a new quality assurance sampling process to comprise some 30 per cent of all complaints received within the Clients' Benefits Division, and to include feedback from clients.[272]

These moves indicate that a new, more suitable complaints system should be in place in DVA, with processes for complaint-handling and alerts, by the first half of 2019.

Processes to improve 'at-risk' flags or tools including in ICT systems

A significant feature of DVA's response to the events leading to the untimely death of Mr Bird and other veterans, is the initiative taken by DVA to introduce flags/client risk indicators which staff can use to identify clients who are at-risk or vulnerable. A list of potential risk flags was developed in late 2017, and disseminated to delegates by a *Businessline* in February 2018. The information has been uploaded into CLIK. The flags are supported by scripts to assist staff communicating with clients exhibiting behaviours indicating a client may fall into these categories.[273] These steps are discussed at recommendation 9. Further work on dissemination of this information and to improve the ICT processes follows.

Another improvement is that the Improving Processing Systems (IPS) team is developing a prominent label to appear on ISH for all claims where the client has a current or accepted claim for a mental health condition. The label states 'Mental health condition accepted'/'Client has mental health claims'. DHS is scoping and costing the addition, which will be followed by a schedule for the release. The 'go-live' date has been set for April 2019.

A problem with this alert is that mental health issues, although predominantly the cause of vulnerability (see below), are only one of multiple circumstances which can bring a client within the high risk or complex circumstances categories. ISH is a claims management system rather than a client management system, and has not been developed to provide a holistic 'client-view'. This means that while there are some additional indicators which can be selected by staff, such as financial hardship, the multiplicity of indicators may be confusing.

A related issue is that the Coordinated Client Support (CCS) policy requires clients accepted for management by CCS to have an active claim. In other words, if a veteran has not commenced the claims process or sought a DVA service there is a barrier to providing assistance for vulnerable and high risk clients seeking such information or services.

[269] DVA Progress Report 31 December 2018, 32-33.
[270] Information provided, February 2019.
[271] DVA Progress Report, 31 December 2018, 32-33.
[272] *Businessline* 'Changes to Feedback Management within DVA'. 3 October 2018.
[273] *Businessline* 'Tools to support the identification of, and staff interactions with at-risk clients'.

A further issue is that during the transfer between initial liability, needs assessment, or from prior to new claims, indicator flags get lost in the system. These deficiencies highlight the need for better systems and tools to enable the identification of people at-risk. These problems have not yet been rectified.

Several workshops have been held by IPS with staff around the country to identify priority areas for future enhancement of DVA's processing systems. The IPS team is in the process of considering feedback from these sessions, as well as the specific system issues raised in other forums or documents, to inform and prioritise improvements to existing systems. The Department of Human Services (DHS) is working with DVA to load the DVA additions into its system, and devising timelines for incorporating system changes. The necessity for DHS involvement is the software development and costing of DVA systems. This has increased the complexity of these developments and has inevitably delayed implementation.

Other process initiatives

Other valuable systems and processes which help staff support high risk and vulnerable clients include:

- expanded use of a team of social workers based in the Melbourne office to conduct 'wellness checks' or psychosocial assessments. New clients are referred to the social worker team, which will seek to make contact. Where contact can be made (the phone call reaches the client only on average in less than half of cases[274]), this provides an opportunity for early support and intervention;
- the establishment of the Triage and Connect team to support the quick and appropriate referral of clients, and escalation where required;
- risk indicators developed by Open Arms have been shared with DVA staff in training sessions;
- national training on these initiatives has taken place, including education on the Client Support Framework;
- the ongoing operation of the CCS program (see recommendation 7), provides additional support to access services and entitlements for clients with complex or multiple needs.[275]

The increase in the number of referrals to CCS is indicated in that in the 2016/2017 FY there were 1030 referrals but in the 2017/2018 FY the number had increased to 1216. This increase likely to be exceeded in the 2018/2019 FY if figures for the first 6 months (636 cases) are an indication.[276]

Process initiatives by Open Arms

Open Arms has engaged additional clinical capability to deliver mental health case management. Open Arms clinical policy has been updated to include a process for contacting clients identified as high risk, referred to as 'reach out calls' (see recommendation 9). DVA Professional Support Workers or Open Arms counsellors made 65 successful reach-out calls to veterans who made submissions to the Senate Inquiry to offer additional support.[277]

[274] ISH records 17,205 requests for social worker between 4 December 2017 and 11 January 2019, with the social worker unable to contact the client in 9,260 cases, able to speak with the client or their representative in 7,525 cases, and referred to a case coordinator in 111 cases. Source: DVA unpublished data – 'Social Workers – Primary Claims'.

[275] *Coordinated Client Support National Policy* Issue Number 01/16.

[276] Unpublished DVA data - the number of referrals of clients to CCS (July 2016-December 2018).

[277] *Joint Inquiry into the management of Jesse Bird's case* (2017), Recommendations; Progress of implementation as at 31 December 2018, 7.

Open Arms has also developed protocols to facilitate case conferencing between Open Arms and DVA for individual clients. This *Open Arms Escalation Process* is being developed and had largely been completed by September 2018.[278] The protocols describing the steps in the escalation process are helpful and in diagrammatic form.[279]The steps cover the period from initial referral to the closure of the escalation file, and include triage administration.

Actions envisaged following assistance include stabilising a client in urgent need, reach out calls, or advice or referral to the best source of assistance. In escalation/referral cases a triage team member will assist the client with an appropriate ('warm'/supported) handover to an appropriate service.[280] This may include a referral to DVA's Coordinated Client Support team (CCS): see recommendation 5.

Open Arms has a separate complaints management system in order to protect client confidentiality. Open Arms is also revising its Risk Assessment Management Plan (RAMP) tool, to be finalised in early 2019. This tool supports the clinical risk assessment undertaken by Open Arms counsellors for those at-risk, and RAMP is being updated to reflect current best practice in risk assessment.

Other systems and processes

The Triage and Connect service was implemented in August 2018, and it continues to develop.[281] The Triage and Connect team is small (5 positions as at 31 December 2018[282]) and will need supplementation as usage increases. Formerly three Open Arms clinicians were embedded in the Triage and Connect team but that clinical support has now been withdrawn following concerns, including about breaching client confidentiality.[283] The service needs an appropriately qualified clinician and DVA should commit to providing one of its clinical staff to the service if it is to perform its task effectively.

Between 13 September 2017 and 31 December 2018, Open Arms received an estimated 40 assisted referrals from DVA.[284] This figure does not include referrals which may have occurred regionally through local arrangements. In the same period, 561 client cases were escalated from DVA to Open Arms. Between 19 September 2017 and 31 December 2018, Open Arms conducted 439 reach out calls, including 345 occasions of direct client contact and 94 occasions of contact with a treating health professional involved in client management.[285]

No figures have been provided on referrals by Open Arms to DVA. Given the insights available to Open Arms counsellors, it is inevitable that they become aware of DVA services to which a client may be entitled, or are at least aware that services are available from which the client could benefit. The interaction between DVA and Open Arms is intended to be collaborative, and though I was assured that the contacts between the two occur daily, it would be helpful if actual referral numbers could be kept.

Training

The training package 'Complex Case Management – Support for staff interaction with complex or at-risk clients' was released in December 2018 and was undertaken by staff between December 2018 and February 2019. The package provides staff with information and tools to assist with the early

[278] *Open Arms Escalation Process* December 2018.
[279] *Open Arms Escalation Process* December 2018.
[280] 'Triage Workflow'; 'The Triage Service'.
[281] Eg *Triage and Connect Policy Documentation – June 2018*.
[282] *Triage and Connect Policy Documentation – June 2018*, 6.
[283] Discussion with Open Arms, 8 February 2019.
[284] Open Arms unpublished data.
[285] Open Arms unpublished data.

identification of clients at-risk, information about the Client Support Framework, and the role of the Triage and Connect process, expanded client risk indicators and referral options; and guidelines for communicating negative claim decisions.[286] As at 31 December 2018, 235 staff had completed the training package. More detailed information has been uploaded to CLIK and other internal information databases.

Watchpoint

Senior officers in DVA emphasised in discussion a need for some caution about an overemphasis on expediency. Their message was that a light touch and semi-automated approach to claims management can diminish personal contact and the opportunity to build relationships with clients and their families, which in itself is an important part of Veteran Centric Reform. The goal is also at odds with the development of more coordinated, holistic case management, which can require more interaction, not less, with those DVA is designed to serve.

