WHITHER ADVOCACY, ENTITLEMENTS AND SUPPORT?[1]

INTRODUCTION

This quarter, I'd like to take a different tack. Rather than dealing with aspects of current veterans' legislation, I will look at the RAAF Association's emerging social environment to consider what may shape advocacy, entitlements and support into the future. My objective is to prompt discussion.

The following article is not RAAFA policy nor endorsed at any level. If successful, the article will initiate identification of the key strategic issues RAAFA must address to meet the future needs of its rehabilitation and compensation client base. The future relevance of RAAFA amongst younger ex-RAAF personnel is an associated objective.

ENVIRONMENTAL SCAN

Let's turn first to some of the changes in the future advocacy, entitlements and support environment.

Client Base

Essentially, the future will see two broad groupings of need: (1) aging ex-service members and their families; and (2) younger "contemporary veterans", ex-ADF members and their families.

Vietnam-Era and Prior Cohort

Compensation. As it ages, demand for compensation under the VEA by the veteran and ex-RAAF community from Vietnam and earlier conflicts is declining. Personnel from this era are now 65 years of age or over and, with one exception[2], are no longer eligible to claim for TPI. Irrespective of their age, however, personnel with at least three years continuous full time peacetime service between 7 December 1972 and 6 April 1994, and operational service up to and including 6 April 1994, can submit at any time:

- a claim under the VEA for a Disability Pension (DP), or
- an application for increase in DP, or
- a claim or application for increase to Extreme Disablement Adjustment (EDA).

The pool of claimants or applicants under the VEA will reduce for the next thirty or more years, until the last of the Vietnam-era veterans die.

Welfare. As the last of our WWII, Korea, Malaya, Konfrontasi, Ubon and Vietnam-era veterans, ex-RAAF personnel and their families' age, a rapid increase in need for "welfare" services is occurring. Concurrently, the community-wide "Aging in Place"

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2 See DVA Factsheet DP29, page 2 for a special provision if you are over-65.

policy is causing a fundamental change in the nature of "welfare" support. "Advice is being replaced by connecting members to a raft of "community support" or "aged care" services. As the current cohort of younger veterans replaces its predecessors into advanced old age, a high level of demand for these services is expected over the long-term.

Contemporary Cohort
Rehabilitation and Compensation. As demand for compensation claims under the VEA reduces, a significant increase in MRCA claims is starting to occur.[3] As discussed in Article No 2 in this series, the focus of MRCA is first and foremost, rehabilitation. Compensation is, effectively, a "safety net" when rehabilitation is not effective, or not possible. The significance of this change is only now starting to be realised by "traditional" Ex-Service Organisation (ESO). Similarly, while TIP[4] has been offering MRCA training for almost 8 years, there is still no specific training for Advocates presenting MRCA appeals at the VRB or the AAT. This situation will not be remedied for twelve months or more.

Affiliations. The evidence is that "contemporary veterans" and younger ex-personnel are not joining "traditional" ESOs such as the RSL and RAAFA. Instead young ex-service personnel have strong affiliations with unit-based organisations such as squadron or trade-based associations. RAAFA must meet this challenge if it is to be a source of support for the future rehabilitation and compensation client base.

Trained Practitioners. Shortfalls in the number of MRCA-trained practitioners are being exacerbated by the disinterest "contemporary veterans" and younger ex-service personnel have in training as "welfare" or pension officers or advocates. This situation is understandable. It mirrors previous generations: making a new career in the civilian workforce and raising a family are all-consuming. Helping others may become an interest, and feasible, only as retirement is approached.

Challenges confronting "Welfare" Service Provision
Let's now turn to the changing nature of "welfare" services.

The term "welfare officer" has typically been used to identify non-TIP-trained RAAFA members who visited veterans or widows, typically in aged care facilities or hospital, to provide companionship. As they were in residential care, their medical and para-medical support, personal care and meals were provided in-house. Under the "Aging in Place", however, these services are provided in the community by government and private care agencies, and increasingly by families.

As implementation of the Aging-in-Place policy matures, the number of veterans and their families remaining in their own homes will increase. Increasing demand for the

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3 To minimise complexity, I have deliberately not included SRCA in this article even though it is a valid rehabilitation and compensation option for many in both cohorts. See Article No 3 in the series for an outline of SRCA. Provisions.

4 TIP, the DVA-funded Training and Information Program trains welfare and pension officers and advocates.

services provided by “Welfare” Officers will follow. Simultaneously, the complexity of the service options is changing fundamentally. No longer are welfare officers (untrained) companionship providers. Now they are the veteran and defence community’s source of advice on support and the person responsible for arranging access to “community support” or “aged care” services. The knowledge and networking needed by “Welfare” Officers has therefore changed fundamentally. The already heavy demands on their temporal and emotional capital is compounded.

