**The Australian Peacekeeper & Peacemaker Veterans' Association Incorporated (in Victoria)**

**National Executive**

# Response to the ALP Policy of Veterans' Affairs 2007

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**Appendices:**

AUSTRALIAN PEACEKEEPER & PEACEMAKER VETERANS' ASSOCIATION
**NATIONAL EXECUTIVE**
P.O. BOX 552, TORQUAY, VIC, 3228

(INCORPORATED IN VICTORIA)

ABN 59 558 194 094

**Patron**
**Major General John Pearn AM, KStJ, RFD (Ret'd)**

Telephone & Fax: (03) 5264 8244
Mobile: 0419 355 226
Email: president@peacekeepers.asn.au
Website: www.peacekeepers.asn.au

***Listed Ex-Service Organisation with the Department of Veterans' Affairs ESO Directory***

*Commemorating 60 Years Of Australian Peacekeeping Operations.*

25 January 2008

**Subject: Executive Summary: APPVA Feedback to "Labor's Plan for Veterans' Affairs."**

1. In general the APPVA supports most of the initiatives announced in the Labor's Plan for Veterans' Affairs. We are cautiously optimistic that what has been presented by the Rudd Government will be implemented, and we look forward to being a part of this process in the consultative manner.

2. We highlight the rejection of public listing of Practitioners and the audit of these Practitioners as an unnecessary burden placed on these volunteers. The PM Advisory Council also needs to be carefully considered in relation to the Terms of Reference, the content and the membership. The APPVA would like to see veterans equally represented, without political agenda and without the participation of the National Presidents of the Peak ESOs. In addition, is the selection should be based on excellent communications skills, research and analytical skills and a working knowledge of the three Compensation Acts and COMSUPER.

3. We look forward to changing reforms within the Department of Veterans' Affairs, in order to make the process of a veterans' claim more simplistic, efficient and relatively stress-free. The National Forums that the APPVA has mentioned and made suggestions are an integral process for this smooth operation.

4. The APPVA would also request that the Minister accepts our National younger Veteran Outreach Program and continually funds this project for improved, timely and efficient service to our current and ex-serving members of the ADF and Police Overseas Veterans.

5. The Review of the MRCA is important to us, as is the consideration for changes toward the Legislation to make the Compensation more equitable and commensurate with the contemporary environment that our veterans now serve Australia. We will be seeking the removal of the age, gender and service bias to make the payments a simpler process for the calculation of NEL lump sums and/or pensions. We also call on the Government to remove s206 (SRDP Offsetting) from the MRCA.

*"Looking After Our Own"*

6. The significance of Commemoration and recognition of service holds a very important place for every veteran and Australian. We seek your Government's further commitment toward the recognition of Young Veterans and those who have served on PKO since 1947. This would be in the forms of medallic recognition and supporting the APMPC (PK memorial). We also ask that the Rudd Government formally declare the 14th September as "Australian Peacekeeper Day."

7. The APPVA has a number of other issues outside of this paper that we would like to discuss with you. The APPVA looks forward to a positive working relationship with you and the Department under the Rudd Government.

**P.A Copeland,**
*CBus, Adv Dip Comms Mgt, Dip TAS, Dip FM, Dip Proj Mgt*
National President.

## 1. Background.

1.1. Established on 24th October 1997, the APPVA has been involved in the consultative role to Government, Political Parties and the Australian Defence Force (ADF), since 2002. Whilst relatively new to the Veteran Community, the APPVA has been successful toward many issues, particularly focussing on issues of those concerning reclassification, which are important to our constituents.

1.2. Our constituents cover **war service** in Iraq, Afghanistan, East Timor, Somalia, Cambodia, Rwanda, Gulf War, Bosnia/Herzegovina, and Namibia. In addition, we cover ADF and Police Forces in Peacekeeping Operations (PKO) since 14th September 1947, to the current day. We also assist current and ex-serving members of the ADF, regardless of service. Our constituency for those who have returned from war service; PKO; Humanitarian Operations and other operations is estimated to be over 73,000 veterans.

1.3 We have unfortunately noted throughout the Plan that there is an emphasis on **war service,** not necessarily covering the above operations, which may be misconstrued as the Labor Government not considering a large portion of veterans that do not have war service. There are now three defined types of service, which are: **Peacetime Service (PS), Non-warlike Service (NWLS) and Warlike Service (WLS)**, which is now covered under the VEA and MRCA respectively.

1.4 The APPVA maintains a continued and interactive consultation toward the Government and the ADF and we look forward to this continued consultation with the new Rudd Government.

1.5 Regardless of our fledgling presence, it is felt that the APPVA has a lot to offer and has done so through various National Forums. We believe that we have made an impact for understanding of the Government and ADF into current and ex-serving ADF members, including Police Overseas Veterans.

1.6 The APPVA has reviewed the Labor Plan for Veterans' Affairs and wishes to place comment, in order to undertake a further understanding toward your party and the APPVA as to the issues that are important to our group of veterans.

## 2. Aim.

2.1 The APPVA wishes to provide the Minister of Veterans' Affairs a constructive feedback toward the Labor Plan for Veterans' Affairs, which was used in the Election 2007 (Policy Document).

## 3. General.

3.1 This paper will attempt to address the key issues highlighted in the Election 2007 Policy Document on Veterans' Affairs, herewith known as "The Document". This paper will also attempt to address and raise issues of importance to the APPVA constituency, in order to provide an insight into these issues toward Strategic Planning.

## 4. Ensuring the Department of Veterans' Affairs is efficient and responsive to the needs of the ex-service community.

4.1 The APPVA strongly agrees with the statement that the *"veteran community is changing."*[1] Indeed, it is pleasing to note that the document highlights the diminishing numbers of World War II veterans, and the ageing of Vietnam Veterans. We do note however that there appears to be an emphasis toward war service as a classification of veterans, including the notation of the needs of veterans of Iraq and Afghanistan.

4.2 Whilst we would like to place the needs of these veterans as a matter of importance, there have been well over 73,000 ADF and Police veterans who have deployed on various service on operations since 1947. This is exempt Korea, Malaya, Borneo and South Vietnam conflicts. It is important to place these young veterans into consideration, particularly Post 1975 Veterans. It must be understood that there is an equal attribute to these veterans who have risked their lives, suffered, or paid the supreme sacrifice, in the aim of international peace and security, or who have served at home. I am sure that the exclusion of other veteran groups, in contrast to just **war service** may be an oversight, and it is difficult to mention all of these operations, however we would be prefer to see that we are placed into a category of Post 1975 veterans, rather than segregation.

4.3 We note the figures for claims of Iraq and Afghanistan and have been actively involved with these veterans and afford them the same level of thought to all veterans of our constituency. We are most concerned toward the health of veterans who have served during the period 1991-1996. This group of veterans comprise of operational deployments to Somalia; Rwanda; Cambodia; and other PKOs within Africa and the Middle East.

4.4 To date, it has been very difficult to capture this data from the Department. Perhaps one of the most convincing studies conducted was for those who were aged 45 years and below as to the pathways to care in 2005. This study found that a large number of Younger Veterans do not know what health and mental health services are available to them. This is an area that has been identified by the APPVA as an area of concern.

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[1] *Election 07 Policy Document, Labor's Plan for Veterans' Affairs p.6*

4.5 We agree in the commentary within "*Australia's new veterans*"[2], however the conflicts have and will have serious and significant impact on all of our constituents as we witness increased latency of a number of our veterans of all conflicts and PKO, suffering from a range of illnesses.

## 5. Restoring the value of compensation and entitlements.

5.1 The APPVA strongly supports this initiative. For too long our young veterans and their families have suffered with sub-standard quality of life and below standard lifestyle on the VEA Special Rate. The Veterans' – meaning any service veteran, regardless of where they served[3] , *Service* related or caused conditions must be counted as their sacrifice in making Australia and the world a safer place to live. There is no other profession that provides such sacrifice to themselves and their families. For too long these veterans suffer whilst trying to manage schooling for their children, mortgage payments or rental, and the basic costs of living that so many people are able to afford on above award wages and salaries. TPI/TTI veterans have been denied this opportunity as a result of their service to Australia.

## 6. Temporary Totally Incapacitated (TTI) Young Veterans.

6.1 TTI veterans do not have access to Income Support. Suffice to say that a Young Veteran who is on TTI, with no other income is an arduous outcome, particularly if they are on TTI for a period of two years. On top of this difficult position is that the veteran has a young family, face incredible financial hardship during this period, along with paying the bills. Another problematic area, of which you have correctly recognised, is to have the partners of these TTI veterans access to the War Widow Pension (WWP), in the event of their death.

6.2. There must be a way to address this situation and we seek your Government to resolve this issue with our consultation.

## 7. Increased Non-Economic Loss compensation payments.

7.1 Non-Economic Loss (NEL) does need to remain as a payment for pain, suffering and changes to life. It is thought that this was the reason for the TPI, Special or Immediate Rates, in order to recognise the extreme suffering of a veteran. Notwithstanding, many veterans receive compensation NEL on the General Rate, along with other NEL payments through the Safety Rehabilitation, Compensation Act 1988 (SRCA); and the Military Rehabilitation & Compensation Act 2004 (MRCA).

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[2] *Ibid*

[3] Veterans' – meaning any service veteran, regardless of where they served

7.2 We call on the Rudd Government to not only review the Veteran Entitlement Act 1986 (VEA) NEL (or General Rate (GR)), but also the NEL for SRCA and MRCA. We will elaborate further on the matters of concern with the MRCA.

## 8. Remove the Simpler Super tax hike.

8.1 All of our constituents will be affected by this latest situation with taxation toward our members, particularly those in receipt of the Defence Force Retirement and Death Benefit Fund (DFRDB); and the Military Superannuation Benefit Scheme (MSBS). The previous Howard Government was slow to advise ADF members of the changes not affecting DFRDB members prior to 1 July 2007. This caused unnecessary concern to the members, with Service Chief being very concerned of the potential damage toward the retention of long serving ADF members leaving in droves.

8.2 Simplistically speaking, the APPVA wants to see the same tax benefits for those who retire as those in the Public. In addition, it is believed that retirement pay, be counted as self-funded superannuation and be inclusive of a 10% taxation from the Notional Retirement Age (NRA); Compulsory Retirement Age (CRA) or 20 year service mark and further reduced upon retirement to no taxation.

8.3 Additionally, it should be realised by Government Bureaucrats that DFRDB and/or MSBS are both self funded by ADF members, with Employer contributions, as is the requirement within normal superannuation schemes. Too often there is a repetitive comment that DFRDB and MSBS are provided by the Government. This is totally incorrect, which has placed a great deal of misunderstanding. This point becomes pertinent when we discuss the Special Rate of Disability Pension (SRDP) under the MRCA.

8.4 SRCA also penalises a veteran by the reduction of 5% as a "superannuation levy". Meaning that the Incapacity Payments (IP) or Economic Loss (EL) payments under the SRCA are reduced to balance a normal superannuation contribution. However the 5% value is inexplicably unknown as to which Government Funds the money is placed. Nevertheless, it is an issue that requires consultation and the APPVA is seeking the removal of this unrealistic penalty to veteran's EL under SRCA.

## 9. Release and consult on the Military Superannuation Report.

9.1 We thank the Rudd Government releasing this report on the 24th December 2007. However it does prove that this was not going to be a popular report. The impartiality of the Panel is questioned, along with a number of the recommendations. We look forward to further consultation on this matter.

## 10. Introduce a new National Transport Concessions Scheme.

10.1 This initiative is welcomed; however we would be concerned if say, some concessions are lost in some states to maintain a consistency of these concessions

nationally. As you will be aware, the Transport Concessions are applicable in respective states, which has been recognition by the State Government of the sacrifices of incapacitated veterans past, present and future.

10.2 We would welcome further Transport Concessions, particularly in states that do not provide these valuable concessions.

**11. Increase access to Widow's Benefit for post-retirement marriage.**

11.1 The APPVA supports the rationale of the ALP Policy Document to remove a distinct disadvantage to widows of former servicemen, or vice versa (widowers and former servicewomen). Please note the latter as a contemporary aspect to recipients of the Widow's Benefit to that of both sexes in their relationships.

**12. Provide extra financial support through "Making Ends Meet"**

12.1 The APPVA supports all the Rudd Government points in the provision of various increases to Utilities Allowance; Telephone Allowance; Senior's Internet Fund ($10,000); and Seniors Concession Allowance.

12.2 Whilst the increases and initiatives above are welcomed, it must be highlighted that Younger Veterans significantly use the Internet, along with the use of Telephone lines. We have witnessed great increases in internet and phone billing over a long period of time. This is particularly pertinent to those Younger Veterans who are in receipt of TPI and TTI.

12.3 We seek further increases for Younger Veterans in concessions for internet use (including phones). Younger Veterans are more likely to use these services and it is important that we aim to keep these veterans in touch with other veterans, their families and also maintain an interest.

12.4 Not so obvious is the Younger Veteran who may be in receipt of Intermediate Rate, who would also greatly benefit from these concessions. We view Intermediate Rate as a worthwhile Rate for Younger Veterans, in order to at least have them working up to 20 hours per week. This is good rehabilitation and provides resilience to the veteran in a work environment and is perhaps preferential rather than being in receipt of TPI under the VEA.

12.5 We note that the Concessions and Allowances have deteriorated over a 10-year period for veterans on Intermediate Rate. We strongly suggest that these concessions and allowances are made available to younger veterans, including War Service Pension (if so duly qualified).

12.6 We also suggest that the Senior's Concession Allowance for self-funded retirees be also available to those who have retired from the ADF, who are semi or fully retired on DFRDB or MSBS, at age 55 (CRA).

12.7 We note with interest the Seniors' Internet Fund for ESO with grants of up to $10,000 each to establish free internet connection for their members. We would like to see that the term Seniors' be changed to Veterans under the auspices of your portfolio. This is because the APPVA, along with other ESOs do have younger veteran members. We look forward to further perusal of this fund, and hope that this will be pertinent for younger veterans.

12.8 Another issue for Younger Veterans is the empowerment to home ownership. Currently the Defence Services Home Loan (DSHL) is $25,000. This amount has not been increased since 1973 – a period of erosion of 35 years. The opportunity for home ownership for our veterans is now more important than it ever has. This is due to the rising cost of the Housing Market across Australia.