Balancing the objective of more efficient and timely claims management, partly facilitated by ICT solutions, with the desire to improve interactions between staff and clients, involves investment in training and the development of people skills, and requires careful attention by management. The programs need to take account of the fact that systems are designed by people for people and that automation is a tool and should not wholly supersede human contact, particularly in the case of at-risk or vulnerable clients.

Conclusion and suggested actions

Much has been done to implement better systems and processes to identify and alert staff to the need to support high risk and vulnerable veterans. A complete overhaul of the complaints system, the development within the ICT systems of alert flags or tools, including one planned to be implemented in April 2019 for those with mental health problems, together with processes to triage and case manage high risk or vulnerable clients, and training in these developments, go a considerable way to meet the objectives of this recommendation.

At the same time, DVA ICT architecture needs urgent updating to reflect the changed architecture for support of those at-risk and to avoid the potential for inconsistent practices from manual workarounds.[287] In the longer term, consideration needs to be given to the establishment of an ICT system for DVA staff which provides a single client view and which can better support the goals of VCR.

Implementation has not been appropriately speedy. Even allowing for the inevitable delays for the development and implementation of complex ICT changes, more urgent attention is needed on improving the systems which support DVA's frontline staff and ultimately the veterans and their families who are their clients. The implementation of the veteran centric transformation program together with adoption of a holistic approach to veterans' care indicate the need for a speedier resolution of these issues.

[286] DVA Progress report 31 December 2018, 34; *Businessline* 'Tools to support the identification of, and staff interactions with at-risk clients'.
[287] *Triage Team Project Management Plan* 26 November 2018.

Recommendation 12: Put in place wellness checks for uncontactable clients with mental health conditions and trigger additional support mechanisms for clients with mental health conditions who repeatedly submit incomplete documentation or exceed expected response timeframes.

Resource constraints and limitations in ICT systems, meant that DVA was not able successfully to follow up with Mr Bird at several points during the management of his case. These are among the issues identified by this recommendation.

Wellness checks

Wellness checks, or psychosocial assessments, are conducted for new clients by DVA's social workers, and can also be requested by DVA staff at any point in the claims process.

The DVA social worker team in the Melbourne office (six full time equivalent staff) attempt to contact clients or their families who may need immediate support or assistance during the claims process: see recommendation 11.[288] That support may involve referral to counselling services, local community groups, accommodation agencies, home care assistance and for financial aid.[289] The social workers attempt to contact new clients, as well as responding to DVA staff requests, for example, where DVA is informed by a client that they have previously contemplated self-harm. The social worker team has dedicated social workers to conduct wellness checks for clients whose initial liability claims are managed by the Complex Case team, including clients whose claims relate to physical or sexual abuse in the ADF.[290]

The social workers also inform clients regarding services run by other government agencies and the private sector which may be accessed by those who are at-risk or have vulnerabilities.[291]

The concept of 'wellness' encompasses physical health but also recognizes the importance of emotional, social, financial, and purposeful health. It is a concept which has value in workplaces and is associated with the holistic approach to improving the wellbeing of clients. The concept of wellness aligns with the veteran centric approach adopted by DVA under its Transformation program.

The Department has taken significant steps to identify health and wellbeing issues of veterans. An indication of these steps is that from 2017, in partnership with the Australian Institute of Health and Welfare, DVA and AIHW have produced six research publications on these issues.[292] The research programs from which these publications emerged are to be conducted over four years and are to build a profile of the health and welfare of Australia's veteran population.[293] Among these programs is the

[288] Email, 31 July 2018 'Social Work Team Information, Resources and Referrals'.
[289] Email, 31 July 2018 'Social Work Team Information, Resources and Referrals';'Resources for Social Workers'.
[290] 'Social Workers – Primary Claims'.
[291] 'Veteran & Family Assistance'; VVCS 'About VVCS'; Provision Access to Medical Treatment Trial'; Australian Tinnitus Association (NSW) Ltd 'Coping with Tinnitus – Tips from ATA (NSW) Members'; 'ON Mental Health Line Australia Crisis services'; RSL Defence Care; 'Mates4Mates and RSL Queensland Branch Advocacy Services'; Australian Pain management association; APMA Pain Support Groups; VVCS 'Stepping Out Program'; RESTORE Treating Veterans & Military Personnel with PTSD 'RESTORE Trial Seeking Participants; 'MIND 'Access to Mind services'; ONE Link Services; 'Digger Dogs – The Dog Squad'; Financial Counsellor State Listings; PTSD and Mental health Program for Brisbane and elsewhere; VVCS Programs by Region 2016; DVA Factsheet HSV131 – Alternative therapies; Military Superannuation.
[292] *Incidence of suicide in service and ex-serving Australian Defence Force personnel detailed analysis 2001-2015* (2017b); *Development of a veteran-centred model: a working paper* (2017c); *Australia's Health 2018* (2018d); *Causes of death among serving and ex-serving Australian Defence Force personnel 2002-2015* (2018b); *National suicide monitoring of serving and ex-serving Australian Defence Force personnel* (2018c); and *A profile of Australia's veterans 2018* (2018f): Productivity Commission Draft Report Box 16.1, 610.
[293] Productivity Commission Draft Report, Box 16.1, 610.

Development of a veteran-centred model: a working paper (2017) which 'sets out a model to support holistic analysis and reporting of veteran's health and welfare'.[294]

A peer engagement model by Open Arms in Brisbane has been developed that can make use of peers with experience akin to those clients identified as at-risk due of suicide, for which an indicator may be client disengagement from DVA: see recommendations 6, 10. The program has been accepted to become part of the regular program and has been launched in the first half of 2019.

DVA may also separately refer a client to Open Arms. Open Arms is using its clinical case managers and those involved in its peer network pilot to support veterans: see above. Health professionals are engaged where the client may be at-risk. Open Arms delivers reach out calls which are for the purpose of contacting a client because risk of safety to themselves or others has been identified as a potential concern.

Clients requiring additional support to navigate claims processes effectively can be supported by the CCS Program and its dedicated case manager (see recommendation 7). With the implementation of the single referral point of Triage and Connect, client circumstances are also able to be holistically reviewed to identify if a clinical reach out call is required, or if contact from a member of the team is appropriate to discuss support being provided by CCS to facilitate action on claims processes, where clients have disengaged or do not have capability to meet the requirements of the process unassisted.

Alerts for tardy or unavailable clients

There is a need to address the processing time required for clients, what is ideal for clients and ways to keep the client informed regularly of progress. The ISH system is being enhanced to better support the management of clients who have submitted late or incomplete documentation.[295] The ANAO report (see Reports) recommended that 'DVA develop and implement R&C reporting … that: (a) will allow the identification of claims that are potentially problematic at an individual claim level for operational management' (Rec 6). DVA agreed with that recommendation. The R&C ISH December 2018 Release in response to those recommendations, provided:

> *4. R&C ISH will provide team leaders/R&C managers with a view/early warning of tasks that are indicators of claims (ie Incapacity payments and DRCA/MRCA permanent impairment) that have the potential/are at-risk of becoming problematic.*[296]

It is not clear whether the claims that are at-risk of becoming problematic extend to delays in responding to correspondence, missing appointments or not meeting expected timeframes.

Some of the delays in processing Mr Bird's claim arose because of such problems.

Commonwealth Superannuation Corporation (CSC)

A new claims management system has been implemented which supports a team-based approach to managing customers, making it easier to avoid a break in continuity of service if a staff member is on leave or absent. This has improved the relationship between CSC and its customers. The system also raises a flag every 20 days to remind the team to make contact with the customer even if there is no change to the claim. The system permits flags to be attached to claims to identify high risk customers. Priority can be accorded a claim in some circumstances.[297]

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[294] Productivity Commission Draft Report, Box 16.1, 610.
[295] R&C ISH 'PAMT changes in a nutshell'.
[296] ANAO Audit report No 52 2017-2018 *Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs* Recommendation; R&C ISH 'PAMT changes in a nutshell'.
[297] Discussion with CSC, 22 January 2019.

