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

Also caring for veterans of Iraq, Afghanistan and Peacetime Service

Commemorating 60 Years of Australian Peacekeeping Operations

Sunday, 6 April 2008

Colonel Stephan Rudzki, AM,
Director Occupational Health & Safety – Army,
R8-2,
Department of Defence,
Russell Offices,
CANBERRA, ACT, 2600

Subject: APPVA Paper of Problematic Areas of Medically Discharged Soldiers.

Dear Sir:

This letter covers a paper that has been authored by WO1 Michael Quinn, who is an Inactive Reservist located at the Heidelberg Repatriation Hospital Veteran Centre in Melbourne.

This paper has been authored at your request, in order to provide the Army Chain of Command information as to the problems being experienced by soldiers during their Transition due to Medical Reclassification.

In context to the attached document, it is felt that there is a justification for a uniformed members dedicated to the members of the Army to enable smooth transitions. This paper highlights three Case Studies, of which many more exist. The names have been withheld, however are able to release if required.

It is also important to emphasise that these cases are similar to many that have been handled by the APPVA. Clearly, there is room for improvement within Service and DVA Policy. It is hoped that the Integrated People Support Strategy (IPSS), launched on 15 August 2007, may include the recommendations made by this association.

Yours Sincerely,

P.A. Copeland,
CBus, Adv Dip Comms Mgt, Dip Proj Mgt, Dip FM, Dip TAS, TAA40104
National President.

"Looking After Our Own"

Problems within the Army when

Injured Soldiers Discharge or are

Medically Discharged

By

Warrant Officer Class One Michael Quinn

-Table of Contents-

Executive Summary

Army has a growing problem of the mismanagement of injured soldiers separating from the army without acceptance of liability for service caused injuries. To add to this problem the transition of army personnel who are injured to the point of a medical discharge are not being handed over to the Department of Veterans Affairs for ongoing management with acceptance of liability.

The current system for handling an injured soldier on transfer to the Inactive Army Reserve or medical discharge is very complex and is failing in the majority of cases. Soldiers are missing out on entitlements and acceptance of liability for service caused injuries. This is because the legislation has become so complex that it has become difficult to gain professional case management over the multitude of acts.

Current serving soldiers in the majority of cases are covered by 3 different legislations for compensation and rehabilitation and 2 differing superannuation schemes. Families are being put under financial hardship as the confusion of all entitlements is not being finalized until long after discharge. Those soldiers being discharged with psychological conditions are having their conditions worsened due to discharge with no acceptance of liability, medical treatment or income.

Consideration has to be given by Army to set up an advocacy cell to ensure the correct entitlements are obtained by the relevant compensation and rehabilitation scheme. Transition management of injured soldiers over to the Department of Veterans Affairs needs to be seamless to provide the appropriate level of medical care and compensation.

Failure to implement a system that looks after an injured soldier on discharge will have a significant effect on the family and friends of that soldier. The number of soldiers affected by the current system who have deployed on current operations in Timor, Solomon Islands, Iraq and Afghanistan continue to grow. Multiple deployments are becoming more common than periods of peacetime operations; the army needs to provide for the needs of the men and women who are injured.

It is proposed that an advocacy cell be set up within army to ensure that the army looks after their injured personnel and ensure a people first approach that will enhance capability and public perception. The men and women that have served Australia deserve this level of care. The Army needs to be seen doing the right thing by injured personnel.

PROBLEMS THAT EXIST WITH INJURED DEFENCE PERSONAL LEAVING SERVICE

Aim

1. To provide a briefing on the short falls that exist within army for injured soldiers and those who are being medically discharged. This brief does not target any programmes or departments but is more aimed at the gaps that exist in the current way injured soldiers and medically discharged army personnel transit from the military over to the care of the Department of Veterans' Affairs. Each of the following issues will be addressed:

    a. Transition Management System (TMS);

    b. Australian Defence Force Rehabilitation Plan (ADFRP);

    c. Integrated People Support Strategy (IPSS);

    d. The problems that current serving soldiers face with multi eligibility of rehabilitation and compensations acts being the (Veterans Entitlement Act 1986 (VEA1986), Safety Compensation and Rehabilitation Act 1988 (SCRA) and the Military Rehabilitation and Compensation Act 2004 (MRCA 2004);

    e. COMSUPER for both DFRDB and MSBS and the medical classification at discharge and the offsetting complications and decisions that soldiers under medical discharge are faced with when this is combined with Compensation and Rehabilitation elections;

    f. The handover of injured solders to the Department of Veterans' Affairs (DVA) after discharge;

    g. Shortage of suitably qualified practitioners to assist current serving members in the complex arena of multi eligibility; and

    h. Soldiers falling victim to high priced law firms.

