ADSO ALLIANCE OF DEFENCE SERVICE ORGANISATIONS

PO Box 4166
KINGSTON ACT 2604

11 October 2016

The Committee Secretary
Senate Foreign Affairs, Defence and Trade Committee
PO Box 6100
Parliament House
CANBERRA ACT 2601

SUPPLEMENTARY SUBMISSION TO SENATE FOREIGN AFFAIRS, DEFENCE AND TRADE COMMITTEE INQUIRY INTO SUICIDE BY VETERANS AND EX-SERVICE PERSONNEL

On behalf of the Alliance of Defence Service Organisations and with the Committee's kind indulgence, I would like to cordially request that you accept the enclosed **Supplementary Submission** to add to the original Submission tendered by the Alliance on 7 October 2016 via the Senate's on-line lodgment facility. The Committee Secretariat acknowledged receipt of it immediately thereafter. The original document should continue to stand as a Submission from the Alliance and remain as your Committee document.

The Alliance's Supplementary Submission herein is made because, after having a little more time to re-examine and analyse our original Submission, it was found be deficient in a material particular which was considered to be of sufficient seriousness as to warrant a Supplementary offering.

Both matters had been drafted for inclusion, however regrettably, were excluded during the final editing process. ADSO apologises for any inconvenience for the omission.

ADSO seeks leave to tender this Supplementary Submission in respect of the following Term of Reference; viz

Term of Reference (f)
- Any other related matters

Add the following sub-headings and paragraphs under the heading:
6.2 Post–Transition Health Care

6.2.1 Post – Discharge Realities

Notwithstanding the Lighthouse Project initiatives, ADF members who separate from the Service continue in large part to be left to fend for themselves to navigate the Repatriation and MRCC pension and compensation determining system. Subject to their medical condition, many make fruitless attempts to search for treatment in an over-burdened civilian medial health system even if their condition was incurred or aggravated as a consequence of their service.

The inability of veterans after discharge to no longer be able to reasonably quickly access what is a first-class ADF medical care and treatment umbrella, is known to have a profound effect on them, often as not, both mentally and physically. Being unable to obtain ongoing treatment for documented service-related injuries incurred in either operational or non-operational service (eligible Defence service) remains one of the primary aggravating factors for veterans, compounded by the need to seemingly battle the pension/compensation system of DVA.

To that end, ADSO encourages the Inquiry to look closely at the following two initiatives and recommend to the Government that they be accepted and implemented.

In order for this proposal to succeed, implementation of these initiatives will be required to address veterans who post-discharge, come within the ambit of the VEA 1986 or MRCA 2004.

6.2.1.1 Operational Service

All veterans who render operational service should be granted a **Gold Card** for treatment of all conditions at time of discharge or retirement. ADF members who render qualifying operational service are entitled to a more generous beneficial application of the Gold Card.

The issue of a Gold Card would in this particular instance be for treatment only and not attract a disability pension or compensation payment. This is a separate process and one which any veteran will still be required to access for the Commonwealth to determine financial liability, as opposed in this instance, to ongoing treatment liability.

The Alliance is unanimously of the view that the beneficial approach to granting veterans a (non-pensionable) Gold Card in the first instance, is a significant application of the beneficial provisions of the legislation and relies on the decision of the Federal Court in *Kohn's* case [1] per Hill J, in which the Court held:

> ***The legislative policy behind the Veterans' Entitlements Act is that a person who has rendered operational service in the sense defined in s.6(1) should more readily be able to obtain a pension than a person who has not rendered such service. It was the intention of the legislature that it was only members of the Armed Forces who, in truth, were on service outside Australia during World War 2 who should receive this preferential treatment as to pensions.***
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> *It cannot be conceived that Parliament intended that veterans who were at all times stationed in Australia but who travelled from one place in Australia to another and thereby were for short periods of time outside Australia, should be treated in the same way as veterans who fought in a theatre of war, sailors who served continuously on a ship engaged in or likely to become engaged in combat or members of the Air Force engaged in flying missions outside Australia.* (Writer's bold emphasis added)

Notwithstanding the application of the decision by Hill J to the issue before the Court, His Honour's remarks regarding the beneficial intent of Parliament to afford veterans who rendered operational service as an entitlement to preferential treatment is directly analogous to ADSO's contention of ensuring beneficial treatment to operational service veterans, by issuing a Gold Card at discharge.

The fact of the matter is that there is a considerable body of case law reinforcing what the Courts believed – namely that Parliament had drafted a law to give preferential treatment to veterans who had actually rendered active (operational) service and as such, a clear distinction exists in the assessment of and grant of pensions of those applicants who had rendered operational service and those who had not.

This distinction is clear. It enunciates on any level, the Government's intent to do the right thing by those who had put themselves in harm's way.

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[1] ***Repatriation Commission v Kohn* (1989) 87 ALR 511, 10 AAR 363**, per Hill J

ADSO contends the time is now ripe for implementing a process whereby a member discharging/retiring from the ADF who has been treated during their service for an injury, illness or disease incurred or aggravated during that service is automatically issued with a Gold Card.