Education of staff

Information in DVA to help staff identify high risk clients and processes to escalate cases has been developed and distributed to all staff. This is described in the Client Support Framework training delivered nationally in late 2018 and early 2019. This training includes education as to client risk indicators and flags which identify whether a client requires further support to participate in and navigate claims processes, or is unable to access essential services or support. This includes the escalation of cases where a client has withdrawn from services and/or has disengaged from processes. The training package includes information on wellness checks as well as flags.[298] Refresher training for existing staff and training for those new to the agency has been discussed at recommendation 8. Discussion of flags is found at recommendations 5, 9 and 11.

Other initiatives

Specific programs of relevance for veterans, not all of which have been discussed in detail elsewhere in this report include:

- DVA's White Card for non-liability health care treatment for cancer, tuberculosis, or any mental health condition;[299]
- The veteran payment to provide interim financial support to veterans with a claim for a mental health condition under the MRCA or the DRCA;[300]
- The Provisional Access to Medical Treatment Trial (PAMT). The trial is being conducted over a two-year period to 30 June 2019. The trial provides veterans with access to medical treatment for specific conditions while their claim for liability under the SRCA or the DRCA is being processed. The trial covers all those who have left the ADF unless they already have a Gold Card. Given the introduction of non-liability health care for all mental health conditions, the medical conditions covered are physical.[301]

Conclusion and any suggested actions

There are now arrangements for wellness checks for clients identified as at-risk for mental health or other reasons; there is also an alert for staff if there is no action on a claim after seven days which can assist in identifying clients who have disengaged from the process, miss appointments, are tardy in submitting documentation, or delay to respond within expected timeframes. In addition, since 1 May 2018, financial support in the form of the veteran payment is available for those with mental health conditions who are struggling financially, and reach out calls are being implemented. Open Arms assessment on intake of risk of a client is another trigger to provide appropriate support.

These improvements go much of the way to ensure the wellbeing of a veteran is known to and taken account of by staff, to prevent a client's needs being overlooked, and to provide a veteran with financial support until a claim can be determined. In summary, this recommendation has been actioned.

The only suggested action is that the systems in place need to be monitored to ensure they are working effectively.

[298] DVA Progress Report, 31 December 2018, 36.
[299] Factsheet HSV109 – Non-Liability Health Care; DVA Factsheet HSV 61 – DVA Health Card – Specific conditions (White); DVA Factsheet HSV14 – Osteopathic Services.
[300] Veteran Payment.
[301] Provisional Access to Medical Treatment Trial (PAMT).

Recommendation 13: Implement action to ensure letters and emails are accurate, easy to understand and appropriate in tone.

Another initiative is the redesign of DVA letters to clients. Correspondence from DVA can be overlong, and unnecessarily complex and the Department has acknowledged that its written communications need to be improved.

A program to improve correspondence and other publicly available material has been accepted by DVA management. On 22 November 2018, the DVA Executive Management Committee endorsed a comprehensive reform of DVA letters, fact sheets and the CLIK. The request for funding was also approved.[302] The letters reform program is designed to provide DVA clients with simple, readable, succinct and accurate information, couched in language which is appropriate in tone. Achievement of this goal is designed to reduce the volume and complexity of communications.

The revision of written communication will inevitably take time, given the extent of material. The DVA library contains nearly 1000 (902) template letters alone. [303] The proposal is for a hub and spoke document improvement model with a central team working on content and advising business lines, while also testing the revised material with clients and the broader veteran community.

Work has commenced.[304] The first report of the Knowledge Management project, which occurred on 8 November 2018, recommended that the reform of DVA's written material should align with the project.[305] The purpose of the project is to improve knowledge management generally within DVA, including improvement to internal and information sources such as CLIK, as well as to the tone and readability of materials such as fact sheets, client letters, and website.[306] The website upgrade is to be launched in mid-2019.

A key issue is that template letters need to be changed easily and quickly to match legislative and policy changes. A barrier to achieving this aim is that it is not possible for letters in ISH to be automatically revised to reflect changes in policy and legislation. As a result, changes to letters or advice have to be made manually.[307] Advice on the manual inserts has been provided.[308] This exemplifies the steps to overcome the barriers to change required by this wholesale renovation of DVA's written material.

CLIK has over 1800 documents, is clunky and clearly out of date. There is now so much material in the system that it has lost its effectiveness. Staff often develop their own sources of information rather than relying on CLIK. Practices of this kind lead to inconsistency in information exchange with clients. There is a clear need for a better system to notify legislative, practice and procedural principles.

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[302] Brief for Secretary 'Proposed Review and Redesign of DVA Factsheets and Letters' (approved by Secretary, 4 June 2018).

[303] Discussion with DVA, 29 November 2018.

[304] *Knowledge Management Kick-off Report,* 8 November 2018.

[305] DVA Progress report, 31 December 2018, 24; *Knowledge Management Kick-off Report,* 8 November 2018.

[306] 'Claims withdrawal, Registration and Needs Assessment Workshop – Action Items Register, 4-5. See also at Recommendation 13.

[307] DVA Progress report, 31 December 2018, 39; 'Registration of Benefit Claims & Needs Assessments'; 'Guidance for delegates to delete wording in MRCA and DRCA PI ISH acceptance letters – a manual workaround'; *Businessline* 'Removal of 21 day timeframe to advise DVA of an intention to sue the Commonwealth' 26 July 2018.

[308] 'Guidance for delegates to delete wording in MRCA and DRCA PI ISH acceptance letters – a manual workaround'.

As a separate initiative, DVA has published training material, templates, exercises and general information in its *Using Behavioural Insights to Write Better Letters* to assist staff.[309] Training for staff included applying behavioural insights to letters to improve client and departmental outcomes.[310] The *Using Behavioural Insights to Write Better Letters* workshop reached 223 attendees across 13 different workshops undertaken in all state capitals and in Canberra.[311]A booklet was also provided.[312]

Commonwealth Superannuation Corporation (CSC) experience

CSC, like DVA, is simplifying its templates for letters (about 430 of them) with a view to making them more accessible for customers. Between 50-60 per cent of correspondence involves three templates so CSC has actioned these as its first priority.[313]

Conclusion and any suggested actions

Funding has been approved for a department-wide project to ensure client communications are accurate, easy to understand and appropriate in tone. Advice letters already contain information about appeal rights and DVA contact numbers for further information, but more needs to be done. Aligning these actions with the broader Knowledge Management program should not be used as an excuse for delay in implementing this recommendation. The steps taken to date, including the development of a training manual, are insufficient without a broader overhaul of letter templates.

The letters improvement project should start with the most frequently used letters under the three Acts – at most no more than 9-12 templates. These should be updated as a priority to ensure most clients enjoy the benefit of correspondence meeting this recommendation.

ICT changes are also needed promptly if mistakes, inaccuracy, lack of readability or inappropriateness are to be avoided due to manual workarounds for existing letter templates. Further steps are needed to ensure templates accurately reflect legislative and policy changes.

Recommendation 14: Implement action to ensure liability and compensation rejection or claim denial correspondence occurs only after a DVA staff member phones to discuss the outcome with a client. This discussion should detail:

- **The nature of the decision or determination;**
- **Opportunities for the member to appeal the decision, should they wish to;**
- **Alternative services that DVA can offer;**
- **Options to defer the decision and revisit at a later stage (eg once conditions have stabilised), not implications for recording times taken to process; and**
- **DVA point of contact in case further explanation is desired.**

[309] *Letters Improvement Project Report – Transformation Program, Final Working Draft,* November 2018.
[310] Emails encouraging staff to attend training course 'Using Behavioural insights to write better letters', 27 June 2018, 10 August 2018.
[311] The workshops were held in Sydney (17 & 18 October) 30 attendees; Melbourne (15 & 16 October) 24 attendees; Brisbane (30 & 31 October) 30 attendees; Hobart (18 September) 13 attendees; Perth (29 & 39 August) 35 attendees; Adelaide (19 & 20 September) 37 attendees; and Canberra (17 July; 8 November) 54 attendees: DVA Progress Report 31 December 2018, 38.
[312] *Letters Improvement Project Report – Transformation Program, Final Working Draft,* November 2018.
[313] Discussions with CSC, 22 January 2019

Two issues are at the forefront of this recommendation: the need for sensitive handling of information about denial of a claim or request for a service; and advice on rights of appeal and contact details in DVA.

The second issue was not identified as a concern in relation to Mr Bird; the first did arise.

Option to defer decision

There is no legislative basis for deferring a decision until a condition has stabilised. However, the Department's increased use of the interim payment option avoids the need to rely on the deferment option: see recommendation 2.