Background and knowledge base of the writer

2. I served in the Army for 21 years as a communicator and transferred over to the Inactive Reserve (IAR) in 2002 at the rank of WO1. During my period of service and the nature of my work in the Royal Australian Corps of Signals (RASigs), I have been employed in; tri service environments, within most Corps in the army and nearly every environment that the army employs soldiers. I have also served on operational warlike service. I served for 2 years as a Career Manager when the army was going through the process of discharging soldiers that were not

deployable and the introduction of AIRN. On completion of my time as a Career Manager in RASigs, I worked as the Trade supervisor of ECN 266 at the Defence Force School of Signals and after giving notice of transfer to the IAR, I spent 12 months in 138 Sig Sqn which at that time had 60% of it's soldiers under medical discharge action and medical waivers; my primary role in this unit was as resettlement officer which was secondary to the role of Communications Manager.

3. I assisted my wife through a medical discharge after 17 years of service and after finding little or no expertise in the area of multi eligibility in the Ex Service Organisations, I became self taught on the 2 relevant compensation acts at the time (SRCA 1988) and (VEA 1986) along with COMSUPER invalidity assessments under DFRDB and MSBS. I later gained the non accredited qualifications through the Training Information Program (TIP), which is a program funded by The Department of Veterans' Affairs, aimed at training selected practitioners in the field of veteran support in rehabilitation, compensation and welfare.

4. For the past 2 years I have been employed by the Australian Peacekeeper & Peacemaker Veterans' Association (APPVA) as a Pension Officer and Advocate. I am qualified under the TIP programme under the SRCA, VEA1986 and MRCA2004 and been deemed competent to Advocate level 3. During this employment period I have only dealt with cases involving post 1975 veterans, current serving and ex-serving ADF members. I have handled approximately 700 claims over this period and have assisted many soldiers through the complex process of; being medically discharged, acceptance of liability, permanent impairment, medical services, rehabilitation and repatriation. I assisted the Victorian TIP training group in the development of the MRCA 2004 advanced course (Level 2) through consultation which is now being delivered as current training.

5. As part of my work for the APPVA I represent on a number of forums concerning younger veterans' entitlement issues and have provided presentations to promotion courses, unit induction training and resettlement seminars.

6. My office is located at the Heidelberg Repatriation Hospital, Melbourne, and a large percentage of my cases have involved current and ex-serving ADF psychiatric patients. I have kept abreast of the development of Transition and other changes within the ADF and have first hand experience in handling soldiers, sailors and airmen/airwomen with broken bodies and minds both in and post service.

Transition Management System (TMS)

7. This system was introduced into Military Discharge Procedures around 2000 in order to assist those members who were being medically discharged. This means that a soldier who is carrying a number of service related conditions does not get picked up by the system unless they are medically discharged; those who are being medically discharged are explained the process and given the paper work to access superannuation and apply for acceptance of liability for service related injuries or disease. These soldiers are also provided a brief on how the DVA entitlement system works and potential compensation entitlements.

8. Unfortunately, it has been observed that the TMS Case Officers are mainly conversant with entitlements under the Military Compensation and Rehabilitation Service (MCRS). Therefore, the soldier does not comprehensively receive information on the VEA 1986 and MRCA 2004. If they have multi-eligibility under the 3 Legislative Acts there is limited knowledge available within TMS. There is also limited knowledge being provided on invalidity retirement under MSBS and DFRDB.