12.9 The APPVA suggests that the Rudd Government overhaul this inadequate home loan and provide an opportunity for Younger Veterans to obtain a home loan at the Australian Home Median Price Index and continually index this amount, commensurate with market rates. In addition is the provision of Stamp Duty Free access for any veteran, regardless of status. Therefore, access to a loan in today's terms of around $360,000 with discounted interest rates would be the appropriate course of action with this issue.

**13. Healing our veterans both physically and mentally.**

13.1 The APPVA supports this initiative and provides further comment.

13.2 The issue of pharmaceuticals has been a long one and it is hoped that those veterans either on Specific Treatment Entitlement Cards (STEC aka The White Card); or Treatment for All Conditions (aka The Gold Card), are able to have a deteriorating Repatriation Pharmaceutical Benefits Scheme (RPBS), changed to reflect nil expense to those with **service** related conditions for their pharmaceuticals. It would be acknowledged that the Pharmaceutical Allowance may be removed in order to have veterans with their service caused illness (STEC) or all conditions (Gold Card), access to free pharmaceuticals.

13.2.1 The APPVA is also conversant with the procedures for SRCA and MRCA payment of Pharmaceuticals, of which both Acts will pay for any reasonable costs for treatment to the claimant. The Pharmaceuticals under these Acts are paid up-front by the veteran and billed for reimbursement back to the Department.

13.2.2 The problem with 13.2.1 with up-front payment of pharmaceuticals is the problem of having the money to pay for the pharmaceutical bill. It is much preferred that a billing system is established, using the veteran ID number from DVA to invoke an online billing system. This will alleviate the concerns by our veterans of paying up-front, when they do not necessarily have the cash.

13.2.3 The APPVA is aware of a billing or account system established for various clients; however there have been inordinate delays in paying the Pharmacy in a timely manner. We have found that the Pharmacy tends to direct their inquiries to the veteran, rather than the Department. Perhaps an educational program may need to be in place, with confirmed Departmental Procedures to ensure timely payment of these bills, in order to remove the burden off the veteran.

13.3 A concern that has been noted within our membership is attendance on Applied Suicide Intervention Skills Training (ASIST) courses. This for a number of reasons is difficult for younger veterans to participate, particularly as many young veterans are too ill to deal with Suicide Intervention. Therefore, we have identified an area which is difficult to recruit people to attend these courses, along with a reluctance to be involved in Suicide Intervention or prevention. The impact on a person who has failed to intervene or attempt to prevent a person committing suicide would be significant.

13.3.1 Consideration must also be given to Younger Veterans who have families. Most of our veterans are employed and simply do not have the time to dedicate themselves toward this program.

13.3.2 It is also difficult for a Young Veteran who has young children to attend these courses, due to child care arrangements. This is consistent toward a number of programs available from DVA.

13.4 It has been our experience that young veterans who have suicided have done so without any indication of committing the act. Therefore it is very difficult to identify these people who may suicide and there is a preference to leave the counselling to qualified practitioners and utilise the services of the Veterans and Veteran Families Counselling Service (VVCS).

13.4.1 In addition to our experiences there has been a mixed variety of veterans who are married with children and those who are single. The married veterans usually suicide after an irreconcilable difference with the partner. How do we propose to intervene in this situation is made most difficult, as many of these veterans hold these thoughts inside and remain undetectable?

13.5 Another matter is the point of insurance coverage of those APPVA members who participate in Suicide Intervention after the ASIST Course. This concern has been raised by a number of our veterans, which has been unanswered; therefore we are unable to recruit people as a result.

13.6 It is understood that the ADF has initiated a Mental Health Strategy (MHS), and there is further development of the MHS with the Integrated People Support Strategy (IPSS). The IPSS was launched by your predecessor on 27 August 2007 at ADF HQ in Canberra. It would appear that whilst the initiative is sound, there was little policy development.

13.7 In addition to the MHS and IPSS, the Chief of the Army (CA), Lieutenant General Peter Leahy, initiated a Project called "PROJECT AKESA". The Project explored areas of concern for the "hidden wounded", which looked into providing better mental health identification along with peer support. This has further developed and policy is currently being reviewed and re-written. (APPVA Submission Attached.).

13.8 The implementation of the ADF Mental Health 'lifecycle' package appears to offer further enhancement toward the MHS and the IPSS. The APPVA will be hoping to see that ADF members are retained within the ADF system, provided that the full provision of treatment and rehabilitation is conducted. The ADF member should also have ample time to retrain within the ADF, or if the member is unable to retrain, it would therefore be obvious for Medical Discharge.

13.8.1 We note the case of Captain Andrew Paljakka, an Iraq veteran involved in Explosive Ordnance Disposal (EOD), found dead on 27 February 2007, from apparent Suicide. The circumstances surrounding this case are a clear indication that the ADF has yet to be transparent in member's psychological illnesses and treatment strategies.

13.8.2 Whilst the ADF has a very transparent Unit Medical Record documentation system, it appears that the Psychological/Psychiatric documentation system needs to be reviewed and potentially overhauled to provide Unit Medical Officers and other specialists access to the member's Psychological File.

13.8.3 We feel that Captain Paljakka's unfortunate death may have been prevented, had various treatment bodies been made aware of his Psychiatric condition, with appropriate follow-up treatment strategies made for the member.

13.8.4 The APPVA is interested in this case, as it may present flaws within the current ADF Psychiatric Treatment regime that requires a robust overhaul.

*ADF Rehabilitation Policy*

13.9 It should be clear that the ADF member is given ample opportunity for rehabilitation, vocational training, resettlement and a seamless transition into civilian life post ADF. This process should be over a two-year period, and not as we have witnessed over a 3-month period, which is the apparent policy.

*Policy of the Integrated People Support Strategy (IPSS).*

13.10 In line with the IPSS, we are strongly of the belief that OPERATION LIFE should be enhanced to cover this initiative. OPERATION LIFE was launched by your predecessor on 10 September 2007, which encapsulates a large area of well-being initiatives, including Project ASIST. We also want to see an involvement of Police Overseas Veterans with OPERATION LIFE.

13.11 Therefore, we feel that policy should begin to be reviewed, formulated and decided upon the areas of the IPSS and OPERATION LIFE, which should satisfy your Government's Veteran Policy, in line with "Healing our veterans both physically and mentally."

*Veterans' Health Week.*

13.12 The initiative of a Veterans' Health Week is supported and we look forward to consulting and participating in this program. One of the key areas that we will seek with these Health Weeks is to provide Young Veterans with pathways to care, knowledge of treatment programs and advice on contact details of veteran friendly practitioners.

*Younger Veterans in Residential Care (YVIRC).*

13.13 The provision of young veterans with complex care needs has been an area that has required unnecessary delays in our veterans receiving adequate treatment, in particular residential care. The case of Gulf War Veteran Bevan Taylor highlighted this frustration, with a lack of support from DVA, until the APPVA assisted and lobbied the former Minister to rectify the problem.

13.14 There was an inference from DVA that the veteran should seek assistance from the State Government of Victoria. This was an outrageous suggestion, as this veteran is considered a DVA case, not a State Government case as was indicated. A pathway to Younger Veterans in Residential Care needs to be firmly established in all states, with treatment provided under VEA (Defence Housing Act) for TPI; SRCA; and MRCA.

13.15 Whilst it has been proven a success toward the case of Bevan Taylor, who was entitled under the Defence Housing Act of the VEA as a TPI, it was stated by the Department that *SRCA* would not sustain Incapacity Payments (IP), if the veteran was in residential care. This needs to be further explored, as it is an unfair expectation for a veteran to forego compensation entitlements (IP) and support his/her family, whilst in permanent residential care. (A synopsis of Bevan's case is attached).

13.16 In what should be a similar contrast to the SRCA, the APPVA has identified under the MRCA that all reasonable treatment and rehabilitation is available toward the member (veteran). In particular, there does not appear to be any restriction in the definition of Treatment or Rehabilitation that would restrict a young veteran seeking residential care, without having to pay for this treatment out of their compensation or entitlements.

*Deployed Health Surveillance Program (DSHP).*

13.17 Currently, under the auspices of the Centre of Military & Veteran Health (CMVH), a Deployed Health Surveillance Program (DSHP) has been developed. The DSHP has already sampled veterans of East Timor, Bougainville and shortly Solomon Islands. The intention of the DSHP is to continue this Health Surveillance as an ongoing program from the operations in Bougainville (1998) onward.

*Younger Veteran Health Snap-shot – Operations from 1991-1995.*

13.18 Therefore, we ask that the Rudd Government be cognisant of the needs of veterans, who have served on operations from 1991-1995, by a snap shot of the health of these veterans for further analysis.

*Carer Availability.*

13.19 Carer availability and payment needs to also be considered with this initiative. It has been most apparent that young veterans with severe disabilities are struggling to access quality care and the onus has been placed onto the partner or family of the veteran. Respite for these people is very important toward their well-being and the provision of adequate carer assistance is needed to relieve this burden.

13.20 Within the philosophy of OPERATION LIFE, it is suggested that the area of Carer availability may be developed to tend to the needs of younger veterans.

## 14. Caring for the families of veterans.

14.1 As mentioned in the previous paragraph (13.20), there is a substantial burden on families who care for their severely disabled veteran. In addition is the post death situation of the veterans' family. It is acknowledged that Legacy works hard in this area and in current terms, a veteran in receipt of compensation as a result of their service caused condition and COMSUPER, will be able to adequately provide for their family post mortem.

14.2 The APPVA also acknowledges the good work of Legacy, and would also like to highlight the support that is provided by the APPVA and Legacy toward our widows (ers) and families. Care for post mortem of veteran's families is a precious situation and needs to be handled by experienced people. In addition, we have found that families of deceased veterans, at times, want the assistance and support from the veteran's peers and peer ESO. It is important that this is considered when providing care for the families of veterans.

14.3 Concerns would be of those veterans' families that will not necessarily have these benefits, but only VEA entitlements. This is an area that requires further investigation and consultation with the ESO community.

## 15. Conduct of the Vietnam Veterans Family Study.

15.1 The Intergenerational Study for veteran's families was announced by Bruce Billson in 2007. It was noted that Vietnam Veteran Families will be the first to undergo a comprehensive study. Whilst we acknowledge that this is a worthwhile venture, we remind you that the study is meant to continue onto veterans of more recent conflicts and PKO. We would be monitoring this situation to ensure that young veterans are not overlooked in this Intergenerational Study.

15.2 In particular are our concerns for the effects of veterans and their families, who served in Somalia, Rwanda and Cambodia. Anecdotal evidence indicates that there are a large number of psychological illnesses within this group of veterans, along with the incidence of cancer. As a consequential affect of these illnesses is our concern for the wellbeing, not only for the veteran but for their families. We would support that this group of veterans are the next in line to this study, given the degree of time elapsed since 1992-1995.

## 16. Empowering the ex-service community.

*The APPVA National Younger Veteran Outreach Program.*

16.1 *Increase financial assistance for ESO.* The APPVA has implemented the APPVA National Younger Veteran Outreach Program.

16.2 We note, with appreciation of your Government's commitment toward the funding of the BEST and TIP programs within this policy. Since 2006, the APPVA has embarked on a National Younger Veteran Outreach Program, in order to provide quality, professional and timely assistance to our Younger Veteran constituency.

16.3 The APPVA has had great success with this program and it is intended in developing this program further. However, funds will be required from the Government to ensure that the National Younger Veteran Outreach Program is sustainable and is able to develop. We have paid Full Time pensions officers operating in Victoria (Heidelberg Repatriation Hospital & RSL Albury Branch). These 2 officers cover an area of Victoria and Southern NSW. Unfortunately, these pensions/advocate officers are in high demand, with an increasing clientele.

16.4 It is planned that the APPVA will request further funding, in line with the IPSS philosophy of providing continuity toward our current and ex-serving members of the ADF. It is therefore intended to recruit a Pensions/Advocate Officer in Edinburgh S.A.; one in Townsville QLD; and one in Brisbane QLD. These positions will greatly enhance the delivery of pension/welfare and other assistance to those current and ex-serving ADF members.

16.5 A copy of the National Younger Veteran Outreach Program is attached for your perusal and perhaps consideration for further funding. Please note the diminishing volunteer base of practitioners, of which the APPVA has had no choice but to source competent full time employees to fill this shortage.

16.6 Therefore, the intended additional $8 million to support ESO in BEST, along with the one-off capital equipment program of $5 million this financial year will greatly assist the APPVA, however the majority of our funding will need to be toward salary for our full-time practitioners. The TIP program increase of 10 per cent, which will total $3 million, is most welcomed.

16.7 *Establish a Prime Ministerial Advisory Council on Ex-Service matters.*

16.8 The APPVA is supportive toward this move; however we would be insisting that this Council is not dominated by people with secret agendas. The PM Advisory Council, in our humble opinion, would need to have a wide-spread representation of the veteran community; be well-balanced in this representation – by having equal representation from Key ESO groups who have different focus or constituents, rather than an overloading of a particular veteran group; and finally that the representatives selected are **not** National Presidents of any given ESO. The latter will ensure that pre-conceived idealism, agendas and egos do not interfere with sound, competent and timely consultation with the PM.

16.9 It is preferable that the ideal candidate will have excellent communication skills, possess a contemporary knowledge of the issues of the constituent group, and also possess a good working knowledge of the three compensation acts (SRCA, VEA, and MRCA), including COMSUPER (DFRDB, and MSBS). This will ensure that the PM will be provided with accurate information that has been researched, with constructive recommendations. Ideally the candidate will be able to conversely elaborate on these recommendations and/or consultation forums, with accurate knowledge of the subject(s).

16.10 It is suggested that an item for the Terms of Reference for the PM Advisory Council would be to analyse the effectiveness of the processes of DVA. There have been a number of complaints fielded by APPVA, which are of great concern to the veteran and his/her family. On too many occasions complaints have been submitted, with a standard rebuttal from the Department in relation to these complaints. The APPVA suggests that a more involved investigative process is initiated from this Forum, with a view to oversee changes and report any complaints via this Forum.

16.11 *Inquiry into the former F-111 Deseal/Reseal workers.*

16.12 Unfortunately the F-111 Deseal/Reseal workers are continuing to await adequate compensation and acceptance of given conditions under the auspices of the VEA. Whilst it is acknowledged that the former Government made ex-gratia payments to veterans, this matter is far from being resolved. Extra resources are needed to ensure that all recommendations, psychological, medical and physiological conditions are accepted under the Repatriation Medical Authority (RMA).

16.13 We are not after a time consuming investigation of the Howard Government's handling of the matter. We want to see the issues arising from the F-111 Deseal/Reseal study be actively perused, accepted and the veterans compensated appropriately.