Other options to ensure appropriate services are provided is to advise on the services offered by Open Arms, the support available from ex-service organisations, from Centrelink (financial support) or the availability of the Family Support Package and the veteran payment. Other assistance includes non-liability health care for certain conditions, the white card for financial support for medical conditions for members who have left the ADF, rehabilitation services, and external providers of services: see recommendation 15.

Sensitive handling of preliminary oral advice about an adverse decision

From December 2017, protocols have been developed for DVA staff to contact clients in person in the case of an adverse claim decision. Guidelines have been circulated which provide directions to staff in undertaking such conversations and provide a greater level of support to clients who may be affected by these decisions.[314] The protocols include consultation, if appropriate, with Open Arms or CCS for them to advise on the appropriate delivery of adverse claims outcomes.

Under the protocol, the client is to be phoned before the adverse decision is sent out denying liability, or in other adverse decision cases.[315] The direction is part of moves generally to improve communications with clients. Where a client is being managed by CCS, the phone call is to be made by the client's single point of contact person. In other cases, it is the staff member managing the case, supervised if appropriate by the team manager, who makes the call.[316] There is a script for the phone call.[317]

Training on managing oral advice with sensitivity

Training specific to improving communication with clients in these circumstances was developed and implemented.

The course 'Managing Communications and Relationships with DVA Clients'[318] was developed internally to build communication skills of staff who are making personal contact with a client. Between 30 April 2018 and 14 June 2018, 18 sessions were held in the offices in all capital cities except Hobart with 233 staff attending. Training is ongoing.[319]

Guidelines on the revised process have been circulated via *Businessline*,[320] as well as information on managing communications.[321] The staff instructions do provide for contact to be made by SMS/email

[314] DVA Progress Report, 31 December 2018 40.
[315] *MRCA Claims Management* Chapter 2.6.4.
[316] *MRCA Claims Management* Chapter 2.6.4
[317] *Businessline* 'Guidelines for Contacting Clients Regarding Negative Decisions', 19 December 2017.
[318] Magical Learning, *Managing Communications and Relationships with DVA Clients.*
[319] DVA Progress Report, 31 December 2018, 41.
[320] *Businessline* 'Guidelines for Contacting Clients Regarding Negative Decisions', 19 December 2017.
[321] Magical Learning, *Managing Communications and Relationships with DVA Clients.*

if the attempt to phone is unsuccessful. Advice is provided to the client of available support services if the staff member discerns distress on the part of the client.[322] Staff liaise with the client and Centrelink to ensure continuity of payment if that form of assistance is needed.[323]

Workshops identified concerns on the part of some staff about these 'in person' processes. Some staff were worried that calls might be made at an inopportune time, not be picked up because the phone number of the caller is a private line and the client assumes the call is a marketing call, or that the reason for the outcome was too complex for easy explanation by telephone. These concerns indicate reluctance on the part of some staff to comply with the new processes.

Another issue is that there is no checklist or evidence that these calls occur. Equally, there is none to confirm that all aspects of the legislation, policy, and associated *Businessline* are followed. Discretion is used by staff when deciding what information to disclose on contact with a client. This is appropriate and necessary provided the file contains the information about what was discussed. Absence of these steps was identified in the HMA report which commented critically on the lack of support for front-line staff, and of KPIs for client service skills, and the need to better monitor performance of front-line staff.[324]

Advice on appeal rights and information on DVA points of contact

Adverse decisions letters always contain information about appeal rights when DVA advises of an adverse decision,[325] and provide a contact number for further information.[326]

Conclusion and any suggested actions

This recommendation is substantially complete, subject only to three minor further steps. Actions undertaken include the policy to phone a client in advance of an adverse decision letter, the face-to-face sensitivity training of relevant staff providing that advice, and the development of appropriate written material and scripts. Letters to clients all contain appropriate information about appeal rights and DVA contacts for further information.

Suggested actions are: an endorsement of the Health Management Advisors (HMA) suggestions for the setting up of a program of support for frontline staff experiencing stress following an adverse advice phone call; for more consistent monitoring of their performance; for the possible need for changes to scripts, guidelines or training materials to take into account suggestions made by staff involved in implementation of these approaches; and given clients advised orally of an adverse decision may not read the written notification, steps are needed to ensure clients receive information in writing about options to defer, appeal opportunities, and DVA contacts for advice.

Recommendation 15: Expand scope of reviewed circumstances to include services sought through other Government agencies and community services

The difficulties for ADF members attendant on transition from the forces are well documented.[327] Translation of the many skills and attributes of those who serve into criteria for civilian employment requires skill and an understanding which is not possessed by many ex-service members. Upskilling is

[322] *MRCA Claims Management* Chapter 2.6.4.
[323] DVA Progress Report, 31 December 2018, 42.
[324] HMA *Final Report*, 15.
[325] *Claims Management Guidelines* 2.6.4 'Guidelines for Contacting Clients Regarding Negative Decisions'.
[326] Eg Template letter 'Determination of your claim for MRCA Permanent Impairment compensation'.
[327] Eg Productivity Commission Draft Report, Chapter 7.

often required, financial support during retraining, as well as education of civilian employers about the use which can be made of those who have served.

Mr Bird did not seek vocational or rehabilitation assistance when he left the ADF and his intermittent employment experience post-service, and lengthy periods of unemployment contributed to his financial difficulties and compounded the stresses to which he was subject.

This recommendation focuses on supports for at-risk or vulnerable veterans other than the assistance or programs provided by DVA or Defence.

Notification of external supports

DVA has implemented a web-based information page providing links to support services for veterans and families in need. The link is entitled 'External Supports for At-risk Clients'. The page is available for external users through the 'Need Help Now' button on the front page of the DVA website,[328] and the information is also included in the CLIK.[329] The list is on the DVA intranet for use by staff in providing support and assistance to veterans and was advised in a *Businessline.*[330] A new DVA website under construction will be launched in mid-2019.[331]

The link is to information on a range of private sector organisations and government agencies who can provide immediate, specialised advice, support and referral services, many of which can be contacted 24 hours a day, 7 days a week. This initiative is part of broader department-wide changes underway. The Defence Engage portal provides information for ADF members and their families to access support from Defence and outside sources, including employment services.[332]

The new learning and development processes will see regular training packages for staff on recent changes to policy, process, and information sources.[333] Work to identify the other services will be conducted in early 2019 and will be included in a training package during the year.

Conclusion and any suggested actions

This recommendation has been actioned effectively. The DVA links on its website to 'External Supports for At-risk Clients' and the 'Need Help Now' icon, together with the Defence 'Engage' portal alert veterans to multiple sources of assistance from other government agencies and community services. Staff have been advised of the advice sources through training and departmental communications.

A watchpoint will be for changes to information included on the website, or any 'glitches' in ICT programs when the new DVA website is launched in June. The period from February to June 2019 should be used to test the information provided on the website to ensure it is current.

Recommendation 16: Introduce a case-response team with specified resources across public affairs, legal, strategic communications, executive and divisions to create a DVA response to emerging issues and messaging that is respectful and supportive in tone.

As mentioned at recommendation 4, neither Open Arms nor DVA had a complete picture of Mr Bird's vulnerabilities. One of the aims of the subsequent changes within the Department is for there to be a holistic view of a client's circumstances, in order that a more complete picture of the issues the client

[328] DVA Progress Report, 31 December 2018, 42.
[329] CLIK 'External Supports for At-risk Clients'.
[330] *Businessline* 'External Support for at-risk Clients', 6 December 2017.
[331] DVA Progress Report, 31 December 2018, 43.
[332] CLIK 'External Supports for At-risk Clients'.
[333] DVA Progress Report, 31 December 2018, 43.

is facing can be taken into account by departmental decision-makers. To this end, this recommendation is for there to be an overarching body considering all the factors affecting both individual clients, but the issues facing veterans more generally. That body would then be in a position to provide advice on individual cases, but importantly, strategic advice and information, in appropriately couched terms, about emerging issues for its clients more generally, their families, their medical, rehabilitation and legal advisers, and other groups with a focus on veterans' matters.