9. All the clients that I assist after their TMS interview are extremely confused about multi eligibility and invalidity COMSUPER assessments. I step them through the process step by step until all the bases are covered and they are ready for discharge. Acceptance of liability for service caused conditions often occurs during the medical discharge process and this is often too late, and results in soldiers not being able to access medical treatment or compensation until long after the discharge process has taken place; leaving them with no compensation for long periods. TMS has become a service that hands out application forms and limited advice. There is little or no case management to transitioning soldiers over to the care of the DVA. The soldiers who suffer the most at the hands of TMS are those with psychiatric conditions who require absolute case management and follow up.

10. An observational problem that exists with the TMS is that it is part of the DVA, which from a soldier's perspective makes them part of the insurance company that handles injured soldiers and therefore; does not provide confidence to the soldiers in the management of the entitlements. TMS does not provide advocacy on behalf of soldiers and this is often to the soldiers' detriment. Many of the cases which I have provided assistance with post army, have been to fix up the guidance given by TMS in relationship to acceptance of liability and incorrect assessments of permanent impairment by DVA contracted practitioners. The soldiers lacked adequate representation at the primary level of the claim.

11. A previous practitioner of the APPVA and current National President (Paul Copeland), whilst operating out of the Heidelberg Repatriation Hospital (HRH), was aware of 2 cases where the TMS Case Officer of soldiers receiving treatment within Ward 17 (Veteran Psychiatric Unit (VPU), were told to sign their pre-

discharge checklist. In addition they were apparently provided with briefings of their entitlements. These soldiers were heavily sedated and could not comprehend what they had signed or assimilate the TMS briefing. On further investigation, it was found that the TMS Case Officers were acting on a deadline to enact the fastest Discharge of the member.

12. The cases above highlight that there appears to be a lack of empathy toward soldiers who are very ill, are on debilitating medication and are not responsive toward their awareness in comparison with a person who is mentally alert. The emphasis of these cases is to provide feedback that TMS Case Officers **must** process these ill soldiers after they are discharged from hospital, with the approval of their consulting psychiatrist and the soldier has stabilised to a degree where they are able to comprehend the information and sign the forms in a sound mind.

Australian Defence Force Rehabilitation Programme (ADFRP)

13. The introduction of this rehabilitation plan was a good initiative which requires much more development; the rehabilitation management of soldiers will become better over time but a number of issues need to be addressed, these are;

    a. There is reluctance by the medical practitioner to hand personnel over to case managers.

    b. The case managers are civilian contractors who have little or no understanding of army. Soldiers need to give a civilian contractor authorisation to access their medical files and they then deal with civilian rehabilitation managers who have little knowledge of the ADF requirements.

    c. Soldiers who are under case management are confused by the myriad of personnel who are looking after them and do not fully understand who does what. They have a rehabilitation manager, a rehabilitation coordinator, a TMS manager, a resettlement officer, a doctor and in most cases an advocate/pension officer from one of the Ex Service Organisations (ESO) explaining it all to them. On top of this they need to have an understanding of a myriad of acronyms of which many financial decisions need to be made.

    d. The ADFRP has only concentrated on the rehabilitation side of the MRCA 2004 and has made no provision to address the problems of acceptance of liability. The latter is understandable as the Service Chief is designated a Military Rehabilitation and Compensation Commissioner (MRCC), only at the Rehabilitation phase of the soldier. The ADFRP is inclusive of all soldiers, regardless of Legislative eligibility.

e. Soldiers have been historically given 3 months and at times less that 3 weeks notice for Intent to Discharge (Termination Notice). This situation is simply inadequate for the soldier to rehabilitate, stabilise, and be fit for Discharge.

f. Opportunities for soldiers are not actively managed by Career Managers and the MECRB, in that rehabilitation, vocational training, re-training, and resettlement appear to be not of a priority. It should be emphasised that soldiers require at least 12 months from date of Termination Notice to be adequately prepared for Discharge. This is most pertinent to those with families.

g. Once downgraded to MEC3R or MEC4, Unit Commanders appear to want to get rid of the soldier, in order to maintain an Operational Level of Capability in manning.

h. The ADFRP needs to be cognisant that these soldiers are experiencing a difficult period of their lives and in many cases it has been observed that the soldier develops Anxiety Disorders and/or Depression during the Transitional Period.

i. Members need to have their compensation entitlements finalised prior to discharge. This alleviates the stress on the soldier post-discharge in obtaining adequate income and receipt of their veteran entitlements.