16.14 The health of these veterans is deteriorating and to delay active resolution by a Parliamentary Inquiry is only going to frustrate these veterans and their families. It will also delay the appropriate path for compensation that is long overdue.

**17. Improve the operation of the Department of Veterans' Affairs.**

17.1 *Establish an inter-departmental working group to help deal with multiple agencies.*

17.2 The APPVA is mindful of the experiences of our veterans, when they have had to explore and deal with a number of agencies. One of the purposes of the APPVA National Younger Veteran Outreach Program is to alleviate the knowledge gap that our veterans have, particularly in regard to entitlements from a range of departments.

17.3 The compensation process for current and ex-serving members is very complex and needs to be handled by experienced and knowledgeable practitioners. We feel that there is an education gap that could be filled by implementing TIP training courses for eligible practitioners in pensions and welfare areas. This will self empower and educate the veteran community to actively handle a number of inquiries that are not necessarily defined to the Department of Veterans' Affairs.

17.4 We are hopeful that to some degree that the IPSS will alleviate some of these problems. In addition, we are also aware of variations of criteria within cross-Government departments when it comes to assessment and eligibility of various entitlements.

*Commonwealth Superannuation (COMSUPER).*

17.5 One of these areas is COMSUPER, in particular DFRDB and/or MSBS. We note the difficulty of young veterans who are TPI, and who are repeatedly undergoing assessment by COMSUPER to determine suitability and eligibility for COMSUPER Class A, or Class B pensions. To this end, we insist that COMSUPER is cognisant of the requirement for veterans to be TPI or TTI (s24 of the VEA) and to consider these veterans to be permanently Class A, until their TPI ceases or is changed. COMSUPER need to be aware of this impact and need to be cognisant that these veterans are TPI for a good reason. That is that they cannot work more than 8 hours per week and this should be enough to satisfy the COMSUPER criterion for Class A pension.

17.6 Under the same philosophy described in 17.5, consideration must also be given toward Class B pension recipients, who are Intermediate Rate veterans. Again, these veterans are assessed for Intermediate Rate for a good reason, in that they are unable to work more than 20 hours per week. Regular assessments conducted every 3 years by COMSUPER have a severe impact on these veterans. In addition, the amount of anxiety and pressure that is placed on the family unit of these veterans undergoing COMSUPER re-assessment is significant.

*Defence Force Income Support Allowance (DFISA).*

17.7 Problems have arisen from veterans without Qualifying Service (QS), or WLS, in accessing the Defence Force Income Support Allowance (DFISA). It appears that there is great confusion within the Centrelink Client Officers of the knowledge of this allowance. Veterans have approached various Centrelink outlets to apply for the Disability Support Pension (DSP), only to be told that because they are TPI, they do not have access to DSP. There may be variables to this statement, for example the veteran may or may not be in receipt of COMSUPER pension; however there has been a culture of turning these veterans away from applying for the DSP from Centrelink, and hence accessing the DFISA through DVA.

*Other Agencies.*

17.8 Other problematic areas are that once a veteran is out of the ADF, he/she are not aware of the entitlements that they may have access. For example the Family Assistance Office (FAO), Family Tax A (FTA), or Family Tax B (FTB); Centrelink Carer Allowance and/or Payment, Mobility Allowance etc. These entitlements need to be presented to veterans and their families in the form of an educative approach for ESO Practitioners and DVA staff, in order to be able to refer these veterans to these additional entitlements.

*Complaint Resolution.*

17.9 It is also suggested, that rather than concentrate on auditing dedicated veterans with their volunteer work, that an increase in interactive consultation is initiated. As mentioned previously under the PM Advisory Council subject, there have been a number of complaints from veterans that appear to be rebutted, without any formal investigation conducted. Too many times the Department has erred on the side of contractors, rather than taking a serious interest in the wellbeing of the veteran and the seriousness of the complaints made.

*Retention of Current National Veteran Forums.*

17.10 We seek further development with the Department in maintaining the following:

17.10.1 *The National Younger Veteran Consultative Forum (NYVCF).* The NYVCF to concentrate and focus on the issues of veterans of Post 1975, with a view to resolve these issues. Not to provide an information session on behalf of the Department to ESO leaders, but to re-consider the terms of reference to effect the participants are Younger Veterans (Post 1975) and that they are representative of the issues confronted by Younger Veterans in a dynamic context.

17.10.2 *The National Treatment Monitoring Committee (NATMOC).* That NATMOC is also more defined in its approaches and consultation with ESOs. Those complaints are fully investigated and an attempt to rectify identified shortfalls is actively pursued by the Department.

17.10.3 *The National Veteran Mental Health and Wellbeing Forum (NVMHWF).* That the NVMHWF is the Minister's consultative forum to discuss, resolve, analyse and recommend improvement strategies for the wellbeing of our veteran and widow population.

17.10.4 It is suggested that the APPVA has an involvement in the *National Advisory Council (NAC).* The APPVA feels that it is very important for the APPVA to have feedback and input into the ongoing development of the VVCS, particularly as the dynamic and contemporary changes within the veteran community present challenges toward the development of the VVCS. To date the APPVA has been refused participation on the NAC.

17.10.5 Re-instigate the *Operational Working Party (OWP)*. The OWP has not met for a long period of time, some years as a matter of fact. The OWP was viewed by ESO practitioners as a forum to raise complicated matters toward the VEA Legislation. For some reason, in the cut-backs of staff from DVA, this Forum was also axed. The APPVA seeks re-establishment of this important Forum, but to have the Terms of Reference to be inclusive of the VEA, SRCA and MRCA Legislation. This is particularly required in the field of multi-eligibility, as ESO Practitioners across the nation grapple with some difficulty with this challenge. Pathways and better understanding of the three Legislative Acts needs to be developed for simplicity for practitioners and veterans.

17.11 *Time Taken to Process Claims (TTTP).* Since the elected Government has taken office, the APPVA has been aware of a very harsh approach by the Department. The APPVA believes that the problems with TTTP (not only for VEA but for SRCA and MRCA), have been arisen from a number of problematic areas, not necessarily the problem of the Department. Areas identified are the following:

17.11.1 The veteran has been reluctant to attend specialist or GP appointments or has missed these appointments for various reasons.

17.11.2 That the Specialist or GP have taken an inordinate amount of time to action Department reports and assessments.

17.11.3 That Historian Reports appear to take extra time for investigating claims that are made within the Reasonable Hypothesis for Younger Veterans in particular. We feel that DVA Claims Assessors and Delegates simply do not have a wide understanding of the deployment of Younger Veterans, particularly from 1989 onward. To remedy this situation, perhaps ongoing consultation with ESO, along with educational materials provided within the CCPS programs would provide this knowledge to practitioners under the Consolidated Library of Information and Knowledge (CLIK), which is a tool used by both DVA Case Officers and Practitioners.

17.11.4 That there is anecdotal evidence to suggest that many practitioners are only conversant with the VEA and not the SRCA and MRCA. On a number of occasions the APPVA has come across various claims that have been unnecessarily referred to Lawyers, which not only delays the claims but also loses the value of any awarded compensation to the veteran by paying large fees for Solicitors. The APPVA has experienced a great deal of misunderstanding by various ESO practitioners of the multi-eligibility entitlements

available to young veterans and who have subsequently provided poor advice to the veteran in having the veteran claim under the incorrect Legislation. A large number of these practitioners (other than APPVA) are also not aware of the implications and entitlement toward COMSUPER and other Inter-Departmental allowances and entitlements.

17.11.5 That there has been experienced a degree of inconsistency with Case Officers of DVA, as many move on, undergo training and are unavailable on a number of occasions. This promotes anxiety within he veteran as they attempt to seek fast processing of their claims.

17.11.6 That reasons, beyond the control of either veteran, practitioner or Case Officer/Delegates are delayed.

17.11.7 That consistency within ESO of their practitioners vary as many are not well, are TPI and have difficulty in presenting ongoing support to a given veteran with their claim on a regular basis. These practitioners may only avail themselves for a few hours per week, with an increasing workload. Hence the APPVA concept of the National Younger Veteran Outreach Program to alleviate these difficulties.

17.11.8 The processing of claims appears to be a one-way communication between the practitioner and the Claims assessor/Delegate. Decisions have been made on available evidence, when there existed opportunities for the Case Officer to contact the Practitioner in order to identify and source further information and evidence for a given veteran's case. Claims Officers need to be more interactive with ESO Practitioners, in order to ensure that the veteran is given every opportunity to present their case in the Primary Level of the Claims.

17.11.9 The remaining factor is the reduction of staff numbers within DVA, on a premature basis, according to projected decline within the WWII veteran and the War Widow populations. It would appear that there have been no allowances for the introduction of a very complex Legislation (MRCA 2004), of which it would be a preferable approach to have DVA staff numbers increased within MRCA processing, in order to reduce the TTTP on MRCA claims.

17.11.10 SRCA Claims also suffer extraordinary delays, as the Delegates or Case Officers have a preference for Medico-Legal reports from Government Contracted specialists. The decision making process appears to also take a complicated approach, with inappropriate

decisions on the rating of the Whole Person Impairment (WPI), which are normally below the Effects of Lifestyle Tables; Non-Economic Loss Component (NEL) and also with Incapacity Payments (IP).

17.11.11 As for 17.11.10, however when the claimant disagrees with the WPI, NEL or IP decisions, there is a lengthy delay waiting for the Reconsideration phase. It has been our experience that the Reconsideration phase will be upheld by the Director of Appeals. This then necessitates the claimant to apply for a hearing with the Administrative Appeals Tribunal (AAT).

17.11.12 At the AAT, it is common to note that a team of Australian Government Solicitors (AGS) are representing the Government, with on-going advice and decision-making by the Director of Appeals. This is viewed as a Conflict of Interest and non-impartiality, particularly when the Director of Appeals has been involved with the decision-making process within the first step of appeals at the Reconsideration stage. Too often we have encountered claimants buckling under pressure from the methods of the Government at the AAT. We feel that this is a strong denial of Natural Justice and Procedural Fairness.

*Problems now being experienced with ALP TTTP Directive.*

17.12 The APPVA is now experiencing problems in that DVA Case Officers feel under pressure to perform time constraints on each claim and they are referring claims for assessment by specialists to Departmental specialists or contracted specialists. For a veteran who has had a close relationship with their treating and consulting specialist, this places a degree of danger in that the veteran will not have a comprehensive and knowledgeable assessment, in comparison if the veteran had these assessments completed by their consulting specialises.

17.13 A moot point with this is that our veterans are reluctant to be assessed by a stranger and have to tell their whole story over again to someone who will only know them for an hour. This places a degree of stress on the veteran and also does not encapsulate a fair assessment within one hour.

17.14 It is suggested that a thorough appraisal is conducted in order to identify the problematic areas within DVA in these time delays and provide solutions, rather than enforce Key Performance Indicators, or time constraints on Departmental Officers and Delegates.

**18. Establish a public register of ex-service officials and will conduct regular surveys of them.**

18.1 The APPVA is a little mystified with this position of the Rudd Government. Whilst we appreciate that there are veterans who are not actively practicing in pensions and welfare, there appears to be a performance criterion toward this statement.

*Volunteer Practitioners.*

18.2 It should be noted that most practitioners are in fact volunteers and/or TPI and are unable to work. The ability of these practitioners to assist another veteran places a great deal of self-esteem back on the individual and is considered to be therapeutical.

18.3 We note that the practitioners will be placed on a public register. We have concerns with this manner of public scrutiny. Indeed, we would like to see that the Department is able to refer people onto various ESO that hold experience and expertise in a given area.

*Privacy and Confidentiality.*

18.4 To place these people on a register with a view to publish these details online not only breaches privacy and confidentiality concerns of an individual, but places them into a position of not being trusted. Indeed, some of our practitioners have threatened to resign from these duties as they feel they will be "spied" on.

18.5 There is **no need** for public registration of these individuals and the ESO will be in a position to provide the best possible outcome for such enquiries. We suggest that a given ESO is placed on a public register, along with the respective ESOs capabilities, for example, VEA; SRCA; MRCA; DFRDB; and MSBS assistance and Welfare support. That the ESO is capable of assisting Current ADF Members; Ex-serving members; veterans of a particular campaign or group; War Widows(ers); Entitlements and Assistance to Families on the death of a veteran (with varying entitlements); Police Overseas Veterans; Peer Support and other areas pertinent to veteran needs. This suggestion therefore relinquishes the concerns of individual practitioners.

*Annual Survey of Practitioners.*

18.6 It is also a concern that Labor intends to conduct an annual survey of practitioners. Again, we highlight that many of these members are ill and are helping where they are able to comfortably, without such scrutiny from the Government and the public. This is viewed as a step to take-away ownership and empowerment of these individuals within their ESO, by what appears to be micro-management.

18.6.1 An additional note is that Con Sciacca, the ALP Minister for Veterans' Affairs, prior to the Howard Government win into office in 1996, provided an instrument or waiver to allow Practitioners under the VEA, who were unable to work (e.g. TPI), to be able to practice as pensions and welfare officers. The self-esteem returned to these veterans was and is most notable.

18.6.2 The problem facing Younger Veterans, particularly those who are not under the VEA, but more so under the SRCA and MRCA, is that they will be assessed as having the potential to work under the given Legislation. The APPVA seeks the Minister to include this group of veterans to be exempt from any test or deemed ability to work, if they are accredited practitioners under the TIP/BEST programs.

18.7 The APPVA is aware of ESO in various states that appear to be receiving BEST Funds and not expending those funds for the given project that they claim. This is perhaps a matter that the Department may be able to rectify with a new criterion. We are also aware that funds are allocated for a given amount of veterans per state. We feel that there must be consideration toward ESOs who are doing a large portion of claims for various veterans.

18.8 The credibility of ESO who are conducting quality services to veterans should be awarded with ongoing funding and if possible expansion of funds, commensurate with their performance and clientele base. Within the APPVA for example, we are able to account for every dollar spent through audited accounting; periodical reporting of expenditure; quarterly reporting of statistics; project comments and recommendations; and on-going monitoring of the given Project. We feel that this has been adequate in the past and should not be removed in the future.

18.9 The Minister is surely able to receive such feedback within your given portfolio and Departmental Directors, Managers and Subject Matter Experts. The people who have a true indication of such practice within the pensions, welfare and advocacy field are those BEST coordinators that are located in each DVA State Office.