As the “Welfare” Officer’s role has changed, the need for both generic and location-specific training has increased. The DVA-funded Training and Information Program (TIP) provides such training in all States,. Information relevant to your State is on the TIP website: www.tipaustralia.org.au by following the <Contact Us> link.

On another tack, WWII veterans are generally reluctant to seek support be it provided by Government or by RAAFA practitioner. They have grounded their lives on self-reliance and self-sufficiency, and typically remain unprepared to seek help now. On the other hand, the Vietnam and post-Vietnam era veteran community has a high level of awareness of the psychological and physiological consequences of war and service. Their attitude to Government support is therefore different. The evidence is that demands for support from veterans of more recent conflicts are even more trenchant. In other words, while the numbers of veterans is reducing as aged veterans “depart the fix”, the likelihood younger ex-service personnel will seek support is increasing markedly.

Compounding this situation is the increasing range and complexity of medical conditions arising from combat in the Vietnam and subsequent eras. Examples are the incidence of PTSD and traumatic brain injury (TBI), exposure to chemical and other toxic agents, and the consequences of multiple deployments including deployments to different conflicts. Added to these trends are the peacetime service consequences of the F-111 Deseal-Reseal program and, possibly, the consequences of exposure to aviation turbine fuels. As the latter are on an industry scale, the ramifications for in-community support services are huge.

Defence and Veterans’ Affairs Programs

The Departments of Defence and Veterans’ Affairs are putting in place a range of joint programs to support contemporary veterans, ex-service personnel and their families. These programs can, however, only go so far. Neither Department is funded or staffed to provide the long-term in-community pastoral care that practitioners have traditionally provided (and, through TIP Welfare Training, are being increasingly more thoroughly trained to provide). The increasing capacity of “welfare” officers to support is, however, being offset by the younger cohort’s reluctance to approach the “old” practitioners in traditional ESOs.

Cooperation and coordination between the Departments of Defence and Veterans’ Affairs can only be for the better for the quality of support received by veterans and ex-service personnel and their families. But, as mentioned above, this support can only go so far. How long-term, pastoral care is to be provided still remains formally

unresolved. A recent paper presented by DVA to the ESO Round Table indicates, however, official will to engage ESOs. A range of programs is relevant:

a. **Integrated People Support Strategy (IPSS).** Initiated in 2007, IPSS is not a new program. Its goals are to provide:

    - Through-Service Support: to ensure ADF members are informed about and access physical and emotional wellness, injury remediation and impairment support services provided by Defence, and DVA programs that facilitate well-being and work-place performance;

    - Separation Ready: to ensure that all reasonable support is provided to ADF members preparing for the transition to civilian life;

    - Separation Reconciliation: to ensure all Defence-related matters are resolved before separation, with the member's CO formally confirming satisfaction; and

    - Separation Review: Separation Ready and Separation Reconciliation are reviewed formally 3-6 months after separation, and support offered.

b. **Transition Management Scheme (TMS).** Also initiated in 2007, TMS recognises that a member being medically discharged must engage with a number of other Government agencies (eg., DVA and ComSuper). Through TMS, Defence cooperates with agencies to facilitate the member's separation from the ADF.

c. **On Base Advisory Service (OBAS).** This service has placed 50 trained DVA officers on 35 military bases around Australia. OBAS officers advise on the services DVA provides, and refers clients to those local ESOs they are aware provide welfare, pension or advocacy support. The frequency of attendance varies from one day per month to 5 days a week.

d. **Support for Wounded, Injured or Ill Program (SWIIP).** Initiated in 2011, SWIIP is a collaborative program between Defence and DVA. Its objective is to identify a member's individual support needs as early as possible, facilitate contact with DVA, streamline rehabilitation and compensation processes, and jointly support the member's transition to civilian life. If a member is killed, through SWIIP, Defence and DVA work as an integrated team to support the widow and orphans through the processes from notification onwards. Long-term pastoral care provided by an ESO is, however, not yet inclused in SWIIP.

e. **Career Transition Assistance Scheme.** The Defence Community Office (DCO) is considering how to implement the recommendations of a recnt review of CTAS. In July 2012, the evidence was that up to 50% of the ADF workforce will

retire or resign over the next 5 to 7 years. RAAFA can support personnel in career transition from the RAAF.