j. Anecdotal evidence suggests that a full Rehabilitation Plan, with aims, goals to be achieved and time to heal do not appear to be provided to the soldier. Simplistically, under MRCA, Division 3 – Provision of Rehabilitation Programs, section 51 (Rehabilitation authority may determine that a person is to undertake a rehabilitation program), we have yet to see a comprehensive Rehabilitation Program, Plan and incentive for soldiers who have been injured/wounded or ill. Closer consultation is required to fully develop the protocols of these Rehabilitation Plans.

k. As a result of confusion and frustration at the system, soldiers are resorting to the assistance of lawyers, which is costing them time and money, whereas ESO, who specialise in this complex environment, such as the APPVA, provide this service for **free.**

Integrated People Support Strategy (IPSS)

14. The briefings I have been involved with to date and the information I have been able to gain from this programme have been very positive. The concept of management of ADFRP to encompass medical rehabilitation to tie in with Medical review boards, Medical classification, Medical discharge and acceptance of liability for soldiers and where necessary the handing over of cases to the DVA for ongoing management is to be applauded.

15. When a medical discharge takes place or a soldier who discharges at own request with service injuries that have liability accepted; it will show that the army is a people first organisation. The perception of people first organisation will hopefully help retention and recruiting. The Public image of the Army will also be potentially improved.

16. In addition to the above, IPSS policy has yet to be developed nor released. It would be prudent for the Army if skilled practitioners, who have the skills and qualifications of multi-eligibility, experience in the Legislations, COMSUPER and knowledge of the transition process, would be able to consult with the IPSS policy and development team.

Multi-eligibility

17. Current serving soldiers in the majority of circumstances are now covered by 3 differing Legislative Compensation acts, including the Defence Act 1903 for Seriously Ill or death. Some have dual eligibility under the VEA1986 and SCRA with post Jul 2004 service being under the MRCA 2004. Some defence members have long periods of time under the VEA1986 due to when they enlisted. Some are covered by VEA and SCRA when they were operationally deployed prior to 1 Jul 2004 and some are not. Army reservist also have the same complications of multi eligibility with some also having coverage under all 3 acts.

18. Soldiers also have elections they may need to make which have serious financial implications that can not be reverted once the decision is made. The ESO community are making good efforts to provide a quality service however the problem remains that unless the advice and assistance is of the highest quality the soldier may end up making ill informed decisions or in some cases not even get the rehabilitation and compensation they are entitled to.

19. Suffice to say, that the complexity of multi-eligibility requires a specialist approach in order to manage and advise current serving and exiting members of Defence.

DFRDB/MSBS invalidity discharge

20. When a soldier is under the medical discharge process they need firm advice as to how they will be assessed for COMSUPER purposes and what entitlements comes from an A, B or C invalidity determination. The solders not only need assistance understanding the remunerative effects of an invalidity assessment but also what happens with off-setting provision within compensation and rehabilitation Legislation from DVA.

Examples of the failing of the current system

21. These are three actual cases that I have handled and the members concerned have given me permission to use their information but wish to have their names excluded from this document. The names can be provided separately "Medical-in-Confidence" for validity if required. These particular cases are ones that have stood out within the past 12 months however is only a sample of the cases being handled by my office.

Case one

a. I was approached by an RMO to speak to a soldier who was going to be medically discharged. The soldier had been diagnosed with a number of psychiatric conditions (4 in total and all had been determined as not related to service after he was advised by DVA to lodge a claim under the MRCA 2004 for acceptance of liability). After interviewing the soldier I found that he had been passed between 5 psychiatrists since his psychological problems had started. He had also been posted from Brisbane to Darwin and then to Melbourne during this period and had operational deployments to both Solomon Islands and Kuwait.

b. After some quite extensive interviewing and investigation the soldier revealed that he had a number of fairly significant stressors during his deployments and that the psychiatric symptoms he was suffering came under his VEA and SRCA eligible service. The soldier was medically discharged prior to his claims being processed and he was assessed as a Class A for COMSUPER purposes. Three months after his discharge another advocate I work with and myself were able to consolidate the psychiatric reports and provide evidence to have the condition of schizophrenia accepted as being aggravated as the result of a severe stressor he was exposed to in the Solomon Islands.

c. His case is also being processed under the VEA and his full entitlement will be determined within the next few months. This soldier, under the current handling procedures of TMS, ADFRP and the MEC Review Board (MECRB) was discharged with a service aggravated condition with no medical assistance available from DVA and the financial hardship of having no compensation. This soldier is now receiving the entitlements he should however the current system let him and his family down severely during the current medical discharge system.