The evidence of the strategic importance attached to respectful and supportive messaging was seen in the agreement by the Executive Management Committee referred to at recommendation 13. That advice was for the program to revise publicly and internally available material to and about clients to achieve a more accessible and appropriate tone. This covered DVA template letters, fact sheets, the CLIK and the *Businessline.*

Evidence of the determination to improve communications and reduce complexity for users is that by early 2019 the avenues for people to access DVA will have reduced from 170 to about 12.[334] In time it is planned for there to be a single portal. This will reduce one aspect of the frustration expressed by clients about the complexity of accessing departmental services.

Weekly Client Discussion

The Weekly Client Discussion (WCD), part of the Client Support Framework, is a new mechanism to manage the escalation of cases which require specialist oversight at the SES level, as well as to consider and formulate responses to systemic issues. Accordingly, it resolves specific client issues, with the support of clinicians, and ensures there is timely support and assistance for individual clients. At the same time, it draws on specific cases to identify complex eligibility and policy matters including the need for changes to practices, if required, across the Department, and uses individual cases to provide guidance to business areas on how to improve client services. This can include cases involving vulnerable and at-risk clients, and high profile and sensitive clients which have been escalated (see recommendation 16). For urgent cases the WCD can be convened offline.

Problem Solving Forum (PSF)

For discussion of the PSF see recommendation 5.

Steering Committee

The Delegates Support Projects and Initiatives Steering Committee (Steering Committee) has been established to assist with avoiding the tactical gaps between DVA policies and client services identified by the events leading to Mr Bird's death. Some of the gaps are referred to in the discussion of specific recommendations. Those gaps were due variously to a misunderstanding of the legislation, to a misapplication of the legislation in some locations, and to systemic issues. These systemic issues raised the need for a body better able to coordinate existing or proposed projects and initiatives.

The role of the Steering Committee is to:

- *determine how these projects and initiatives fit together;*
- *determine the resourcing and timeframes required to best coordinate and integrate relevant projects and initiatives, including the tactical plan, namely, 'an approach and activities to engage and support delegates';*
- *ensure that DVA is taking a strategic and system-level approach to bridging the gap between policy and service delivery*.[335]

[334] Discussion with DVA, 29 November 2018.
[335] Action Brief for COO/Deputy Secretary, [Establishment of Steering Committee – Delegate Strategy', 1.

The Steering Committee comprises relevant Assistant Secretaries, and is co-chaired by the First Assistant Secretaries of Clients' Benefits Division and Client Engagement & Support Services Division.[336] The Steering Committee will report to the recently created Client Services Committee (see below) on a quarterly basis. The purpose of the Steering Committee is to provide enhanced support to the more than 500 DVA delegates in their decision-making. Its establishment indicates a willingness to take proactive steps to improve departmental decision-making by providing for leadership at the highest levels within the agency.

The Steering Committee had its first meeting in February 2019 so it is too soon to judge its effectiveness. This is a long-term project involving cultural change. Nonetheless, among the projects of relevance to this inquiry which will require the attention of the Steering Committee are the VCR initiatives to implement the training strategies identified by the Health Management Australia report (see recommendation 8) and those recommendations of the final report of the Productivity Commission which government accepts. These strategies include, in the context of recommendation 1, establishing clear roles and responsibilities for delegates, including effective accreditation and competency tools for their respective roles, and guidance on the application of the principles of beneficial legislation. The review of training and competencies was discussed at recommendation 8 of this review.

Departmental restructure

There have been structural changes within DVA designed to improve strategic and policy oversight of the Department. These changes have included the creation of the Client Engagement and Support Services division in July 2018, which brings together previously disparate parts of DVA to ensure a clear focus on engaging veterans and their families and providing appropriate supports.

On 4 September 2018, the Legal, Assurance and Governance Division was established, including the Legal Services Branch, the Security, Governance and Quality Assurance Branch, and the Portfolio Assurance Branch (PAB). One of the key roles of PAB is to work across DVA and with the Executive to identify risks and issues that could either impede delivery of review outcomes, impact corporate reputation and delivery of reforms, or undermine safe delivery of services to clients. The Branch reports these risks and issues directly to the Departmental Executive.[337] PAB also includes the creation of a team responsible for assurance coordination and reporting.

By the end of 2018, DVA had also implemented a new governance framework, responding to recommendations of a major governance review conducted in 2018. The framework includes a Client Services Committee (CSC), which is the primary forum for executive consideration of matters relating to:

- Client experience and engagement;
- Service quality and outcome delivery for DVA clients
- Holistic consideration of trends, issues and opportunities in achieving outcomes; and
- Portfolio and program governance and continuous improvement.

The CSC held its first meeting on 24 September 2018, and is chaired by the Deputy Secretary, Policy and Programs Group, with the First Assistant Secretary, Client Engagement and Support Services as the Deputy Chair.

[336] Action Brief for COO/Deputy Secretary, [Establishment of Steering Committee – Delegate Strategy', 1.
[337] DVA Progress Report, 31 December 2018, 45.

Conclusion and any suggested actions

DVA has implemented this recommendation through departmental reorganisation and the setting up of several bodies to undertake these tasks, both under the Client Support Framework (the Weekly Client Discussion and the Problem Solving Forum), and as standalone committees (the Client Services Committee and the Steering Committee). In different ways, these bodies help identify and address systemic issues, problems with policies, and the need for legislative change. The establishment of these bodies, comprising senior DVA staff, with the capacity to respond at a DVA-wide level to systemic, specified personnel and individual issues. Although these bodies have been set up since the second half of 2018, making it premature to judge their impact, their establishment indicates a firm intention to respond to this recommendation.

The recommendation for DVA to adopt 'messaging that is respectful and supportive in tone' is primarily being actioned under recommendation 13.

THREE ADDITIONAL RECOMMENDATIONS TO THE MINISTER FOR GOVERNMENT TO CONSIDER (17-19)

Recommendation 17: The provision of more timely compensation payment by using a current assessment of the service-related level of impairment, instead of delaying compensation payments until the service-related level of permanent impairment has stabilised.

Recommendation 2 chronicled the changes to policies, procedures, training and documentation to advise about payments of interim permanent impairment compensation. This recommendation focuses on expediting other compensation payments.

Some fundamental changes have already occurred which meet the objectives of this recommendation. More timely compensation payments have been instituted through a combination of forms of expedited decision-making (streamlined and straight-through processing, see following), the payment of interim permanent impairment compensation (recommendation 2), and ICT developments (recommendation 6).

The Productivity Commission Draft Report found:

> *Since VCR was implemented in mid-2016 there has been a consistent and significant reduction in the time taken to process initial liability and permanent impairment claims under the newer, more complex Acts (DRCA and MRCA). Permanent impairment processing times have been cut by more than 50 per cent, while all DRCA and MRCA claims processing areas are currently sitting comfortably within DVA's internal targets*[338] (see Figure 7 below).

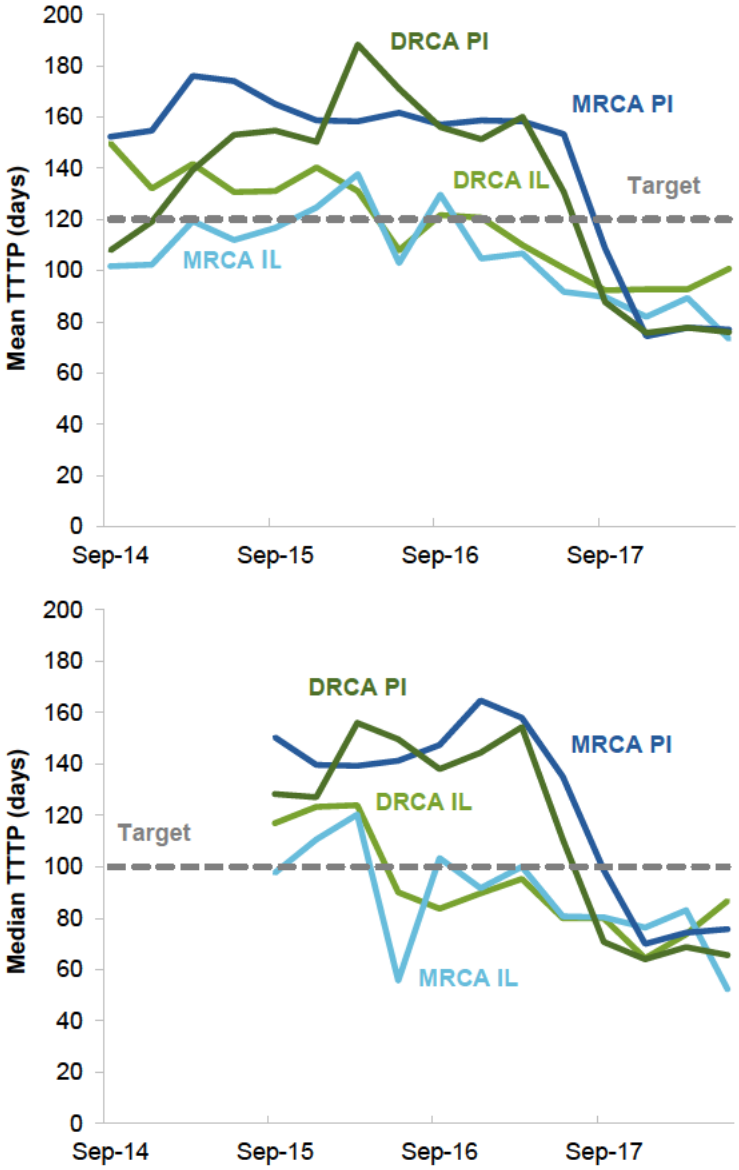
Interim Permanent Impairment Compensation