Attitudes to "Welfare" and Pensions

Across the ESO-wide pool of trained "welfare" and pension officers and advocates, the overwhelming majority are ex-NCOs. (The ratio is possibly a little better within the pool of RAAFA-accredited practitioners.) From one view, this reflects the level in the Services at which most contact with, and the primary level of care of enlisted personnel occurs. From another, it is a mute indictment of the focus of the officer corps. From the latter perspective, the following examples are grist for the mill:

a. the time taken for the command structure to respond to the damage being done to enlisted personnel during the F-111 deseal-reseal (DSRS) program;

b. the very limited involvement of RAAF commanders in the 2009 Dunt Report "Review of Mental Health Care in the ADF and Transition through Discharge" (see pages 4-8); and

c. the paucity of information and commentary on "welfare" and pensions issues in Wings over the years.

Accepting that this is a limited sample, it nevertheless suggests that advocacy,[5] entitlements and welfare support are low on the RAAF and RAAFA horizon. An educative role is open to RAAFA to remedy this situation.

Engagement of Serving Personnel

Discussion with NSW Branch executives indicates that the Richmond, Radar, and Fighter Squadron Branches are attracting serving RAAF personnel as members, and that the Caribou and Helicopter Squadron, Engineer and Armament Fitter and like Associations are maintaining robust memberships. At RAAF Amberley, a cell of serving-members has been trained to prepare rehabilitation and compensation claims. The Compensation Claims Liaison Office does not, however, offer advocacy support for appeals to the VRB or AAT. These must be referred to an external advocate, suggesting a role for RAAFA practitioners.

Accessing Information

Contemporary veterans, ex-service personnel and their families are heavy users of ICT and especially social media. This has been recognised by Defence and DVA, each of which provides Twitter and Facebook access to information. Many unit-based associations have password-protected Twitter sites or Facebook "friends" links on which younger members share information and support those who are not faring well. By their nature, these exchanges are opaque to institutional or traditional support providers.

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5 Advocacy has two streams: support of members' appeals to the VRB and AAT, and to governments and departments to influence veterans' policy.

Emerging Issues.
Three emerging issues provide an immediate concern for RAAFA:

a. **F-111 DSRS.** Since the 2009 release of the Joint Standing Committee's report into the health consequences of the F-111 DSRS, DVA has implemented the SHOAMP Health Care Scheme. SHOAMP is canvassed regularly in the service newspapers and public media. DVA has funded VVCS (Veterans and Veterans' Families Counseling Service) to provide counselling for mental health issues arising from exposure to DSRS solvents. DVA also administers ex gratia or *Safety Rehabilitation and Compensation Act 1988* (SRCA) compensation. Compensation is also available through the VEA for DSRS "participants with certain peacetime service" (see: http://f111.dva.gov.au/compensation.htm). The arrangements, however, have a significant deficiency. Ex gratia or SRCA lump sum payments may suite some claimants; however, a claim under the VEA is necessary to obtain a Disability Pension.[6] For a VEA claim to be successful, the claimant's medical condition must be either consistent with a Statement of Principle (SOP) or supported by expert medical scientific opinion. The Repatriation Medical Authority (RMA) has, however, yet to investigate the medical conditions arising from DSRS exposure. Unless they are able to substantiate that their condition(s) arose from a non-DSRS aspect of service, DSRS personnel are therefore unable to claim a Disability Pension for conditions that have already been accepted under SHOAMP. As many of those affected are approaching 65, RAAFA has a duty of care to ensure that the RMA legislates SOP for all accepted conditions as a matter of urgency.

b. **Jet Fuel Exposure.** Recommendation 18 of the Joint Committee's DSRS report canvassed research into "mitochondrial changes" (page xxv) thought to arise from exposure to aviation turbine fuels. In 2010 the Mater Medical Research Institute was funded for a three-year study of jet fuel exposure syndrome (JFES). It has held meetings at which RAAFA has been represented. However, understandably, the JFES team has a medical, rather than a rehabilitation and compensation, focus. If damage has occurred, RAAFA has a duty of care to ensure the RMA reviews the JFES findings so that affected members are eligible for rehabilitation and compensation under VEA and MRCA.

c. **Mental Health.** Discussion with practitioners who are in contact with veterans from the most recent conflicts report an alarmingly high incidence of mental illnesses. Multiple deployments seem to exacerbate the incidence. Anecdotal reports are consistent with DVA reports of findings from the US Forces and US Department of Veterans Affairs (VA). In August 2011, the Journal of the American Medical Association reported that up to 20% of Afghanistan and Iraq returnees has PTSD. In 2010, the US Army Times reported that the VA's suicide prevention hotline is receiving 10,000 calls per month and 18 US Iraq or Afghanistan veterans commit suicide each day.

[6] Noting that weekly Incapacity Payments (INCAP) paid fortnightly is possible under, and a number of advantageous support options are specific to SRCA.