18.10 It may be prudent for the Minister to consider Accreditation toward ESO that deliver these services to veterans. That On-the-Job (OJT) and experience may be needed by an individual under the guidance of an experienced mentor. Perhaps the Accreditation would provide a criterion of which ESO must be able to satisfy and comply for future funding? Accreditation may also be pertinent to the philosophy of Competency Based Training and Assessment, in order to provide further quality controls.

18.11 Therefore, whilst we acknowledge that the Minister may be attempting to seek a quality control measure for practitioners, and accountability of BEST Funds, the APPVA rejects this proposal outright. We suggest a consultative approach with TIP/BEST Practitioners representing ESOs in the states, inclusive of DVA BEST Coordinators, would be the most appropriate course of action.

**19. Establish a DVA Hotline to assist ex-service officials.**

19.1 The APPVA supports this initiative and we are hopeful that the right information is provided to the particular veteran group or individual. Indeed, we feel that ESOs should be published in a DVA publication for Repatriation assistance purposes.

19.1.1 This DVA Hotline should not be used as a filter in order to micro-manage case loads of a given practising ESO. Moreover, this hotline would be best suited to advise clients of the appropriate ESO to seek assistance with their given claim under certain Legislation. Refer to the suggested criterion in 18.5, which provides listed abilities/services of the referred ESO.

19.2 Another moot point is that we have experienced ongoing one-way communication with Case Officers. Encouraging DVA Case Officers to liaise directly with the Veterans' nominated representative will assist the progression of the claim at hand.

19.3 There have been many occasions where the DVA Case Officers have contacted the Claimants directly, requesting various information or evidence, causing confusion between the Practitioner (the Authorised Veteran's Representative), the Department and with the Claimant.

19.4 Closer liaison will alleviate the problem above and it should be a matter of priority that the Practitioner is the single point of contact for the veteran, as long as the practitioner remains the Authorised Representative of the Claimant.

19.5 We view the DVA hotline a good initiative to ensure that quality service is provided to the Claimant.

**20. Examine Military Compensation Arrangements.**

20.1 The APPVA applauds the Rudd Government's promise to rectify a number of complaints relating to the MRCA 2004. The main issues for our constituency is the complexity of the calculation of the rate of pension for Non-Economic Loss (NEL), or Permanent Incapacity (PI) through Lump Sums and/or a combination of Lump Sum and tax-free pension.

20.2 The complexity is through a number of restrictive tiers and calculations. No where in the history of Veteran Entitlements, has the NEL ever been discriminated because of age, sex and service type. The MRCA requires an extensive review in consultation of practising ESO of the MRCA and resolution toward this discrimination. We raise the following issues for consideration:

20.2.1 Age based and adjusted to the lower rate after the age of 25.

20.2.2 Gender biased, in that females will receive more compensation than their male peers.

20.2.3 That a 3-tiered system of the type of service exists. Those on WLS will receive the premium rate for their compensation, where as a service person who obtains the same injury on Peace time Service will receive the lower rate of NEL. This does not fit into a contemporary military compensation system, particularly as veterans of today and tomorrow are career orientated, rather than conscripted into war. There must be a single tier to ensure fairness to all serving and ex-serving members of the ADF.

20.2.4 That the Special Rate of Disability Pension (SRDP), within s206 of the MRCA does not fit into the precedent that has been previously set within the VEA for TPI or Special Rate veterans, where their COMSUPER entitlements do not offset the amount from 100% of the General Rate (GR) to the Special Rate (SR). COMSUPER entitlements will reduce the effective amount of 60%. This is almost $540 of the Special Rate component. A definite disadvantage to the Younger Veteran of today and tomorrow in comparison to his/her predecessors under the VEA.

20.3 The APPVA suggests that this matter is resolved within the OWP, rather than the Inter-Departmental Working Group.

**21. Revisit the Clarke Review.**

21.1 The APPVA welcomes this initiative, however would like to see in addition to the review of the Recommendations of the Veteran Entitlement Review Committee (VERC) aka The Clarke Review, there are a number of non-recommendations that we also seek for review. The Clarke Review disappointed many Younger Veterans, as it appeared to overlook many key issues affecting these veterans.

21.2 A review of the dangers of Peacekeeping Operations is required to ensure that all veterans of PKO are covered adequately. An example of this is Australian UN Military Observers (UNMO) caught in the middle of the Israeli and Lebanese war of 2006. Other Australian UNMO were also in the middle of fierce battles, often with severe danger to themselves. We consider these wars as high levels of incurred danger to these veterans.

21.3 Three of these periods are from the United Nations Truce Supervision Organisation (UNTSO) from 1956 to the present day. Others noted within the VERC as not recommended for review for WLS is Kashmir (United Nations Observer Group in India and Pakistan (UNMOGIP).

21.4 There are a number of other Operations, particularly OPERATION ASTUTE (JTF631) in Timor Leste that, in our opinion should be reclassified to WLS, given the high risk of incurred danger. We also patiently await the reclassification of the Australian Army Training Support Team – East Timor (ATST-EM) from Peacetime Service to WLS, and retrospective force assignment to the United Nations Transitional Administration in East Timor (UNTAET).

## 22. Improve the Transitional Management Service Process.

22.1 We welcome the Rudd Government's pledge to improve the Transitional Management Service (TMS) process. We advise that the previous Government initiated the Integrated People Support Strategy (IPSS), which is to be a "whole of Government approach", toward the discharging processes of ADF members. We remain hopeful that a much better process is afforded to our Service men and women.

22.2 It has been our experience that the TMS falls very short of what we would term as an effective management system for discharging ADF members, particularly those who are being Medically Discharged from the ADF. The ADF terms Medical Discharges as "Notices of Termination". This provides a somewhat gloomy end to one's career in the ADF. We would prefer to see the utmost dedication of the ADF to retrain, retain and rehabilitate these medically unfit members. Medical Discharge (or "Termination"), should be the last measure for an individual.

22.3 The TMS has also been viewed as a "tick and flick" measure toward medically discharging members. Indeed, there appears to be a lack of knowledge of cross or multi-eligibility that the TMS people require to adequately advise discharging members.

22.4 We have also noticed TMS managers approaching young veterans in Psychiatric Wards at the Heidelberg Repatriation Hospital (HRH) in Melbourne, in order to expedite a discharge. We view this as very poor practice, particularly when the veteran concerned has not stabilised from their treatment. The psychological impact during psychiatric treatment is significant.

## 23. Recognising Courage and Sacrifice.

23.1 Commemorations of veteran service remains a significant item, that promotes the service of past, present and future veterans. The Australian Community will be reminded of the courage and sacrifice of our service men and women in all conflicts, PKO and Humanitarian Operations. Particularly service at home, serving the Nation.

23.2 We view Commemorations as an important component of veterans' matters, as the public are educated of the deeds and selfless service of our veterans, which in turn provides support to the treatment of our veterans.

23.3 During the Federal Elections of 2003, the ALP pledged that the Peacekeeping Memorial on ANZAC Avenue should not be paid for by veterans fund raising millions of dollars. Indeed, the then Opposition Spokesman for Veterans' Affairs, Senator Mark Bishop, pledged $1 million toward the National Peacekeeping Memorial on ANZAC Parade.[4]

23.4 The APPVA would like to see a significant commitment by the Rudd Government to assist the Australian Peacekeeping Memorial Project Committee (APMPC), in funding the National Peacekeeping Memorial Project. This project is very important to our constituents, as it provides, after serving on PKO since 1947, that finally National recognition is made by the Australian Government and its people of these veterans who have sacrificed so much for International Peace and Security.

23.5 The APPVA would also ask the Rudd Government to declare the 14th of September every year as "Peacekeeper Day". We have attempted to raise this with the former Government and did not receive the support that we needed. It is time that the service of Australian Peacekeepers are recognised, in similar context to our Canadian and European comrades, as a National military history that all Australians should know and be proud of.

23.6 In relation to the points that have been promised to have resolution the APPVA supports the points listed.

**24. Formation of an Independent Defence Honours and Awards Tribunal.**

24.1 Our constituents feel that medallic recognition is one of the foremost methods of recognising their service and sacrifice, in any given conflict, PKO, or Humanitarian Operations.

24.2 The APPVA supports this initiative of the Rudd Government, in particular toward the establishment of an independent Defence Honours and Awards Tribunal. On too many occasions the APPVA has been fed regurgitated policy on medals, upon submission of reviews. This creates a great deal of helplessness within our constituency, of which they feel that their service is not providing equal recognition in comparison to those who have gone before us.

[4] Discussion between Paul Copeland and Peter Reece, pre-election 2004.

24.3 We note some of the points of the longstanding issues, in particular:

24.3.1 Service during OPERATION SOLACE (Somalia);

24.3.2 Special Air Service – CT duties; and

24.3.3 Peacekeeping Operations since 1975.

*Operational or Campaign Medals.*

24.4 The issue with OPERATION SOLACE is the recognition of a Campaign medal, as result of that Operation's Active Service. The APPVA has been lobbying the previous Government for almost 7 years to commit a Campaign Medal or Operational Medal for Active Service Operations for the following:

24.4.1 OPERATION SOLACE (Somalia) – 1RAR Battalion Group;

24.4.2 OPERATION GEMINI (Cambodia) Australian Contingent to the United Nations Transition Authority in Cambodia (UNTAC);

24.4.3 OPERATION IGUANA (Somalia) Australian Contingent to the Second UN Operation in Somalia (UNOSOM II); and

24.4.4 OPERATION TAMAR (Rwanda) Australian Contingent to the Second UN Assistance Mission in Rwanda (UNAMIR II).

24.4.5 OPERATION TANAGER (East Timor) Australian Contingent to the UN Transitional Assistance to East Timor (UNTAET).

24.4.6 OPERATION CITADEL (East Timor) Australian Contingent to the UN Mission in Support of East Timor (UNMISET).

24.4.7 Gulf War (1991), ADF elements and RAN Ships deployed to the Persian Gulf. (Multinational Forces in Iraq-Kuwait (MNF (I-K)): 1991).

24.5 To distinguish and further provide and comparative explanation for the striking and awarding of Operational medals for those listed in 24.4 the following is presented:

24.5.1 Those who have served Operational service should be entitled to an Operational Medal, as has veterans for example who served in the Korean War, be entitled as such, to place an equilibrium of recognition of warlike service. It is noted that Korean War service by Australians was awarded the UN Medal Clasp KOREA; Commonwealth Korea Campaign Medal and the AASM Clasp KOREA.

24.5.2 The APPVA is suggesting that in order to maintain an equal recognition of such service that service on Operational service be awarded an Operational Medal for that particular Operation.

24.5.3 This is consistent with INTERFET and the Operational Medal struck for that operation, although it was only approximately 4 months long, the INTERFET Medal was awarded in-conjunction with the AASM Clasp EAST TIMOR.

24.5.4 The Proposed Operational Medals for Peacemaking (Chapter VII of the UN Charter) will be unique and adequately recognize those ADF members who have served on a range of Warlike service operations such as Peace Enforcement.

24.6 Other Medal entitlements remain outstanding for the Australian Active Service Medal (AASM) for those who served short periods of time onboard RAN Ships in Somalia (HMA Ships JERVIS BAY & TOBRUK); ADF members deployed to East Timor during the International Force in East Timor (INTERFET); and RAAF C-130 crew Support to the Australian Contingent of the United Nations Transitional Authority Group in Namibia (UNTAG).

*Australian Service Medal.*

24.7 The Australian Service Medal (ASM), appears to be more difficult to be awarded in comparison of the higher award of the AASM. However there are aggrieved constituents who served with the Australian Army Contingent to the Commonwealth Military Force in Rhodesia, now Zimbabwe (CMF-R), who have not been recognised with the Australian Award of the ASM. The ADF Contingent to the South Pacific Peacekeeping Force in Bougainville (SPPKF) also remains not recognised.

24.7.1 The ASM Clasp SPECIAL OPERATIONS, must also be placed into context of covert operations that may have the risk, if compromised, to be undesirable toward the Diplomatic relations of Australia. There are a number of operations that have been conducted over many years that have involved such operations. These are not necessarily those of the SASR and the Submarines. But more of a Strategic view, along with field operations within and outside of Australia. This issue requires further consideration.

*Proposed Australian Peacekeeping Medal.*

24.8 The members of the APPVA and the UN Police Association of Australia (UNPAA) is also seeking the striking of the Australian Peacekeeping Medal. We feel that the service of ADF and Police veterans are long overdue in the aspect of recognising this service appropriately. The striking of an Australian Peacekeeping Medal would ideally be available to those who served on Non-warlike Service PKO. We stress that

this should be only available to ADF and Police members who have served on various PKO since 1947, and **not** awarded to civilians.

24.8.1 The NWLS under the VEA, Schedule 3 particularly states Peacekeeping service as: "Non-Operational Service; Hazardous Service; and Non-warlike Service." Whilst those who served under the VEA, Schedule 2, lists operations as: Allotted for Operational Service; Operational Service; and Warlike Service."

24.8.2 Schedule 2 is also linked to the UN Charter Chapter VII, for more robust Rules of Engagement (ROE) or the Orders for Opening Fire (OFOF); and force protection measures in a Peacemaking or Peace Enforcement Operation in comparison to Schedule 3.

24.8.3 There is also the distinguishing factor of the "Incurred Danger" test, that relates to the threat assessment of belligerents and/or actions or combat operations from a known enemy, between Peacekeeping Operations and Peace Enforcement Operations.

24.8.4 The proposed Australian Peacekeeping Medal will recognize specific service, in hazardous and arduous conditions, as unarmed or lightly armed Peacekeepers and those operations that are listed within Schedule 3 of the VEA.

24.8.5 This is also consistent with the UN Charter Chapter VI, which describes the Rules of Engagement and a diplomatic and cautious approaches toward securing peace and security to the host nation(s).

24.8.6 We want to highlight the unique service rendered by unarmed Peacekeepers in these conditions in some of the most dangerous places in the world. This is certainly not recognising service that is less than those on Operational service. Peacekeeping Service is a special and unique service.

24.8.7 Therefore, we are attempting to recognise the unique service of Peacekeeping Service (Chapter VI of the UN Charter) with the Proposed Australian Peacekeeping Medal for lightly armed or unarmed service, with risk.

*Proposed ADF Overseas Humanitarian Service Medal.*

24.9 The striking of an ADF Overseas Humanitarian Service Medal is also long overdue recognition for those who have deployed on the many Defence Aid to Civil Community (DACC) in the form of humanitarian operations. These Operations were declared disaster zones and the Australian Government responded at the request of the host country for DACC/Humanitarian Aid.