ADSO recommends that where, upon notification of discharge by the relevant Service, DVA commence steps to automatically issue a Gold Card for maintaining a throughput of treatment which will reduce the trauma and grief associated with navigating what for many is a hostile and adversarial process. The issue of a Gold Card should occur as part of the final discharge process.

6.1.1.2 Non-Operational Service (Eligible Defence Service)

The contraction, acceleration or aggravation of an injury, illness or disease eligible Defence service (**non-operational service**) is ever-present, particularly on exercises, but without the aggravating factor of death, maiming or wounding as a result of enemy action.
It is common ground ADF members rendering non-operational service are injured or fall ill whilst rendering non-operational service.

The proposal to issue a Gold Card to operational service veterans on discharge also has its application to non-operational service through the issue of a **White Card** in the form of a Specific Treatment Entitlement Card (STEC). The criterion is the same as for operational service in that treatment for service-related conditions is maintained post- discharge.

Again, ADSO recommends that where, upon notification of discharge by the relevant Service, DVA commence steps to automatically issue a White Card for maintaining a throughput of treatment which will reduce the stress and trauma associated with navigating what for many is a hostile and adversarial process. The issue of a White Card (STEC) should occur as part of the final discharge process.

6.1.3 Cost Benefits

ADSO considers the introduction of a **Gold Card/White Card** treatment continuum will result in savings for DVA. The most critically important saving is that of traumatised veterans who are no longer required to encounter the current claims and determination process. The lessening of stress on veterans and families a in this process, cannot be overestimated.

Additional savings will result from the need to continually refer veterans to different medical and specialist practitioners at public expense.

Additionally and equally importantly, cost savings associated with reduced litigation could well see DVA reduce its funding of nine million dollars to fight appeals all the way to the High Court, reduced and allocated to more beneficial purposes. Additionally it will operate to reduce the workload of Tier 1 (VRB) and Tier 2 (AAT) Tribunals.

The proposal to introduce the post-discharge card system has tremendous potential.

One suicide prevented by this proposal being initialed for Regular and Reserve Defence members is a major victory and is a victory for natural justice and commonsense.

ADSO contends the issue of a White Card must not deny a veteran access to receiving treatment under the Non-liability Health Care (NLHC) provisions of s.85 of the VEA 1986 which have been cross-vested to MRCA recipients. Regardless of the fact a veteran's STEC may be for medical conditions other than those under NLHC that should not invalidate a White Card veteran's entitlement to NLHC support, including those who come within the ambit of MRCA 2004.

Term of Reference (e)

- The administration of claims by DVA and the legislative or other constraints on effective rehabilitation and compensation for veterans

Add the following sub-heading and paragraphs under the heading: 5.2 SRCA 1988

5.2.3 Hearing loss – redress of problem

ADSO is conscious that many veterans (not just those under SRCA 1988) are being denied free of charge other than basic level (L1) hearing aids even when a strong clinical justification for better performing aids exists. This seems to abrogate DVA's fundamental ethos and reason for being. Many veterans feel the situation seems to be a clear case of DVA focusing on budget and process rather than the beneficial intent of the VEA, SRCA and MRCA Acts.

ADSO accepts compelling evidence that untreated or inadequately treated hearing deficits significantly increases the risk of social withdrawal and isolation, thus leading to anxiety, depression and early onset dementia[2]. Such evidence also suggests that those veterans with Top-Up devices wear them for significantly longer periods than those who have basic level aids[3].

This has the potential, therefore, to have a very positive impact on social inclusion and the debilitating illnesses of depression, anxiety and PTSD. With research also indicating that people with hearing difficulties experience a significant increase in hospitalization[4], the economic burden of providing access to only basic level rather than quality hearing devices is indisputable.

For a person with PTSD and mental stress related issues, level 5 devices are desirable. Although in some cases of extreme tinnitus, L7 devices can be more effective. Tinnitus is a major mental disturbance that contributes to an individual's suicide potential. While a direct link to suicides cannot be claimed, there appears a clear and serious impact on the mental health of veterans when their proven clinical needs are so ignored on a consistent basis.

Evidence continues to mount that those with hearing deficits vis those not afflicted by hearing loss, are increasingly more prone to be hospitalized, thus adding substantially to DVA costs. Early intervention is a truism widely accepted and should be the answer in the case of hearing aids -

Conclusion

As before in our original Submission, if there is a need for any clarification of matters raised in this **Supplementary Submission,** I would be most happy to provide this either verbally or in writing as the Committees sees appropriate.

Yours Sincerely

Colonel David Jamison AM (Retd)
National Spokesman
Alliance of Defence Service Organisations

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[2] Garvan Institute of Medical Research; Mick, & Pichora-Fuller, 2016; Santos, Teixeira, 2015; Contrara, 2016.
[3] Cutterbuck, 2016.
[4] John Hopkins Medical Centre.