Case two

a. A soldier who was on posting from Victoria to Sydney was diagnosed with a severe anxiety disorder and was put on sick leave over the Christmas period 2006. He wasn't handed over to a rehabilitation manager and his psychiatric treatment started at the Heidelberg Repatriation Hospital and he was managed by the local RMO at Watsonia. He approached a local RSL near where he lived and a claim was lodged under the VEA for his service caused anxiety for a condition that developed in Iraq in 2006. As the claim progressed the

pension officer assisting him became confused when his claim was moved from the VEA 1986 to MRCA 2004 and he also realised he had dual eligibility under the VEA 1986 and SCRA 1988 for other peacetime injuries. The soldier concerned was also under DFRDB and needed information as to what were the implications of a med discharge after 24 years in army.

b. The soldier was referred to me to gain assistance and the long process of identifying his entitlements and making claims began. Whilst this was happening the soldier was unable to understand the complex legislation he was making application under. His claims were finalised under the MRCA 2004 for his severe anxiety disorder/PTSD and loss of earnings were applied for and are in the process of being recovered. Prior to his deployment to Iraq he had also been in Timor and had 24 years of service in infantry where he had suffered from a number of injuries based on wear and tear, parachuting incidents and a significant barotrauma. Acceptance of liability for his psychiatric condition has been accepted under the MRCA 2004 and his physical disabilities have been accepted under the VEA1986. He has made a reasonable recovery and is nearly ready to step from the army to a civilian career. Liability still needs to be accepted under the SRCA due to dual eligibility for peacetime injuries.

c. The MECRB has advised that once he is stabilised he will be discharged. He gained no assistance from his rehabilitation manager and as yet has not been contacted by TMS. TMS will be involved once a letter of termination is issued. He will be discharged as a Class C (requested) or Class A under DFRDB, 80% disability pension under the VEA 1986 for his physical injuries and is awaiting MRCA 2004 to make a determination on Permanent Impairment for which his condition needs to be considered stable prior to assessment. His claims under the SCRA 1988 will be submitted once MRCA 2004 has made determinations on a few outstanding issues. He will be in receipt of Incapacity payments until employable from the MRCA 2004 once discharged. In this particular case the soldier was extremely lucky to get assistance at this early stage and will allow for an easy handover to DVA for ongoing management with all claims being processed. Assistance for this kind of complex claim is not available from the majority of ESO, TMS or Defence. The soldier is still currently serving, Med 3 and is to be presented to the MECRB. From a case management point of view as his advocate he is ready for discharge but his case is not finished. The soldier once discharged will need the assistance of ESOs for ongoing management.

Case three

a. A current serving soldier receiving treatment for PTSD, Anxiety and Depression at ward 17 in the Heidelberg Repat Hospital approached me for assistance with making claim for acceptance of liability. He had advised me that he was to be discharged within 3 weeks and that TMS had given him

forms but he had not been able to cope with addressing the problem of dealing with DVA; TMS failed to do any follow up on the soldier who was suffering severe psychiatric symptoms at the time. I contacted SCMA to have his discharge date changed to allow time to process his claims; after some reluctance the SCMA SO3 Separations agreed that there was a duty of care for the army however; I had to meet their deadlines for lodgement of the claims or his discharge would take effect. The claim was lodged and SCMA advised me verbally that the discharge date would be changed to allow for acceptance of liability and handover to DVA for ongoing treatment and the financial fall back of economic loss. After this agreement was reached with the SO3 Separations the soldier was discharged prior to acceptance of liability and had a gap period of approx 1.5 months before liability was accepted for all conditions applied for at the primary level under the MRCA. The SO3 Separations at the time I was dealing with was Capt Waters; I advised of the situation by formal correspondence and received a verbal reply by telephone. The soldier is very disappointed with army and accepted this early discharge without notifying me of his circumstances. He is currently under going treatment as an inpatient at ward 17 and could have easily been another suicide statistic awaiting investigation. This failing on army to assist this soldier considerably contributed to this soldier's current mental state. I would believe that this particular case would prevent any family or associates of this veteran considering a career with army. Therefore may affect future potential enlistments.