*Counter Terrorist Duties.*

24.10 We note the indication that the SAS CT duties may be presented to this Tribunal. Our thoughts are that if the SAS CT duties are accepted, then wider recognition is also appropriate to those who supported these duties. This should not be restricted to Tactical Assault Groups (TAG) East and West, but to the communications and strategic support provided by Communications and other Specialists organic to HQ Special Forces (now known as Special Operations Command). In addition, it should not only be awarded to the SAS Regiment (SASR), but to Direct Support units and of the latter – TAG East (4RAR Commando (Cdo)).

*Gallantry Awards – D Company 6RAR in the Battle of Long Tan.*

24.11 The APPVA strongly supports the issue of reviewing gallantry awards to the soldiers who fought in the Battle of Long Tan. This matter has been long overdue for particular recognition by the Australian Government. This should also include the awarding of the GRVN Cross of Gallantry Unit Citation with Palm to D Company 6 RAR. In addition, consideration should be given toward the awarding of the ADF Unit Citation for Gallantry (UCG).

*UNESCO Preservation of the Kokoda Track.*

24.12 The APPVA strongly supports the issue of preserving the Kokoda Track. The Track is an integral component of Australia's military history.

*Post Armistice Korean Service Review.*

24.13 The APPVA is supportive toward the Post Armistice Korean Service Review Recommendations; however we believe that establishing a "General Service Medal" for this service is not appropriate. We feel that the incurred danger must be measured to seek periodical assessment whether the service was either WLS or NWLS and recognised as such under the current Australian Awards system. In addition, would be the eligibility of Veterans' Entitlements for these veterans under the VEA.

AUSTRALIAN PEACEKEEPER & PEACEMAKER VETERANS' ASSOCIATION
**NATIONAL EXECUTIVE**
P.O. BOX 552, TORQUAY, VIC, 3228

(INCORPORATED IN VICTORIA)

ABN 59 558 194 094

**Patron**
**Major General John Pearn AM, KStJ, RFD (Ret'd)**

*Member of:*
*The National Veteran Mental Health Forum*
*The National Younger Veteran Consultative Forum*
*The New Military Compensation ESO Working Group*

Telephone: (03) 5261 7332
Mobile: 0419 355 226
Email: president@peacekeepers.asn.au
Website: www.peacekeepers.asn.au
***Listed Ex-Service Organisation with the Department of Veterans' Affairs ESO Directory***

Friday, 12 November 2004

Colonel Paul Appleton,
PROJECT AKESA

**Subject: Australian Peacekeeper & Peacemaker Veterans' Association Response to PROJECT AKESA**

**Background.**

1. The Australian Peacekeeper & Peacemaker Veterans' Association (APPVA) was recently made aware of the Chief of the Army (CA) initiative to develop a strategy to improve personnel support to the serving and former Army members affected by their service. It is noted in particular, that the Army recognises the nature of military service and the potential for soldiers to be exposed to experience traumatic incidents.

2. The APPVA welcomes the opportunity to provide this paper to CA, with a view to provide input from the perspective of members who are no longer serving. However, the APPVA is also cognitive of the circumstances for members currently serving, with particular emphasis on Medical Discharges.

**Aim.**

3. The aim of this paper is to provide the CA with feedback of the circumstances of current and ex-serving members of the army, who have experienced psychological effects or problems, as a result of their service.

**Rehabilitation Strategies.**

4. Appropriate time and resources allocated to **Rehabilitation Strategies**, IAW MRCA 2004. The APPVA considers that the Military Rehabilitation & Compensation Act 2004 (MRCA) will enable an extensive rehabilitation program for soldiers. It is understood; that the ADF is to use a holistic approach, regardless of the Compensation Act or Scheme that a

soldier may be eligible.[1] This process is welcomed by APPVA, as the Rehabilitation will provide a comprehensive rehabilitation plan, giving the soldier adequate recovery strategies.

5. **Retraining** or service transfer is suggested to be an option available to those soldiers who may be unable to continue in their chosen or allocated career path.

6. **Retention avenues** IAW MRCA 2004. Retaining the most important Army Resource: The Soldier. The APPVA considers that the retention of soldiers within the army should be a primary consideration. Taxpayers pay many thousands of dollars in order to train, feed, clothe and accommodate soldiers. In addition are the years of experience and knowledge that money cannot buy. Therefore, it is suggested that there is a public expectation that retention avenues are exhaustively pursued, prior to Medical Discharge of a soldier.

7. **Medical Classification Review**, particularly for those who are capable of being employed in non-combat roles, in order to continue with their military career (without detriment). An example of this is reclassifying Established positions for MEC 2 with potential for MEC 3R, or MEC4.

8. Adequate time and resources toward **Resettlement** of those being Medically Discharged. The idea is to allow the member and his/her family to resettle in the location of choice, allowing time for Job Search, Skills acquisition (appropriate to their Medical Condition), seeking of accommodation and settlement of children in new schools.

9. **Drug Rehabilitation**. The APPVA is fully supportive of a “Zero Drugs Policy” within the ADF. We suggest, however that rehabilitative strategies need to be considered for the retention and treatment of those with problems. It has been noted quite evidently by the APPVA in our work with ex-soldiers, that the problem manifests itself, particularly with those who are self-medicating for masking purposes of Psychosis. A "one only warning system", to enable those who may have psychosis or psychological illness as a result of their service, the opportunity to rehabilitate in a similar fashion to those with Alcohol Abuse problems (The RAAF Richmond "Drunk Tank"). Many young soldiers have been found to be foolish enough to experiment or are socially encouraged to take illicit drugs. This may be interpreted as a life mistake, and given the opportunity to learn from this mistake, the army may retain a soldier that will serve indefinitely. The alternative, with the "No Drugs Policy" is to manifest the problem within the soldier, resettle without appropriate rehabilitation and the potential is for the soldier to be a drug addict outside of the army, having a catastrophic effect to their lives. The opportunity must be available for treatment at the earliest opportunity. See attached paper from R. Kennard.

10. **Self-Esteem**. Self-Esteem is something that can be achieved in many ways. The most significant issues faced by the APPVA for ex serving and current serving members are appropriate recognition of their service. This includes medals, honours, and understanding. There are many areas, which place added stressors to those soldiers who have served and seek appropriate recognition. This includes Re-classification of Operations for Rwanda and ATST-EM to Schedule 2 of the Veterans' Entitlement Act (Warlike or Operational Service). Medals of recognition for Operational Service for those who served in Somalia, East Timor, Cambodia, Namibia, Bosnia-Herzegovina and the Gulf War (1991). Medals of recognition for Peacekeeping Service for those who have served with the UN, MFO, PMG, SPPKF, RAMSI etc. AASM for those who served in Rwanda. ASM for those who served with the

[1] Discussion DG DHS & APPVA 9 Nov 04.

SPPKF, CMF Rhodesia. HOSM for those who served on DACC Relief operations in Irian Jaya, PNG, Vanuatu, Samoa. MUC for those who served in the FCU UNTAC and MSF UNAMIR II. Recognition of Peacekeeping/Peacemaking service in the form of a National Memorial in ANZAC Parade in Canberra. All these are symbolic to a soldier, particularly those who suffer illness/injury from their service to the respective operations. Resolution of these awards would promote a better image for the ADF and the Government providing the veteran with satisfaction of being adequately recognised for his/her service toward world peace and security. In other words the soldier does not dwell on the problem and is able to "move on – or get over it"

11. An awareness of **Operational Stress Injury**. A psychological condition or illness that has been identified by the Canadian Forces, of service personnel who have deployed on various Peacekeeping Operations. This may be an illness that does not fit the exact diagnostic criteria of Post Traumatic Stress Disorder (PTSD) or Depression/Generalised Anxiety Disorders; however it may be a hybrid of a combination of all of these conditions. Notwithstanding, Commanders need to be conversant with the signs and symptoms of such illnesses and be prepared to afford understanding and flexibility toward the soldier. An attached paper authored by Lieutenant Colonel Stephane` Grenier for the Canadian Ministry of National Defence (MND) dated 22 October 2004, is highly recommended reading for the PROJECT AKESA Team.

12. **Allowance for Peer Health strategies during and after service**. For example support groups, health groups, fitness groups etc. One area of interest has been a successful program in the Canadian Forces (CF). Called the Operational Stress Injury Social Support (OSISS) and launched in May 2001, it was developed by serving and retired members of the CF, who themselves suffered from OSI, or other psychological problems.[2]

13. The OSISS Project was mandated by the Canadian Armed Forces Council (AFC) in October 2001. The mandate covered:

a. Create a national peer resource network for members, veterans and their families;

b. Validate the development and education of pre-deployment modules, in consultation with health care professionals; and

c. Take a leading role in developing the methodology to effect an institutional cultural change pertaining to the stigma of operational stress.

14. The OSISS has established many support centres across Canada, working in conjunction with MND and the Canadian Veterans' Affairs (CVA).

**A Suggested Australian Model.**

15. Working in conjunction with the Department of Veterans' Affairs (DVA), the Australian army could conduct a similar project to that of the CF OSISS. Perhaps as a pilot project, initially, the project would be expected to develop nation-wide at most Regional centres and culminate in RAN and RAAF involvement, making it an essentially ADF project.

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[2] Operational Stress Injury Social Support paper, *"A new way to look at an old problem",* Major S. Grenier, 2002.

16. DVA has established centres across Australia in the form of State Offices and Veteran Area Network (VAN) Offices in rural areas. In addition, is the Counselling service (Vietnam Veterans' Counselling Service (VVCS)), which could be potentially used as ADF Peer Social Support Centres (ADFPSSC).

17. Ideally these ADFPSSCs would be staffed by current and ex-serving members, who have themselves, suffered a psychological illness. These people would be active in education in the ADF and Veteran communities, soldier rehabilitation plans and provide the following:

a. Provide interactive social support for ADF members, veterans and their families.

b. Provide assistance and advice in relation to service and veteran entitlements and compensation claims, through qualified ADFSSC Training Information Program (TIP) training and mentoring.

c. Provide consultation with commanders, staff and members.

d. Advise the Chief of the Defence Force (CDF) and the service Chiefs.

e. Consult regularly with DVA, VVCS and the Australian Centre or PTSD (ACPTSD).

f. Provide interactive health programs, well-being programs and fitness programs.

18. The above list is considered to be non-exhaustive and would ideally have a degree of flexibility.

**Suggested Retention Path.**

19. The service of a member, who may not necessarily be able to work Full-Time is suggested to be considered for retention in the General Reserve (GRes). The idea is that most GRes units have an Operational Level of Capability (OLOC) of 6-12 months, therefore a longer activation period, as opposed to Regular Army units. Other areas for GRes service is suggested to be within Training, Logistic and Land Command units within HQs, training and development, project management and logistical support.

20. The suggestion above is deemed to greatly assist the army in the conduct of training and operations, provide personnel by not absorbing Permanent FT positions and provide a skilled, experienced and flexible work force, without substantial loss of tax-payer investment and organisational knowledge and experience.

**Conclusion.**

21. There are many issues that face current and ex-serving members and their families, particularly with the stress of physical or psychological illness or injury. The ability of the army to recognise these issues and resolve them would greatly reduce the anxiety and disillusionment among veterans. The action of the army to be visibly seen as a caring organisation, will not only improve morale, but would have lasting positive consequences for Public Relations and the ability to recruit and retain members, whilst maintaining its operational focus and combat power.

**Recommendations.**

22. The following is recommended by the APPVA:

a. that the issues highlighted in this paper is considered for review in consultation with the APPVA;

b. that the PROJECT AKESA team consider recommendations for an Australian system of peer social support in the form of the suggested Australian Model in this paper.

c. the PROJECT AKESA team consider the concept of personnel retention by Transfer of medically downgraded members to the GRes.

The APPVA thanks the CA and the PROJECT AKESA team for the opportunity to consult and provide feedback for helping *"The Hidden Wounded"*.

**P.A. Copeland,**
CBUS (USQ), Adv Dip Comms Mgt, Dip Proj Mgt (UNE), Dip FM (I), Cert Radio Freq Mgt, MAHRI
**National President**

*"Looking after our own"*

**Attachments:**

1. Drug Policy Proposal – WO1 (R) R.S. Kennard.

2. Operational Stress Injury (OSI) – A new way to look at an Old Problem (Maj S. Grenier Canadian Forces).

3. OSI – A Major Change for the Canadian Forces (CF).

# PROJECT AKESA

1. Let there be no doubt as to the APPVA supporting the Zero tolerance when it come to taking illicit drugs in the ADF. We strongly support the zero tolerance drug stances in the ADF.

2. The APPVA believe that follow up action should be introduced to the same level as Alcohol abuse is currently in the ADF. Alcohol abuse in the ADF at the moment is a period of time in the Drunk Tank at Richmond NSW, then a follow up period, by the RMO.

3. I believe that the same scenario can be given to those that have a drug problem. At the moment they are discharged with out any further action. I believe that a first timer can go through the same scenario and the member should be allocated a case officer once their time in the tank has finished, the case officer should be a member of the members immediate sub unit i.e. a Tp CPL or Tp SGT

4. A period of three months initial testing and case officer involvement should be sufficient to know if the member is going to re offend, with a further three months with the members case officer as final follow up.

5. It is believed that those members that are first timers or experimenters may have served overseas or been involved in a critical incident during their service and are suffering from a form of psychosis and if this the case then the psychosis needs to be treated as well, this treatment could take anywhere up to twelve months.

6. Case officers should be senior CPL of SGT, gone are the days when they would perform this task in a voluntary capacity, therefore it becomes the role of the members superior to ensure that members does not re-offend.

7. The Commanding Officer should not have the direct discharge authority at his call; this should now move to the Career Managers of the members relevant Corps or Service.

8. I guess what I am trying to say here is that whether a member is high on drugs or high on alcohol he still posses the same threat behind a loaded weapon and therefore should be treated the same across the services.

9. Not all members that have been found to offend with drugs will be able to re-establish themselves back into the Military Community, for those members there can only be discharge but that discharge must come only after there has been an attempt to rehabilitate them.

Robert Kennard (WO1 Retired),
APPVA National Secretary &
Veteran Liaison Officer.