On 10 November 2017, the Military Rehabilitation and Compensation Commission Responses agreed to a policy change in relation to DVA's management of permanent impairment compensation claims for clients who may have one or more specified mental health conditions. Where the veteran is considered likely to meet the threshold level of impairment, but the condition has not stabilised, an interim payment of compensation must be offered (see recommendation 2). The interim compensation payment must be offered at least at the base rate, but can be offered at higher degree if considered appropriate.

[338] Productivity Commission Draft Report, 366.

Figure 7 **Time taken to process (TTTP) claims**

By Act, for initial liability (IL) and permanent impairment (PI)



Three month moving average.

Source: Productivity Commission estimates based on unpublished DVA data.[339]

The specified mental health conditions are post-traumatic stress disorder, depressive disorder, anxiety disorder, substance use disorder or alcohol use disorder. The new policy has been supported by the issue of a *Businessline*, changes to CLIK, and the delivery of training. As at 31 December 2018, DVA has made 1262 interim PI payments since December 2017.

Streamlining and straight-through processing

These two processes have a different history. Streamlining commenced in 2007 and provides in effect for automatic acceptance of liability for certain conditions under the VEA and the MRCA. Approval for

[339] Productivity Commission Draft Report, Figure 9.2, 367.

straight-through processing for some conditions under the MRCA and the VEA was not given until September 2016. Both processes preceded Mr Bird's death. Nonetheless, the expansion of the conditions to which either of the processes can be applied has been given an impetus by the events surrounding his death. If either a streamlined or a straight-through process applies to a condition, the condition is said to be 'decision-ready', thus avoiding much of the preliminary investigation which slow down the making of decisions on claims. The process applies solely to acceptance of the initial liability stage of a compensation claim and to payment of interim permanent impairment compensation.

There are now 40 eligible conditions for which streamlining or straight-through processing occurs.[340] While the conditions are largely physical injuries or diseases, straight-through processing has been introduced for adjustment disorder, anxiety disorder and PTSD. Core criteria for inclusion are that the Statement of Principles (SoP) factors, the legislative pre-requisites to establishing a causal link with service, have quantifiable elements, for example, lifting or load-bearing factors.[341]

Expansion of this process to other conditions is under consideration.[342] The streamlining process applies to eight conditions for claims under the VEA, and straight-through processing applies to 32 conditions for claims under the MRCA,[343] making a total of 40 conditions. The advantage of these processes is that it reduces the demanding requirements of seeing and getting reports from medical specialists.

Streamlined processing

Streamlined processing under the MRCA or the VEA can be applied where:

- *There is evidence of defence service;*
- *The claim and/or service records point to at least one applicable factor in the relevant Statement of Principles (SoP); and*
- *The claims assessor is reasonably satisfied on the basis of the totality of information (including relevant diagnostic reports from an appropriately qualified medical practitioner) of a condition's existence.*[344]

The streamlined process has been adopted for certain conditions because most people with relevant service will meet the thresholds required to establish that the claimed condition is causally related to service. The assumption is based on the fact that the conditions accepted for streamlining are the most commonly encountered medical conditions of those who have served in the ADF, and have high acceptance rates. Figures provided since 2015 indicate that the percentage of cases which may not meet the SoP factors for specified conditions which fall within the commonly encountered category is likely to be low.[345]

Straight-through processing

Straight-through processing applies:

- *Where an eligible Australian Defence Force (ADF) client's profile and details of service can be used as evidence of meeting the specified SoP factor for a particular condition without the need for further investigation; and*

[340] Streamlining and Straight-through Processing'.
[341] Streamlining and Straight-through Processing'.
[342] DVA Progress Report, 31 December 2018.
[343] 'Streamlining and Straight-through Processing' Attachment A.
[344] 'Streamlining and Straight-through Processing'.
[345] MRCC Recommendations.

- *The profiles focus on particular conditions and Statements of Principles factors which have quantifiable elements, for example, lifting or load-bearing factors*.[346]

Straight-through processing applies where the known conditions of ADF training and warlike service can be used without the need for further investigation as evidence of meeting a specified SoP factor for a particular condition. Again, the conditions initially approved were all physical conditions. More, recently certain mental health conditions, notably, PTSD, adjustment disorder and anxiety disorder (see recommendation 9) were added to the list.[347]

Where straight-through processing is applicable, claimants will no longer be required to fill out questionnaires detailing their specific service activities, potentially reducing the time taken to assess liability. Straight-through processing thus expedites the investigatory process and is less onerous for clients.[348]

As the DRCA does not test liability against the criteria in Statements of Principles (SoPs), neither scheme applies to claims under that Act.

Suggested legislative change

At the same time, caution is needed relating to the automatic acceptance of initial liability for conditions covered by streamlining or straight-through processing. In effect the processes deem a causal relationship to exist between a claimed condition and service. Deeming is acceptable if the condition meets the legislative criteria. However, if the processes encourage officers to avoid consideration of the minimum legislative criteria the approach is likely to be subject to critical comment by the Administrative Appeals Tribunal, the Federal Courts or the Auditor-General.

The beneficial approach to the interpretation of veterans' legislation would be no answer to any criticism. The adjudicative bodies have indicated that a beneficial approach does not enable decision-makers to ignore legislative criteria where there is no ambiguity or doubt about the meaning.[349] It would be prudent for DVA to add this warning in documentation and training on the processes.

The risk also applies to the policy not to recover an overpayment if a client has been granted interim permanent impairment compensation despite the claimed condition ultimately not having stabilised.

DVA's justification for this approach, apart from the small number of such cases, is that the decision was a 'valid decision at the time it was made'.[350] However, as Deputy President Sosso observed in *Re Thompson and Repatriation Commission* [2018] AATA 4526 at [79]:

> *It is not open to the Tribunal [or DVA], to ignore the mandatory requirements of the SoP [Statement of Principles].*

The Deputy President's remarks referred to medical criteria in a SoP but the warning applies to all the legislative criteria relevant to a particular claim.

A solution to this issue is for the introduction of a waiver provision for these categories of decisions akin to that which applies in the *Social Security Act 1991* (Cth) s 1237AB. That provision permits the

[346] 'Streamlining and Straight-through Processing'.
[347] 'Streamlining and Straight-through Processing', Attachment A.
[348] 'Streamlining and Straight-through Processing'.
[349] The Australian Veterans' Recognition (Putting Veterans and their Families First) Bill 2019 cl 7 requires a 'beneficial interpretation of legislation' to apply only 'where that interpretation is consistent with the purpose of' a provision in any of the VEA, MRCA, or DRCA.
[350] MRCC Submission No: MRCC 48/2017 'Streamlining Interim Permanent Impairment Compensation' [17], [38]; discussion with DVA, 11 December 2018.

Secretary to waive requirements '*in a class of debts'*. The current power of the Commission to waive a debt in s 429 of the MRCA refers to a debt incurred by an individual client, not a category of clients. It would be prudent to seek to extend this provision to cover categories of claims, for example, all streamlined or straight-through processing claims, to avoid potential legal challenges.