Along with other ESOs, RAAFA has a long-term duty of care to ensure that rehabilitation and compensation are not attenuated as budget priorities change and governments' focus moves on in the years ahead.

STRATEGIC DIRECTIONS

I would now like to turn to some of the key strategic implications for RAAFA that I see as emergent from the preceding environmental scan.

a. Affiliations. If we are to establish effective contact with contemporary veterans and ex-RAAF personnel, we must meet the Squadron organisations more than halfway. To insist that they and their members must join RAAFA as Branches has been and remains self-defeating.

b. TIP Training. We must encourage:

- RAAFA members to undertake TIP "Welfare" training so that community and aged-care services are arranged expeditiously;
- younger RAAFA members to undertake MRCA training through TIP; and
- serving RAAF personnel to undertake TIP training so that in-service awareness of rehabilitation and compensation is enhanced, and interest in post-separation support for others kindled.

c. RAAFA Involvement in Joint DoD-DVA Programs. RAAFA has a clear role in engaging with Defence and DVA in the joint programs they are implementing. Representations to DVA and/or the DCO are envisaged to:

- engage RAAFA practitioners during early SWIIP support activities;
- arrange for local RAAFA representatives to participate in SWIIP, IPSS, TMS and CTAS activities on RAAF bases;
- facilitate referrals by OBAS to local TIP-trained RAAFA practitioners for "welfare", rehabilitation and compensation support; and
- encourage Defence, DVA and VVCS to see RAAFA practitioners as natural pastoral-care providers for ex-RAAF rehabilitation or compensation recipients and their families.

d. Engagement with Serving RAAF Personnel. A number of initiatives appear feasible:

- **Unit Associations.** To remain relevant as our older generations age, RAAFA should encourage young personnel to join unit associations. It should also approach unit associations to encourage informal or formal

relationships focused on information exchange, mutual support and engagement in each other's activities. As has been the practice of some for some time, older RAAFA members must continue to participate in unit association activities, providing an inter-generational bridge to the next generation.

- **Supporting Commanders' Duty of Care Responsibilities.** Their being unaware of the issues, or not confident they could comment meaningfully on mental health issues, may be reasons for the apparent lack of contact between Professor Dunt and RAAF "line" commanders during the Dunt review. If this analysis is valid, RAAFA has a potentially powerful role in keeping abreast of such reviews and briefing RAAF commanders and personnel on the resulting advocacy, entitlements and support implications. Programs such as IPSS, OBAS, SWIIP and TMS suggest that contact between RAAFA practitioners and RAAF personnel at all levels would be useful.

- **TIP-Training.** Encouraging younger RAAF personnel to undertake TIP-training is, potentially, a very powerful initiative. Even though active service personnel may not practice, they will be an embedded source of information that they can then communicate through face-to-face contact and social media links. In future, when the pressures of a civilian career and a family have passed, they would hopefully be pre-wired to take on an active role supporting others. Said another way, the RAAFA Constitution states that concern about the welfare and well-being of fellow ex-RAAF-ies does not stop at discharge.

e. **Advocacy of Issues Affecting Serving and ex-RAAF Personnel.** In addition to the National President's ongoing attendance at the ESO Round Table, other DVA forums on which there is currently no RAAFA representation are:

National Mental Health Forum (NMHF). The NMHF is convened by the Repatriation Commissioner. Comprising ESOs, health providers, DVA and Defence officers, its objective is to support veterans' mental health recovery and wellbeing.

- **Emerging Issues Forum (EIF).** The EIF identifies and prioritises emerging issues that affect younger ADF members and their families, and considers DVA engagement with them.

- **Operational Working Party (OWP).** The OWP discusses concerns about DVA's service delivery to improve quality and accountability.

- **State Deputy Commissioner's Consultative Forums.** Each State's Deputy Commissioner (DC) holds a bi-annual forum attended by ESO leaders. It is the avenue by which the DC briefs the ex-service community. (RAAFA is represented at some, but not all DC Consultative Forums.)

- **State Training Consultative Group.** In each State, TIP activities are governed by a Training Consultative Group. RAAFA has an interest in ensuring its practitioners are thoroughly prepared to meet ex-RAAF personnel's rehabilitation and compensation needs. (RAAFA is represented at some, but not all TCGs.)

CONCLUSION

This article is not RAAFA policy. The observations and inferences are my own. I hope they prompt dialogue. The future relevance of the Association to a new generation of veterans and ex-RAAF personnel, and RAAFA's ability to meet the changing support needs of its members will pivot on, amongst other things, whether dialogue results and how well dialogue is converted into action. I look forward to hearing from you, either through Wings or directly to me at: richard.kelloway@bigpond.com

December 2012