# OPERATIONAL STRESS INJURIES (OSI)

## A NEW WAY TO LOOK AT AN OLD PROBLEM

*By: Major Stephane Grenier*

Military organizations have had to deal with the realities of stress induced injuries since the beginning of time. However it is not until 1678, when Johannes Hofer published an article in which he described a disease that afflicted Swiss mercenaries serving in France who exhibited various symptoms described as: dejection, continuing melancholy, incessant thinking of home, disturbed sleep, insomnia, weakness, loss of appetite, anxiety, cardiac palpitations, stupor and fever. Hofer's clear description in medical journals of his day led to the acceptance of "nostalgia" as an ailment that afflicted soldiers during and after conflicts[1].

Since then, a variety of terms have been used to describe the condition that many soldiers develop when exposed to trauma. By the 19th century, physicians were attributing the symptoms of nostalgia to pathological changes in patients' internal organs. Throughout the 20th century, the attitudes towards what were called neuropsychiatric (NP) disorders evolved significantly, but not necessarily for the better. It has even been suggested that treatment given to soldiers with NP symptoms during the Second World War were actually less effective than the treatment provided to soldiers returning from the First World War[2]. Treatment for the ailment evolved and changed over the last century from immediate treatment in proximity to the frontlines, to full evacuation to the rear echelons for those who showed symptoms. At times, forced counseling and electric shock were used on those who were less willing to accept treatment.

It was only in the aftermath of the Vietnam War that medical literature introduced the term Post-Traumatic Stress Disorder (PTSD) when large numbers of veterans reported severe stress-related symptoms after returning home. This new disorder began to appear in the medical literature.

In Canada, members of the military had not been involved in a high intensity conflict since the Korean War until the war on terrorism began and the Canadian Forces sent troops to fight along side the Americans in Afghanistan. That is not to say however, that Canadian soldiers have not suffered the consequences of conflicts around the world. Canadian Forces personnel from all elements have played an important role in practically all of the United Nations and NATO peace missions since the inception of the Lester B. Pearson peacekeeping model.

Over the course of the last decade, our sailors, soldiers, and air personnel have participated in an ever growing and demanding number of military operations around the world. Although they have served Canada with great distinction, this service to world peace and stability has not been without a price. The price of Canadian involvement in peacekeeping and peace support operations has been calculated in

[1] Historical and contemporary interpretation of combat stress reaction – Board of Inquiry – Croatia, Allan D. English, PhD – 26 Oct 1999.

[2] Historical and contemporary interpretation of combat stress reaction – Board of Inquiry – Croatia, Allan D. English, PhD – 26 Oct 1999.

many ways over the years, but none more important than the loss of over 100 Canadian Forces members, during peacekeeping missions alone.

Beyond the official list of casualties however, we can no longer ignore that these operations cost Canada and the Canadian Forces an incalculable and significant amount of wounded service personnel. These casualties are not the victims of stray bullets, land mines or vehicle accidents, but suffer operational stress injuries. Unlike physical wounds, operational stress injuries[3] (OSI) are not outwardly apparent. Often these injuries go unnoticed for months or years by superiors, peers, and in many cases by the injured members themselves. To those who eventually come to realize that they have been injured by operational stress, coming forward for help is not a viable solution due to the negative stigma associated to this type of ailment.

Operational stress injuries such as PTSD translate into very real symptomatic responses which cause various types of difficulties: substance abuse, decreased performance, decreased concentration, family problems, divorce, violent outbursts and even suicide. In many cases, leaders and peers interpret these behavior changes without realizing that these soldiers are in fact affected by an OSI. Those who suffer from OSIs have had their image of fairness or stability of the world so disrupted that they are forced to devote much of their time and energy adjusting to the emotional disturbance this has caused. This struggle alone is believed to be one of the main contributing factors for these reported personality changes occurring after the onset of PTSD. The lack of understanding by the victim's entourage often causes secondary wounding which hinders the recovery process even more.

Veterans Affairs Canada (VAC) conducted a survey in 2000 with 2,700 of its clients serving and retired from the Canadian Forces (CF). Over 70% of the client base responded to the survey. The questionnaire was extensive and included a series of questions designed to reveal the incidence of PTSD. The survey concluded that 15% of respondents presented symptoms consistent with a PTSD diagnosis and an additional 10% presented symptoms that fall short of the diagnosis. Similarly, major depression was also evaluated at 28% during the same survey. This represents the harsh reality of the modern casualties we can expect as we continue to deploy our Forces around the world in the service of global stability. In the future, we must dedicate as much attention to OSIs as we do for physical injuries and look at these injuries in new ways in order to normalize them within the context of military operations.

It has now become obvious that members are not getting the support they need to address this problem. In an attempt to rectify this shortfall, Operational Trauma and Stress Support Centres (OTSSC) were opened in Esquimalt, Edmonton, Ottawa, Valcartier and Halifax in 1999. While this helped address the medical aspect of the problem, it did little to address the socio-cultural environment our members face day to day.

It is a sad reality that most of out members injured by operational stress choose to suffer in silence and in isolation for fear of being shunned and ostracized by their peers and superiors as was clearly demonstrated in the Ombudsman's investigation into the McEachern case[4]. It is now apparent that most members who suffer from OSIs do not receive the support they need to foster a prompt and healthy recovery.

In order to address the non-medical aspects of this problem the Operational Stress Injury Social Support (OSISS) Project was launched in May 2001 by the Associate Deputy Minister Human Resources -

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[3] The term "OSI" is not a medical condition. As defined under the Operational Stress Injury Social Support Project, "OSI" is a new term to be used within a non medical context to generically describe the various types of psychological difficulties and conditions soldiers can develop as a result of military operations. By OSI, we refer to a variety of conditions, which include but not limited to, PTSD, anxiety and depression. The term "OSI" is therefore to be used in this context only and not be interpreted as a diagnosed medical condition.

[4] DND Ombudsman Report – Systemic treatment of Canadian Forces members with PTSD released in February 2002.

Military. Serving and retired members of the CF who have been affected by an OSI have developed this project. It's mission is to establish, develop, and improve social support programs for members, veterans and their families affected by operational stress; and provide education and training in the CF community to create an understanding and acceptance of operational stress injuries. Since the project was launched, it received Armed Forces Council (AFC) endorsement in October 2001 and was given the mandate to:

- Create a national peer support network for members, veterans and their families;
- Validate the development of education and pre-deployment training modules in partnership with health care professionals; and
- Take a leading role in developing the methodology required to effect an institutional cultural change pertaining to the stigma associated with operational stress.

Veterans Affairs Canada agreed to assist the Department of National Defence with the implementation of the OSISS project and it has now become an inter-departmental initiative. The intent of OSISS is to establish the peer support network across the country and, to date, has launched sites in Edmonton, Winnipeg, Petawawa, Newfoundland, Valcartier, Gagetown, Halifax and Esquimalt. Over the next 12 to 16 months, OSISS hopes to launch sites in other communities across the country. Peer support networks are very common in society at large and in many large corporations. OSISS believes that providing support to each other, based on shared experiences, can greatly help and speed up the recovery process. As the Peer Support network continues to evolve, OSISS will begin developing the other components of the project in partnership with health care providers.

The Military has now recognized that it cannot simply ask that those who suffer from an OSI put all their efforts into personal change and personal growth while the Canadian Forces itself does not evolve. As well, it is now understood that creating OTSSCs to increase the ability to treat military personnel while not addressing the larger social support aspects of operational stress injuries is bound for failure in the long term because it incorrectly assumes that soldiers can individually change and survive in an institution that has not evolved.

The Operational Stress Injury Social Support project will hopefully result in a gradual cultural shift in the Canadian Forces charting a new course for it's future. OSISS will not only assist those who suffer from an operational stress injury but also help integrate and support those who suffer from other psycho-societal difficulties that military operations can cause.

## OPERATIONAL STRESS INJURIES – PTSD, ANXIETY, DEPRESSION

## HISTORICAL CONTEXT

Military organizations have had to deal with the realities of stress-induced injuries since the beginning of time. This notion, however, only appeared in the medical literature in 1678 when Johannes Hofer published an article in which he described a disease that afflicted Swiss mercenaries serving in France. His description of the symptoms at the time led to the acceptance of "nostalgia" as an ailment that afflicted soldiers during and after conflicts.

It was only in the aftermath of the Vietnam War that modern medical literature introduced the term Post-Traumatic Stress Disorder (PTSD) when large numbers of veterans reported severe stress-related symptoms after returning from their tour of duty.

Here at home, Canadian soldiers have not been involved in a high intensity conflict since the Korean War. That is not to say, however, that Canadian service personnel have not suffered the consequences of conflicts around the world. Canadian Forces members from all elements have played an important role in practically all of the United Nations and NATO peace missions since the inception of the peacekeeping model. More recently, following the end of the cold war, Canadian Forces' men and women have participated in an ever growing and demanding number of operations around the world.

For well over a decade now, sustained military operations such as peacekeeping, military airlift, humanitarian assistance, and naval military embargoes at sea have placed many of our members in difficult and often dangerous situations. These situations have added additional stresses to an already challenging, demanding and sometimes stressful military career.

Over the years, many have wondered if the mental health injuries our modern military members sustain around the globe on conflict resolution missions are as legitimate and as severe as the ones suffered by soldiers who served in WWII, Korea or Vietnam and more recently, the war in Iraq. This question was researched at the Australian Centre for Posttraumatic Mental Health at the University of Melbourne in Australia. The evidence suggests that deeper psychological injuries may result for some peacekeeper/peacemakers when compared with those who have been exposed to combat. The reasons for this are unclear, but may relate to observing atrocities while being unable to intervene due to restrictive rules of engagement, handling casualties including dead and/or mutilated bodies, maintaining neutrality in the face of provocation, and experiencing professional and social isolation.

## OSI – A MAJOR CHALLENGE FOR THE CF

While Post Traumatic Stress Disorder (PTSD) is a well-known resulting condition of stress and trauma, other conditions, which are as debilitating and serious such as depression and other anxiety disorders, cannot be ignored. In 2001, the Canadian Forces coined a new term "Operational Stress Injuries (OSI)" that regroups all of these conditions and that does not focus on one condition *per se*.

Operational Stress Injury is officially defined as any persistent psychological difficulty resulting from operational duties performed by a CF member. The term OSI is used to describe a broad range of problems, which usually result in impairment in functioning.

Operational Stress Injuries are arguably some of the most complex injuries to deal with as they challenge the CF at many different levels. In addition to being complex medical conditions that can be difficult to diagnose, stabilize and treat, operational stress injuries present serious HR policy and socio-cultural challenges for the CF given that they are conditions, which are not outwardly apparent and obvious like most physical wounds or injuries. Often these injuries go unnoticed for months or years by superiors, peers and in many cases, the victims themselves. It is often the spouse who will first recognize that there is a serious problem. To those who eventually come to realize that they have been injured by operational stress, coming forward for help is often not a viable solution given the stigma they may face and the shame they feel due to the general lack of understanding with the CF and the belief that these injuries are not as legitimate as physical ones.

These conditions translate into very real symptomatic responses and cause various types of difficulties that are visible such as substance abuse, decreased performance, decreased concentration, family problems, divorce, insubordination, violent outbursts of rage and in the extreme even suicide. To most in the military chain of command, however, these are often viewed as administrative or disciplinary problems and are dealt with accordingly. Unfortunately, when OSIs sufferers are punished in this way, secondary wounding occurs and their condition most often deteriorates further. Member's symptoms increase, an opportunity for medical intervention is lost and the vicious cycle perpetuates. Those who suffer from an OSI have had their image of fairness or stability of the world so disrupted that they are forced to devote much of their time and energy to adjust to the emotional disturbance this causes for them. This struggle alone is believed to a contributing factor in the personality changes sometimes observed after the onset of an OSI. The difficulty for the chain of command is to identify those whose mental condition may cause behavioural problems and refer those to clinicians in an attempt to address the root cause, as well as take the necessary disciplinary actions, when appropriate.

## RECENT STATISTICS

Veterans Affairs Canada (VAC) conducted a survey in 2000 with 2,700 of its clients serving and retired from the CF. Over 70% of the client base responded to the survey. The questionnaire was extensive and included a series of questions designed to reveal the incidence of PTSD. The survey concluded that 15% of respondents presented symptoms

consistent with a diagnosis of PTSD and an additional 10% presented symptoms that fell short of that diagnosis. Major depression was also evaluated at 28%.

More recently, the CF Medical Services surveyed its members for the prevalence of PTSD and other Operational Stress Injuries and certain other mental disorders. This study found that 2.8% of the Regular Force and 1.2% of the Reserve Force reported symptoms consistent with a diagnosis of PTSD at some point during the year preceding. Over the course of their lives 7.2% of the Regular Force and 4.7% of the Reserve Force would have met the diagnostic criteria.

In addition to the finding on PTSD, the survey determined that depression and panic disorder were significantly more prevalent in the CF than the civilian population. It is important to note that the survey did not report statistics regarding sub-threshold PTSD that some research has determined is as debilitating as PTSD itself.

**TREATMENT AND MENTAL HEALTH SERVICES**

In addition to mental health services present on every base in Canada, the CF has Operational Trauma and Stress Support Centres (OTSSC's) at five military bases across the country to assist CF members and their families in dealing with the effects of operational stress. These programmes are located at Halifax, Ottawa, Valcartier, Edmonton and Esquimalt.

CF members can also contact the Canadian Forces Member Assistance Program (CFMAP), a 24-hour/7-day a week confidential referral service (1-800-268-7708). This program provides external, short-term counselling for members initially more comfortable in seeking assistance outside the direct military health services.

In July of 2002, the Ministers of National Defence and Veterans Affairs Canada inaugurated the Ste. Anne's National OSI Centre out of the Veterans Affairs Ste. Anne's Hospital. This Centre provides assessment, treatment, prevention and support services to military personnel, Veterans and their families who are suffering from mental health problems related to operational stress and also has limited hospitalization facilities for short-term in-patient care needs. The Centre also plays a role in the national standards for the delivery of care and providing clinical leadership, consulting services for programs, and staff training to VAC's contract agencies that are part of the network and the joint DND/VAC OSISS Peer Support program.

VAC is in the process of opening Operational Stress Injury Clinics around the country similar to the five CF OTSSCs. Currently three clinics have been opened in London, Winnipeg and Quebec. Discussions are currently underway to determine if additional clinics will be opened in other areas of the country such as Fredericton, Calgary and Vancouver.

Both DND and VAC have cooperated and are currently working together to ensure that mental health services offered by the respective departments are harmonized and offered

to both serving members and veterans to address the shortage of mental health staff in many areas of Canada. As well, DND and VAC are working together to standardize the assessment and treatment of Operational Stress Injuries to ensure a more consistent delivery of services while members are serving in the CF and following release.