Other initiatives

Other initiatives are that the 2016-2017 Budget provided automatic access to health treatment for certain mental health conditions if the veteran has the White Card. Since 1 July 2018, all mental health conditions are included, and from the 2018-2019 Budget, Reservists may also take the benefit of these provisions if they suffer from mental health disorders.[351]

Staff have been briefed on these changes and the revised policy included in the CLIK.[352] Expansion of this process to other conditions is to commence shortly with further advice on the conditions suggested for inclusion to be provided to the MRCC.[353]

Effects of these developments

The Department's improved processes and systems have dramatically reduced claims processing times.[354] The *DVA Annual Report 2017-18* evidenced that:

- the median time taken to process permanent impairment claims under the DRCA has decreased by 48 per cent, from 137 days to 71 days;
- the median time taken to process permanent impairment claims under the MRCA has decreased by 49 per cent, from 152 days to 78 days; and
- the typical time taken to process NLHC [No Liability Health Claims] claims has decreased by 93 per cent, from 18 days to 1.3 days.[355]

Timeliness targets for all compensation and income support claims processing were also achieved in 2017–18.[356]

Conclusion and suggested actions

This recommendation is effectively complete. The increased emphasis on payment of interim permanent impairment compensation when a condition has not stabilised, the clarification that there is no need for a client to complete a D1360 form prior to registration of a claim for incapacity payment or for permanent impairment compensation (see recommendation 3), and the streamlined and straight-through processing of initial liability claims have contributed to speedier payment of compensation.

It would be prudent, however, to extend the waiver power of the Secretary (MRCA s 429) to be amended to provide that it covered deemed presence of criteria for certain categories of claims, for example, all streamlined or straight-through processing claims, and all claims involving payment of interim permanent impairment compensation, to avoid potential legal challenges.

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[351] Productivity Commission Draft Report, 582.

[352] Chapter 5.8 *MRCA Policy Manual*; *Businessline* 'Interim Permanent Impairment (PI) compensation for clients with certain mental health conditions under the *Military Rehabilitation and Compensation Act 2004* (Cth) (MRCA)', 23 November 2017; *Interim Compensation MRCA Permanent Impairment*, training session PowerPoint.

[353] DVA Progress Report, 31 December 2018, 47.

[354] Productivity Commission Draft Report, 366; *Department of Veterans' Affairs Annual Report 2017-2018,* 78.

[355] *Department of Veterans' Affairs Annual report 2017-2018*, 50.

[356] *Department of Veterans' Affairs Annual report 2017-2018*, 50.

Recommendation 18: The provision of more timely incapacity compensation payments for those former members of the ADF incapacitated for service or work by a mental health condition, without the need for a determination that those mental health conditions are related to service.

Mr Bird had been provided with a White Card in October 2015 which provided him with free treatment for his mental health conditions. On 18 May 2016, Mr Bird submitted a claim for initial liability for his mental health conditions, which was accepted on 5 August 2016Mr Bird submitted needs assessments on 27 August and 28 October 2016, where he indicated he was seeking incapacity payments, however a claim was not registered until his advocate lodged the form for incapacity payments on 1 June 2017. A decision to provide incapacity payments was made on 5 July 2017, 35 days from the registration of Mr Bird's claim, but 312 days from the first needs assessment.

The delay was due, in part, to the failure to register Mr Bird's claim until after DVA had received a completed Form 1360, as discussed at recommendation 3. As a consequence, the determination of Mr Bird's incapacity payments did not occur until after his death. The primary causes of that delay have been rectified as indicated in recommendation 3.

This recommendation is for the payment of compensation for mental health conditions for former members of the ADF without the need for the conditions to be related to service.

Veteran payment

The Government has also responded to this issue with the provision of a payment which can be accessed by a veteran who has lodged a claim related to a mental health condition/s and who is unable to work more than 8 hours a week, the situation facing Mr Bird at the time of his death.

In October 2017, the Government announced funding of $16.1 million over four years for this new 'veteran payment' for financially vulnerable veterans claiming mental health conditions.[357] The *Veterans' Affairs Legislation Amendment (Veteran-centric Reforms No 1) Act 2018* (Cth) included provisions for the new veteran payment. This payment became available to veterans and their families from 1 May 2018.

The eligibility criteria are as follows:

- The payment is income and assets tested.
- The veteran must:
    - have made a claim under either the MRCA or the DRCA for the mental health condition
    - not have reached pension age
    - not be able to work for more than eight hours a week, and
    - be assessed for suitability for rehabilitation.

A veteran's partner may also claim. Between April 2018 and December 2018, 508 veteran payments were made to veterans or their partners.[358] DVA has provided face-to-face training of the staff who assess claims on the eligibility criteria for the veteran payment, and via video conference for general Income Support staff and Veterans Access Network (VAN) staff.[359]

[357] *Businessline* 'Veteran Payment', 30 April 2018; *Compensation and Support Policy Library* 'Part 3A Veteran Payment'; *Rehabilitation Policy Library* 3.12 'Veterans Payment'.
[358] 'Veteran Payment Grants by Month to all DVA clients – 2018'.
[359] R&C ISH Virtual Training Classroom Veteran's Payment.

The veteran payment does not require the condition be related to service, so this too aligns with the recommendation.

Other changes pertinent to this recommendation, such as streamlining and straight-through processing have been discussed under recommendation 17.

Conclusion and suggested actions

The provision of non-liability health care for those with mental health conditions, regardless of whether the condition was due to service, the streamlined and straight-forward processing of initial liability claims, including for those with mental health conditions, and the Government's introduction of the veteran payment for those with mental health conditions struggling financially indicate that the intention underpinning this recommendation have been met. For this purpose, the veteran payment is regarded as compensation. There is no need for any further action.

Recommendation 19: Funding for a trial of an independent legal advocacy service to assist veterans with claim preparation and lodgements to enable long-term improvement in the quality of claims and ensure that veterans receive their entitlements with minimum administrative burden.

While the *Joint Inquiry* did not examine the actions of Mr Bird's advocate, the issue of quality advocacy impacts on veterans in general, and also relates to the appeals and review processes to be surmounted if an initial claim is denied.

On 24 October 2017, the Government announced $1.7 million in funding for a scoping study to professionalise veterans' advocacy. This inquiry was undertaken by Mr Robert Cornall AO. A discussion paper for the *Veterans' Advocacy and Support Services Scoping Study* was published in May 2018.[360] Mr Cornall and his team conducted consultations with veterans, other individuals, ex-service organisations and Defence Communities within Australia and in Canada.[361]

The final report was provided to the Department and the Minister in December 2018. The report was publicly released on 13 March 2019, and the findings and recommendations will be the subject of consultation with ex-service organisations, advocates, veterans and other stakeholders. No decisions have been made on the recommendations of the report, and DVA has called for feedback by 30 April 2019.

The appeal and review processes in veterans' matters involve a multi-tiered process. The system of review and appeals in the military compensation area includes internal review, review by the Veterans' Review Board (VRB), followed by review by the Administrative Appeals Tribunal (AAT), and then an appeal to the Federal Court and further to the High Court. The VRB has review functions under the VEA and the MRCA, but not the DRCA.

The tenor of this recommendation assumes that the VRB's review role as a determining body is to continue. That role has traditionally been supported by advocacy assistance to prepare claims provided by ex-service organisations (ESOs) and there has been some underlying concern, evident in this recommendation, about the quality of that support. The Productivity Commission Draft Report noted that 'the lack of coordination among [ESOs] may be diluting their effectiveness'.[362] The Draft

[360] *Veterans' Advocacy and Support Services Scoping Study* Discussion Paper, May 2018.
[361] 'Veterans' Advocacy and Support Services Scoping Study Consultative Program – Current at 8 June 2018'; *Businessline* 'Veterans' Advocacy and Support Services Scoping Study', May 2018.
[362] Productivity Commission Draft Report, Draft Finding 9.6.

Report goes on to recommend removal of the decision-making role of the VRB, limiting its role to 'providing alternative dispute resolution services only' (Draft Recommendations 10.2, 10.3).

Conclusion and suggested actions

DVA commissioned the Cornall Review to consider this issue. The report of the Cornall review has been published and views are being sought on its recommendations. The Report has recommended that a national body be set up to support advocacy services and that the VRB continue in its current form.[363] The Productivity Commission, however, suggested in draft recommendation 10.4 that the VRB should only provide 'alternative dispute resolution services'.[364] Both of these reports are subject to consultation, and this leaves open the possibility of further reflection on this issue.