Current Problems highlighted by these example cases

22. All the above three cases failed in the same simple areas, these being:

    a. No firm linkage between Medical, Rehabilitation Manager, Rehabilitation co-ordinator, SCMA, TMS and DVA.

    b. TMS failed to provide advocacy to manage the soldiers to the point of acceptance of liability for handover to DVA.

    c. The soldiers had to rely on the Australian Peacekeeper & Peacemaker Veterans' Association, to provide advocacy and briefs of entitlements and organise the linkage from the Department of Defence to the Department of Veteran's Affairs.

Shortage of qualified practitioners

23. Traditionally advocacy for compensation has come from volunteers within the ex-service community. There have been some paid advocates provided by the ex-service organisations that have represented the soldier at the Veteran's Review Board under the VEA 1986. The speciality of these organisations has primarily

been focused on the VEA1986 and there is a small amount of assistance available under the SCRA.

24. To date there are very few practitioners who are qualified and practiced under the MRCA 2004. A combination in knowledge of all 3 acts is required for current serving members along with a full understanding of COMSUPER medical discharge assessments and entitlements. The end result is that a large number of ex-defence personnel with defence caused injuries and disabilities do not get the rehabilitation and compensation they are entitled to.

Soldiers Falling Victim to high priced law firms

25. A number of the cases I handle have already had representation from law firms. I have had a number of clients who have had their disabilities that pay lump sums processed by law firms like Slater and Gordon and Darcy's (these 2 firms have recently amalgamated). The soldiers' sailors and airmen/airwomen have paid up to $14,000 in fees to receive $27,000 in compensation. Therefore the service person is disadvantaged and only receives $13,000 from the potential $27,000. I have had a number of clients with minor disabilities that I have processed for the member after the law firm had finished their claim; this is because the law firm would not make any money on these claims. Another problem these legal firms have caused a number of ex defence members is making claims under the act that pays the largest lump sum to ensure payment rather than the act that is more beneficial to member (i.e.: VEA 1986 or MRCA 2004).

To fix the problem

26. Potentially, the Integrated People Support Program **"may"** address the majority of the issues I have raised in this paper. The problem that is not being addressed is; assistance of current serving members to gain acceptance of liability while they are still serving and before they are advised they will be medically discharged. Also current serving members who discharge at own request that don't have their service caused disabilities accepted for liability and treated by the DVA.

27. Once a Soldier has been identified as requiring the services of a rehabilitation officer there should be a direct linkage to professional assistance to gain acceptance of liability from the Department of Veterans Affairs. The soldier would be rehabilitated and hopefully returned to work in Army. If the injury deteriorates and causes a medical discharge there would be the ability for a smooth handover to the Department of Veteran's Affairs and linkage to an Ex-Service Organisation for ongoing management post service.

28. I firmly believe that this advocacy should be provided within the army chain of command by qualified and experienced practitioners. In an ideal environment these advocacy services are suggested to be provided by reservists in uniform, who would have the interests of the injured soldiers, reservists or cadets as there

primary task; not an extra regimental appointment. There are a number of suitably qualified practitioners who could be in uniform providing this service now. However to grow an adequate amount to service the whole of Defence would take considerable planning and the implantation of an appropriate training programme.

29. I am very keen as an inactive reservist to work on a project with aim of providing these services across army and or defence. As a practicing advocate for post 1975 veterans' and defence personnel I feel that I can offer the professional assistance to help plan for these services being available to all soldiers in the future by creating an advocacy cell and a network of army reservist that could service the whole of army. The network is available amongst some inactive reservist now however medical waivers for ARES or ARA, or the appointment of Specialist Service Officers would need to be recommended in order to obtain the specialist skills required to form a fully trained and working advocacy cell. I am personally prepared to take on this project under DA50 contract, full time under CFTS, or transfer from IAR to ARA and relocate to Canberra.

WO1 Michael Quinn
Advocate APPVA