A great deal of improvement has been achieved over the last five years in the level of care offered to CF members suffering from OSIs. There is little doubt that during the post-cold war period with the sudden and drastic increases in operations around the world and a concurrent reduction in our personnel levels, many of our service members who returned from duty injured may not have received the care they needed. Although there is still much to be done, the situation has improved significantly. It must be noted that Operational Stress Injuries are extremely complex situations that are often resource intensive to treat.

Because the CF can't yet reliably prevent PTSD or other OSIs in those who are traumatized, the best the CF can do at present is to screen people effectively before they go and when they come back and to provide them the very best treatment and support available.

**NEW PROGRAMS**

Under the Rx2000 initiative, the CF's new Deployment Health Section has developed and implemented an "Enhanced Post-deployment Screening Process," which now takes place 3 to 6 months after return from any Special Duty Area. The process consists of the completion by the member of a comprehensive health questionnaire followed by an in-depth interview with a mental health professional. CF members have favourably evaluated this process. Analysis of data collected from Op APOLLO Roto 0 showed that approximately 20% of members who completed this process had further care recommended, in half of those the interviewer identified "major" concerns. Many of the problems uncovered pre-dated the deployment. The interviewers identified "major" concerns about PTSD symptoms in approximately 4% of members; only a minority of these individuals likely had full-blown PTSD.

The Deployment Health Section has also developed, at the request of the CLS, an enhanced pre-deployment screening process for Op ATHENA only. Pilot data from this initiative have shown extremely low rates of endorsement of mental health symptoms in the pre-deployment context.

Among many improvements over the past five years in providing adequate resources to our injured members including those suffering form OSIs, two DND/VAC inter-departmental programs stand out. They are the DND-VAC Centre and the Operational Stress Injury Social Support (OSISS) Program.

The DND-VAC Centre was created in 1999 as an inter-departmental one-stop informational and advocacy organization intended for serving members, veterans and their families. The Centre's mission is to ensure the provision of support services to all military members, who were injured or became ill while serving, and their families. The

Centre's vision is to look after our injured and ill people, support them, and give them confidence in the future by providing information on transition services, casualty administration, vocational rehabilitation and much more.

Based at The Centre is another innovative resource available to serving and former CF members and their families: the Operational Stress Injury Social Support (OSISS) program. OSISS was launched in May 2001 and is specifically designed to address the social support needs of those suffering from an OSI as well as for their families. This ground-breaking, nationwide social support network engages CF members effected by operational stress injuries, such as PTSD, to help develop education and provide social support services (including peer support). OSISS is a long-term program and it is being developed and run by CF members and Veterans of military operations as well as families of members who have experienced an OSI.

In the Fall of 2002, the VAC-DND Mental Health Advisory Committee on Clinical Services was established to build on the well-established partnership between the two departments and provide comprehensive mental health assessment, treatment services and follow-up to all clients whether they are Veterans, still serving CF members or former personnel.

**SHORTFALLS CURRENTLY BEING ADDRESED**

MENTAL HEALTH STIGMA. It has been determined by several sources, including the office of the Ombudsman that the culture of the Canadian Forces has not been acceptant, tolerant or supportive of people suffering from OSIs. This is not surprising given that this is also true of Canadian society in general. One year ago, OSISS began implementing the delivery of educational modules at some CF training establishments. Currently, OSISS is further developing its modules to reach more of the CF population and it is anticipated that by September 2005, OSI briefings will be delivered at every level of leadership development. Furthermore, OSISS has recently started to deliver professional development sessions within units, Bases and Wings and it is hoped that this approach will soon be applied during pre- and post-deployment activities. The aim of the OSISS Attitudinal Change Speakers Bureau is to create a climate of understanding and support for members suffering from OSIs through education.

VAC SERVICES AND PROGRAMS. Over the course of the past several years, VAC has come to realize that many of the services and programs they offer veterans are not suitable or tailored to the new CF veterans. Furthermore, it was realized that the workforce that had been dealing primarily with an aging and elderly veteran population needed to better understand the issues and difficulties that the modern veterans face and more specifically understand the nature of OSIs. As a result, VAC has launched a department-wide modernization initiative looking at all of the existing services and programs in order to make them more relevant to the younger veteran population. It is anticipated that new legislation could be introduced as early as 2005 and that implementation could begin in 2006.

LACK OF IN-PATIENT CARE PROGRAMS. Since the onset of the OSISS program, which assists CF members and veterans suffering from OSIs, it has been established that there is a segment of the OSI population whose degree of illness is such that they are incapable of obtaining appropriate care from currently available resources. The OSISS Program Manager of the OSISS program raised this issue with VAC last March in a letter which requested a better coordination of access to existing In-Patient Treatment programs and that new programs be created to eliminate existing gaps in the health care system. This request is now being considered by a special committee and includes the participation of the OSISS Program Manager. This issue is also on the VAC Modernisation Task Force agenda.

CF HR POLICIES. Over the course of the last several years, some mental health clinicians have raised concerns regarding the lack of time they were given to stabilize and treat victims of OSIs prior to the CF making the decision to release those members. In the opinion of those clinicians complex OSI conditions may require years of treatment prior to someone being capable of fully recovering and returning to normal duties. Although it is accepted that some OSI victims will never recover sufficiently to resume a career in the CF, it is believed that the HR mechanisms need to be reviewed in order to allow for retention of those who have promising prognosis and a chance at a continued career. ADM (HR-Mil) is currently looking at new innovative ways to retain CF members affected by OSIs.

**CONCLUSION**

7. There is no doubt that the post-cold war era has challenged the CF in the area of dealing with CF personnel affected with an OSI in a significant way. Many improvements and changes have been made in the areas of medical treatment and services and programs to assist these members to recover and/or transition out of the CF. VAC has also had to adapt to this reality and has now begun to address the shortfalls for all injured CF veterans. The current level of cooperation between DND and VAC is unprecedented and both continue to strive to ensure that programs and services are adapted and modernized to meet today's needs. There is still much work to be done, but both departments are committed to ensuring that the care of the injured programs is improved and relevant for the 21st Century.

**Prepared by:** LCol S. Grenier DCSA 5, 992-7242
**Date Prepared:** 22 October 2004

# BRIEF ON THE REQUIREMENT FOR AFFORDABLE ATTENDANT CARE ACCOMMODATION FOR YOUNGER VETERANS

In order to outline the full need for affordable/subsidized attendant care accommodation; a relevant case needed to be studied and the permission of that veteran be given to allow the information to be used to provide this brief. I would like to thank Bevan Taylor for allowing the APPVA to use his situation to highlight what is becoming a growing problem in the younger veteran community. Bevan from this point onwards will be referred to as "The Veteran"

## General Outline

A Gulf War 1 TPI veteran had a golf ball sized tumor from removed from his frontal lobe of his brain resulting in a number of complications; Epilepsy, seizures, weather sensitivity and depression. Added to this list of complications was that part of the brain that was removed took away his ability to control his response reaction. Examples of this is that the Veteran may not be able to control anger when dealing with a child and unintentionally harm the child, or have an extreme violent reaction to a relative minor event. Other functions may also have been lost and this will be determined by further testing. The veteran is astute but tires very quickly and his short term memory is severely affected.

The Veteran is 40 years old and is not able to live with his wife and child because of the possible harm he could cause to his family. His son is 2 years old and this was the main influence in the decision to live estranged from his family; the safety of his son.

Advice to date from specialist's assessments is that the veteran is a danger to himself and the public and can not live by himself.

## Financial constraints

As a TPI veteran he is in receipt of a reduced TPI pension and both he and his wife receive the war service pension. As a couple they are not able to sustain a mortgage and the rental accommodation for the veteran to live estranged from his family. The family's home is currently being rented whilst it is up for sale and his wife and child now reside with his wife's mother due to financial constraints. The veteran pays $195.00 per week for an apartment and is heavily reliant on the veteran community to assist him in staying in this self care arrangement. He is heavily reliant on taxis for transport and has the full set of normal bills that go along with maintaining a single person in a unit. He has the added expense of limited cooking capability because of the obvious dangers involved which also raise his individual cost of living.

The veteran's wife is living a very minimalist life style in her mother's home; her mother is financially assisting both the veteran's wife and child to live.

As a couple they are unable to meet their current expenses and are in the process of losing the family home. The veteran is living estranged from the family as cheaply as he can and is still suffering from major financial stress. Welfare assistance from ESO (RSL and the APPVA), is trying to help bridge the gap but is quickly running out.

**Veteran's Accommodation**

The current accommodation for the veteran is unsuitable; there is the immediate danger of harm from seizures and fits. He is unable to properly maintain diet and every time he leaves the house he is endangering both himself and the public. DVA are not able to provide assistance with transport other than to and from medical appointments.

The accommodation that is required is only available from businesses in the private sector. It is not suitable in terms of the tenants that already reside as they are severely disabled and a lot older; however in terms of supervision, meals, washing and social interaction they are the most suitable. This type of accommodation is $440.00 dollars a week with no subsidy available.

**Current Viable solution**

There is no viable solution for this problem today; the accommodation available that is most suitable for the Veteran is outside of the veteran's financial reach. Suitable accommodation is not really available to cater for the veteran's needs if we take into account; mental stimulation, suitable peers, maximum independence and social interaction.

**What is needed?**

Government funded attendant care accommodation needs to be built to cater for younger veterans; it needs to take into account the following:

- The veteran community from ages 18 to 60 years old,
- 24 hour attendant availability to care of the veterans,
- Programs for stimulation appropriate to the age of the veterans,
- Differing levels of independent living,
- Meal preparation or provision of meals,
- Laundry services, and
- Residential or visiting nursing care.

The accommodation also needs to be heavily subsidised. This group of veterans may have children of all ages and are very likely to be the main source of income for their families. As a group they are far more financially vulnerable than the elderly.

**Conclusion**

Attendant care accommodation is very different from aged care. The aged do not have the requirement to put young children through school and have the financial concern of maintaining the family home. Suitable accommodation is not available for younger veterans and private lodges charge well in excess of $400.00 per week. Accommodation needs to be funded and built and should be provided for free.

I would like to personally thank the fantastic efforts of the RSL Victorian Branch and Mick Quinn of the APPVA, for their continual support and guidance toward this veteran and his family. Without this support, the veteran would be in dire consequences.

Paul Copeland,
National President,
The Australian Peacekeeper & Peacemaker Veteran's Association Inc,
P.O. Box 552,
TORQUAY, VIC, 3228
P/F: 03 5264 8244
M: 0419 355 226
E: president@peacekeepers.asn.au
W: www.peacekeepers.asn.au

**Project Proposal:**

**APPVA National Outreach Project**
**BEST Funding Application FY 08/09**

## Background.

1. The Australian Peacekeeper & Peacemaker Veterans' Association Inc (APPVA) has been involved in delivering assistance to veterans for three years across Australian and pre-dominantly in Victoria. The APPVA has assisted ADF and Police veterans of all conflicts and peacetime service, and has evolved to specialize in assisting ADF members with transition from the ADF to civilian life. Whilst providing this assistance it has been evident that the APPVA possesses a degree of expertise in the Medical Discharge system within the APPVA, providing invaluable assistance to exiting ADF members.

2. It has been evident through tours of various regions (interstate) by the National President of the APPVA in 2004-2005, that there exists a requirement to fill a void for Younger Veterans. This void consists of subject matter expertise in the Safety Rehabilitation and Compensation Act 1988 (SRCA); Military Compensation & Rehabilitation Service (MCRS); The Veteran Entitlement Act 1986 (VEA); and more recently the Military Rehabilitation & Compensation Act 2004 (MRCA).

3. Another area of concern is the lack of knowledge that ADF service members have of their veteran entitlements and in many cases, the member, after leaving the ADF has missed out on a number of ADF benefits, along with Veteran entitlements to assist with their transition into civilian life.

4. In the addition to the above is the ability for the APPVA to understand the effects and implications of COMSUPER, namely, the Defence Force Retirement and Death Benefit Scheme (DFRDB) and the Military Superannuation Benefits Scheme (MSBS). This is an important knowledge area, where the APPVA will be able to provide information to the veteran of the complicated veteran entitlement system and the COMSUPER entitlements, in order to provide multi-eligibility information for Young Veterans to make an educated decision of the maximum use and effectiveness of their entitlements.

5. Recently (27th August 2007), the Minister for Veterans' Affairs and the Minister Assisting the Minister for Defence, Bruce Billson, announced a whole of Government approach toward supporting current and ex-serving members of the ADF. This approach is to be known as the Integrated People Support Strategy (IPSS). It is noted that the CDF expects accurate, timely and professional advice to members of the ADF seeking veteran and compensation entitlements, along with adequate support toward families. The APPVA is capable of providing this service.

**Modern Veteran Entitlement Knowledge.**

6. It has become apparent that a large number of Australian ESO specialise in the VEA. To some extent there is knowledge of the MCRS, however there exists limited expertise in the recently legislated MRCA and COMSUPER entitlements. This is not to begrudge those ESO who have provided valuable assistance to veterans for many years. This is to highlight that there is an area that requires immediate and retentive attention, in order to provide adequate assistance to the veteran of today, particularly those who have multi-eligibility and COMSUPER entitlements.

**Sharing Veteran Resources.**

7. The APPVA has been instrumental in the establishment of 2 centres, the Heidelberg Repatriation Veteran Centre (HRVC) in Melbourne, and the Surf Coast Regional Veteran Centre in Torquay. The APPVA now has a paid Full-Time Pension officer servicing Southern NSW, and is based at the Albury RSL Sub-Branch, covering ADF bases in Kapooka, Wagga Wagga, and Bandiana. It is intended to also share resources with the Vietnam Veterans' Association of Australia (VVAA), at the Badcoe building at Edinburgh. This strategy is consistent with the IPSS Pilot program, which is aimed at Fleet Base West (W.A.) and Edinburgh S.A.

8. The APPVA aims to cohesively work with ESO in Australia, in order to promote and foster the needs of Younger Veterans.

**Continuity and Retention.**

9. Currently, the APPVA has experience growth in the area of the provision of assistance to veterans in the primary, review and appeal phases of pensions and welfare. It has been our experience however, that a heavy reliance upon our TPI membership has seen burn out and regression of a number of our members. It is an unfair expectation for the APPVA to rely heavily on TPI volunteers. To exacerbate the matter, many APPVA members are working, or too ill to volunteer. This is contrast to the wider Veteran community where many practitioners have been retired or TPI for some years.