[363] *Veterans' Advocacy and Support Services Scoping Study, 10.*
[364] Productivity Commission Draft Report, 55.

APPENDIX 1: RECOMMENDATIONS OF THE JOINT INQUIRY INTO THE FACTS SURROUNDING THE MANAGEMENT OF MR JESSE BIRD'S CASE

The report of the *Joint Inquiry* made 19 recommendations to improve the service and experience of veterans, drawing from the learnings of Jesse Bird's case. These recommendations include priority actions to current processes and practices in Department of Veterans' Affairs (DVA) and Veterans and Veterans Families Counselling Service (VVCS) (recommendations 1-9), progressing actions that are already being considered as part of DVA's Veteran Centric Reform program (recommendations 10-17) and changes for Government consideration in the Budget context (recommendations 18-19).

Of the 19 recommendations, the inquiry team identified nine priority actions:

1. The Secretary to examine the areas of potential non-compliance with current legislation and policy to provide the Minister advice regarding any redress action/s.

2. Provide delegates with a clear statement of the policy and processes when considering an interim payment of compensation for permanent impairment to ensure that interim compensation payments are being provided in all cases where appropriate.

3. Put in place controls to ensure process of registration of claims is consistently followed when needs assessment is received and not delayed by other information that is not yet provided.

4. Enhance reporting and risk factor escalation between VVCS and DVA through an offering to clients that includes an 'opt-out' model of information sharing, so that all support services are integrated for clients with diagnosed mental health issues.

5. Put in place controls to ensure that complex case management is initiated for complex or high risk clients.

6. Revise Service Level Agreement Key Performance Indicators for information sharing with partner agencies (such as Defence and the Commonwealth Superannuation Corporation), including timeframes for DVA to request information as soon as possible after claim registration and timeframes for partner agencies to respond.

7. Review existing Service Coordination processes that provide coordinated, tailored and empathetic response to families, for relevancy in the case of the death of non-serving clients.

8. Educate staff and monitor implementation of the inquiry recommendations above.

9. Identify indicators for veterans at-risk to develop best practice case management models.

Of the 19 recommendations, the inquiry team identified the following seven recommendations for DVA to continue as part of its Veteran Centric Reform (VCR) program:

10. Continue to pilot an integrated and holistic case management approach, including a whole-of-person view, a holistic care model for veterans, and an increased focus on transition support and vocational assistance. Subject the evaluation of this trial this will require further consideration by Government.

11. Implement better systems and processes to identify and alert staff in order to support high risk and vulnerable veterans.

12. Put in place wellness checks for uncontactable clients with mental health conditions and trigger additional support mechanisms for clients with mental health conditions who repeatedly submit incomplete documentation or exceed expected response timeframes.

13. Implement action to ensure letters and emails are accurate, easy to understand and appropriate in tone.

14. Implement action to ensure liability and compensation rejection or claim denial correspondence occurs only after a DVA staff member phones to discuss the outcome with a client. This discussion should detail:

a. the nature of the decision or determination;

b. opportunities for the member to appeal the decision, should they wish to;

c. alternative services that DVA can offer;

d. options to defer the decision and revisit at a later stage (e.g. once conditions have stabilised), not implications for recording times taken to process; and

e. DVA point of contact in case further explanation is desired.

15. Expand scope of reviewed circumstances to include services sought through other Government agencies and community services.

16. Introduce a case-response team with specified resources across public affairs, legal, strategic communications, executive and divisions to create a DVA response to emerging issues and messaging that is respectful and supportive in tone.

Of the 19 recommendations, the inquiry team identified three additional recommendations to the Minister for Government to consider:

17. The provision of more timely compensation payment by using a current assessment of the service-related level of permanent impairment, instead of delaying compensation payments until the service-related level of permanent impairment has stabilised.

18. The provision of more timely incapacity compensation payments for those former members of the ADF incapacitated for service or work by a mental health conditions, without the need for a determination that those mental health conditions are related to service.

19. Funding for a trial of an independent legal advocacy service to assist veterans with claim preparation and lodgements to enable long-term improvement in the quality of claims and ensure that veterans receive their entitlements with minimum administrative burden.

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APPENDIX 3: ABBREVIATIONS

AAT	Administrative Appeals Tribunal
ADF	Australian Defence Force
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
APSC	Australian Public Service Commission
CBD	Clients' Benefits Division
CCS	Coordinated Client Support
CDF	Chief of the Defence Force
CFMS	Client Feedback Management System
CLIK	Consolidated Library of Information and Knowledge
CLU	Client Liaison Unit
CMA	contracted medical advisor
CSC	Commonwealth Superannuation Corporation
CSF	Client Support Framework
CTAS	Career Transition Assistance Scheme
CVC	Coordinated Veterans' Care
DDEC	Defence / DVA Executive Committee
DDEIE	Defence / DVA Electronic Information Exchange
DHS	Department of Human Services
DLSC	Defence/DVA Links Steering Committee (DLSC)
DRCA	*Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (Cth)
DVA	Department of Veterans' Affairs
ESO	Ex-service organisation
GARP-M	Guide to Determining Impairment and Compensation
HMA	Healthcare Management Advisors
ICT	Information and communications technology
IL	Initial liability
IPS	Improving Processing Systems
ISH	Integrated Support Hub
JHC	Joint Health Command
JTC	Joint Transition Command
KPI	Key Performance Indicator

MEC	Medical Employment Classification
MOU	Memorandum of Understanding
MRCA	*Military Rehabilitation and Compensation Act 2004* (Cth)
MRCC	Military Rehabilitation and Compensation Commission
NLHC	Non-Liability Health Care
NMHC	National Mental Health Commission
OBAS	On Base Advisory Service
PAB	Portfolio Assurance Branch
PAMT	Provisional Access to Medical Treatment Trial
PC	Productivity Commission
PGPA	*Public Governance, Performance and Accountability Act 2013* (Cth)
PI	Permanent impairment
POI	Proof of identity
PSF	Problem Solving Forum
PTSD	Posttraumatic stress disorder
R&C	Rehabilitation and Compensation
RAMP	Risk Assessment Management Plan
RSL	Returned and Services League
SAM	Single Access Mechanism
SOFP	Special Operations Forces Pilot
SoP	Statement of Principle
SSAT	Social Security Appeals Tribunal
T4E	Transition for Employment
THA	Transition Health Assessment
TTTP	Time taken to process
VAN	Veterans' Access Network
VCR	Veteran Centric Reform
VEA	*Veterans' Entitlements Act 1986* (Cth)
VERA	VVCS Electronic Record Application
VRB	Veterans' Review Board
VVCS	Veterans and Veterans Families Counselling Service
WCD	Weekly Client Discussion

APPENDIX 4: LIST OF CONSULTEES

Gayle Anderson	First Assistant Secretary, Client Engagement & Support Services, DVA
Neil Bayles	Assistant Secretary, Portfolio Assurance, DVA
Karen Bird	Mother of Mr Jesse Bird
Connie Boglis	Ex-partner of Mr Jesse Bird
Luke Brown	Assistant Secretary, Security, Governance & Quality Assurance, DVA
Leanne Cameron	Assistant Secretary, Client Channels & Deputy Commissioner, Queensland, DVA
Bobbi Campbell	First Assistant Secretary, Legal, Assurance & Governance Division, DVA
Natasha Cole	First Assistant Secretary, Clients' Benefits Division, DVA
Liz Cosson	Secretary, DVA
Mark Garrity	A/First Assistant Secretary, Transformation & Organisational Performance, DVA
Major General Natasha Fox	Head People Capability, Defence People Group, Defence
Alison Hale	Assistant Secretary, External & Government Partnerships, DVA
Mark Harrigan	First Assistant Secretary, Business Support Services, DVA
Dr Stephanie Hodson	National Manager, Open Arms
Commodore Paul Kinghorne	DG Veterans' Support, Defence People Group, Defence
Matt McKeon	Assistant Secretary, Portfolio & Transformation, DVA
Adam Nettheim	Head of Scheme Administration, CSC
Vicki Parker	Legal Counsel, Legal Services, DVA
Kate Pope	Director, Clinical Services, Open Arms
Air Vice-Marshal Tracy Smart	Commander Joint Health, Joint Health Command, Defence
Jennifer Veitch	Director, Clinical Services, Open Arms
David Wilton	Senior Manager, Defence Liaison, CSC