10. Therefore, the APPVA has identified the requirement to provide continuity and retention in the form of paid Full Time or Part Time practitioners to assist in this growing void. These practitioners will be developed over time to provide a professional, efficient and helpful service toward the wider veteran and ADF community.

**Aim.**

11. The aim of this paper is to provide an understanding of a growing need to accommodate Younger Veteran entitlements across Australia, justify the APPVA National Outreach Program and seek support from the Minister of Veterans' Affairs for funding toward this Program.

**Overview.**

12. It is intended to establish cells of APPVA full-time paid and volunteer pension/welfare officers in various regions, prior to the FY 08/09. These Officers will consult widely with the veteran and ADF Communities, establish networks, links, and practice veteran entitlements, delivering high quality assistance to veterans in line with the BEST program. The overview of the proposed plan is to consist of the following:

Townsville: A Committee has been established. The Committee of Management has identified practitioners and has commenced working with North QLD ESO. This is in order to provide a joint effort toward the support of providing Veteran entitlement assistance to a large Permanent Force and Reserve Force in the NQLD region. The region ranges from Rockhampton up to Cape York, covering the many Reserve units, including the RFSU of the 51st Battalion, Royal Queensland Regiment (51FNQR), which consists of a large indigenous population. It is estimated that the NQLD region has around 7,000 ADF members. This includes a large Veteran community. A **Full time paid pension officer position** has been identified to provide consistency and networking with the ADF, veteran and ESO communities.

Brisbane: A Committee of Management has been established, working within the Brisbane area ESO and establishing links with the ADF units located in the area, including Enoggera; Victoria Barracks; RAAF Amberley; and Oakey (Darling Downs Region). A **Part time paid pension officer position** has been identified to provide consistency and diversity within the various veteran Acts, to service a large current and ex-service community in the S.E. QLD region.

NSW: The establishment of a committee of management, along with **one full time paid pension officer**, has been identified in the Southern NSW area. This has been funded from the FY07/08 BEST. Southern NSW holds a significant ADF and Ex-service population that require a wide range of practitioner skills. Discussion has already commenced for the establishment of a joint veteran centre in Sydney, with APPVA involvement. A volunteer Pensions officer currently operates from RAAF Base Richmond. Sydney, similar to the dynamics of Brisbane will potentially require significant development, in order to provide a wide range of expertise of veteran and ADF entitlements.

Adelaide: A committee of management has been established in S.A. There is support from the VVAA for the APPVA to provide a **full-time pensions officer** at the Badcoe building at RAAF Edinburgh. This is consistent with the pilot program site for the IPSS and should compliment the program for further analysis and development. A large ADF community is located within S.A. In particular the raising of a new Mechanised Battle Group (7RAR); expansion of Army units; RAAF Edinburgh; Reserve units; and a small RAN contingent.

Melbourne: An already established **full time paid pension officer** is operating at the Heidelberg Repatriation Hospital (HRH). The HRH is experiencing a large and increasing workload, with a small amount of volunteers. The provision of a full time pension officer has provided great relief to the increased workload in the HRH, whilst allowing the APPVA to also provide practitioner services within a number of ADF bases in Victoria. Victoria has a significant veteran and ex-service population, along with a large ADF population. The provision of the APPVA to assist these service members and veterans will significantly increase assistance toward those people. The APPVA will also assist and work with other ESO with the delivery of BEST functions in Victoria.

National – 1 x **Part Time Paid Administrative Officer** (20 hrs), to provide compliance with VITA Rules, Constitution; VITA Criteria; BEST Guidelines; manage Funds; manage a practitioner database; manage Practitioner records (qualifications, hours, reporting etc); accreditation of APPVA Practitioners; manage personnel with pay, admin and contracts. This is a continuation from funding from FY07/08, of which this Officer is located at the Surf Coast Regional Veteran Centre in Torquay.

**Management of the Outreach Project.**

13 The APPVA National Executive is to manage the establishment of the committees of management throughout Australia, encourage links with regional and state ESO and facilitate joint working environments with these ESO. It is intended to travel twice per year to the various state and regional centres, in order to nurture this posture and provide positive input into the development of the delivery of BEST functionality, inclusive of IPSS feedback to both DVA and ADF.

14. The APPVA National Executive will also provide high level consultation with the Department of Veterans' Affairs, ADF and Police. It is intended to produce strategic networks and links to allow the flow of information down to unit levels within the ADF community and provide an active awareness of the services available toward ADF members and veterans.

15. The APPVA National Executive is to maintain compliance to VITA Rules, regulations and criterion. The APPVA National Executive is to also ensure compliance to BEST funding guidelines and ensure reporting is regularly conducted. The APPVA

National Executive will also provide cohesive links toward ESO and ADF relations in Australia, particularly with the IPSS Pilot Program that has been announced in August 2007.

16. The APPVA National Executive will also assist fledgling state and territory committees with guidance and assist in the Application for BEST Grants. This may be by utilizing the APPVA National accounting system, until the establishment of approved individual state management practices. This will include statistical and quarterly reporting of BEST Activities, audit of accounting practices and regular Committee meetings.

17. For the time being, the National Outreach Program will utilize the guidelines of the APPVA National Constitution, until individual APPVA entities have been established with other ESO, which may involve the use of a Memorandum of Understanding and other policy directives.

18. The APPVA National Executive will also manage the quality of the delivery by APPVA entities of BEST functions toward the ADF and veteran communities by annual National BEST Conferences in order to provide information feeds to committees and practitioners, develop Operating Procedures and to provide interactive feedback as to the effectiveness of the Project. The National Executive will use this feedback to advise TIP/BEST committees accordingly, along with Operational matters of VEA, SRCA and MRCA at the national level.

**Summary.**

19. The proposed APPVA National Outreach Project has been identified after careful consideration and fact finding missions conducted by the National President of the APPVA. It is most apparent that the ADF and ex-service communities, in particular Younger Veterans need to have an awareness of entitlements and welfare assistance, along with ADF Discharge entitlements. It is intended that the APPVA will provide an interactive joint working approach toward the rectification of this anomaly, particularly as the MRCA continues to grow by demand.

20. The APPVA is enthusiastic in taking a leading role, in conjunction with other ESO, with the implementation of State and Regional cells and the employment of pension officers to provide consistency and professional approaches, particularly with the IPSS.

**Contact Officer: Paul Copeland, National President**
**Australian Peacekeeper and Peacemaker Veterans' Association Inc.**

AUSTRALIAN PEACEKEEPER & PEACEMAKER VETERANS' ASSOCIATION
**NATIONAL EXECUTIVE**
P.O. BOX 552, TORQUAY, VIC, 3228

(INCORPORATED IN VICTORIA)

ABN 59 558 194 094

**Patron**
**Major General John Pearn AM, KStJ, RFD (Ret'd)**

*Member of:*
*The Australian Veteran & Defence Service Council (AVADSC)*
*The National Younger Veteran Consultative Forum*
*The New Military Compensation ESO Working Group*

Telephone: (03) 5261 7332
Mobile: 0419 355 226
Email: president@peacekeepers.asn.au
Website: www.peacekeepers.asn.au
***Listed Ex-Service Organisation with the Department of Veterans' Affairs ESO Directory***

Saturday, 17th March 2007

**Subject: Special Rate Disability Pension Offsetting against COMSUPER Pensions.**

The Special Rate Disability Pension (SRDP) will be offset 60 cents to each dollar of received COMSUPER Pension (either Invalidity or Retirement), under the Military Rehabilitation & Compensation Act 2004 (*MRCA), s204(5) &(6).*

Having studied the COMSUPER Home pages (www.comsuper.gov.au) and gleaning information in support of the Australian Peacekeeper & Peacemaker Veterans' Association (APPVA) contention, that the SRDP, or "Safety Net", under the MRCA is unfair and reduces the prospective veterans' income for life.

To support the above comment, I offer you the following for rationale:

1. **DFRDB.** The scheme ceased to new ADF members in 1991. The provisions of the Scheme are complex, however some principle provisions are:

   a. Contributions by members are at 5.5% of salary.

   b. Invalidity benefits.

   c. Redundancy or Retrenchment benefits.

   d. Death Benefits.

   e. Commutation of Lump Sum.

   f. Pensions paid for life.

2. **MSBS.** The MSBS scheme is compulsory for all members of the ADF since 1991. A copy of the MSBS Investment Performance is attached to this paper.

*"Looking After Our Own"*

a. Member Contributions are at 5%, with increase available as an option to members at 1% increments, to a maximum of 10% of salary. The Member Component of the MSBS Structure is Member Contributions plus accumulated earnings on the contributions.

b. Employer Contributions consists of a defined benefit equal to Total Accrued Multiple X Final Average Salary over a period of three (3) years (FAS 3).

c. 3% Benefit is Employer contribution of 3% of salary less 15% employer contribution tax together with accumulated earnings. The 3% forms part of the employer component.

The member contributions from DFRDB are deposited into the Commonwealth Consolidated Revenue Fund (CRF), and is paid after the member retires after 20 years service (15 years if enlisted at 40 years of age), upon invalidity or to the family of the member on death. The CRF is not a wealth created or invested fund and it is used by the Commonwealth as necessary by the Department of Finance. The DFRDB is more or less a deal that was made with the ADF that service and contributions and retirement will provide generous benefits to those members of the DFRDB, who would be enticed to stay in the ADF for 20 years. One would say an excellent personnel retainer, given today's competitive job market and falling ADF member retention.

The member contributions of MSBS however, are placed into a very different situation that those in DFRDB. The MSBS member contributions are governed by a Trust Deed and rules set out the full membership, contributions and benefits of the *MSBS Act 1991*. Therefore, in contrast to DFRDB, which is Legislation, the MSBS Trust is able to change Rules and conditions, as has been witnessed in the past. The Member Contributions of MSBS are invested by the Trust into Global Share markets and other investment strategies, similar to investment strategies for other Superannuation and Investment entities in Australia.

If a loss is recorded for MSBS, then the Member's fund will suffer that loss. For example from FY 01/02, the MSBS Fund earned -8.7%, in FY 02/03, the MSBS Fund earned -2.0%, as a result of market pressures. In contrast to DFRDB, the Fund did not lose its base, as it is CPI indexed, whereas the MSBS fund is not CPI. Another consideration to note is that the Public Sector Superannuation Scheme (PSS) is legislated to not provide losses for its contributing members in accordance in with the legislation. So, when MSBS members lost -8.7% in FY 01/02, PSS remained on 0% earnings, as the loss below 0% is legislated to be provided by the Government. Hence, the Government does not provide this safety measure to the MSBS Fund, which any loss is borne by the Contributing members and the superannuants of the Scheme.

The relevance of the above comparisons of schemes is deemed necessary to understand how the member's contributions are not counted by the Government in the case of Offsetting IAW *s204 (5) & (6) of the MRCA 2004*. The Government has stated in its reasons behind this Offsetting Provision, is that the COMSUPER Pensions are solely provided by the Government, and therefore constitutes ***"Double Dipping"*** of entitlements to entitled members. This is because the Government provides a Non-Economic Loss payment/pension of the SRDP, and believes the veteran in receipt of COMSUPER is taking double payment.

MSBS members who elect to take the Safety Net of the *MRCA, Chapter 4 Part 6,* will be fundamentally disadvantaged, as the Government has stated that they also fund the Superannuation. This is not exactly correct, as the Member Contributions are invested by the MSBS Board, is market reactive and market dependant. The Government Contributions

(Employer Contributions) are as a result of Superannuation Guarantee Legislation, in which they are obliged to contribute to its employee's superannuation, as much as the employee him/herself.

The SRDP is to be calculated using the current Totally & Permanently Incapacitated (TPI) Special Rate (SR) of pension under the *Veterans' Entitlement Act 1986 (VEA)*. Within the *VEA*, it does not appear to breakdown SR from 100% of General Rate up to the Special Rate as an earnings loss. In Clarke, SR was described as Non-Economic Loss (NEL) for loss of function, Lifestyle effects, pain and suffering.

Economic Loss (EL) is deemed to be income lost, due to the inability to work – therefore veterans with Qualifying Service (QS) are entitled to War Service Pension (WSP), which is Income Support Supplement (ISS) to assist veterans to achieve a quality of life. Those veterans without QS do not have ISS; however the Government has initiated the Defence Force Income Support Allowance (DFISA), in order to provide a form of ISS to veterans under Schedule 3 (Non-warlike or Peacetime service) of the VEA. DFISA is provided after application by the veteran to Centrelink for the Disability Support Pension (DSP), which reimburses the amount of SRDP loss when the DSP is means and assets tested.

Regardless, the EL or Superannuation is Income and Assets tested, in which the ISS is reduced according to Assets and Income that the veteran holds.

Therefore, the veteran will be hit twice with offsetting in the form of *s204 (6) (Offsets)*, which will be the reduction of the SR value by 60 cents in the dollar **and** having their COMSUPER reduced in the means and assets testing of WSP, or Disability Support Pension (DSP)/.DFISA.

**SR under the VEA is not reduced because of income received from COMSUPER.**

Therefore, in consideration of the above, a veteran who is Severely Incapacitated as a result of their service on or after 1 July 2004, who elect the Safety Net Provisions under the *MRCA Chapter 4 Part 6*, will be significantly disadvantaged, in comparison to a TPI veteran under the VEA.

The offsetting provisions of MRCA under the election to choose the option of the SRDP *(Chapter 4 Part 6*), with severe penalty for receiving either or both a pension or lump sum under a Commonwealth Superannuation (COMSUPER) scheme as a result of the retirement under *s204 (Offsets) (5) & (6)* is considered unfair and harsh. It is also noted that further reduction may be inflicted if the person has retired voluntarily, or has been compulsorily retired, from his or her work, under *s204 (5) (a)* of the MRCA. This is seen as a brutal reduction to a given veteran under the MRCA. Under the VEA and/or SRCA (if the member has dual eligibility or not), the Special Rate of pension and/or Lump sum Permanent Impairment (PI) is **not offset** as for *s204 of MRCA*.

This is an anomaly that requires rectification to make the SRDP a viable option for those who are in receipt of COMSUPER pensions or lump sums and wish to make the election toward an attractive option within the MRCA, and provide a reasonable quality of life for a veteran.

***(Signed)***

**P.A. Copeland,**
CBUS (USQ), Adv Dip Comms Mgt, Dip Proj Mgt (UNE), Dip WAT (RMIT), Dip FM (I), Cert Radio Freq Mgt,
**National President**