Advocacy
Training and
Development
Program

# WELLBEING ADVOCATE'S HANDBOOK

# PREFACE

This Handbook is produced to assist Ex-Service Organisation (ESO) Wellbeing Advocates. Its contents are intended to cater for the different degrees of knowledge that these people may possess.

Wellbeing Advocates require a depth of knowledge and a wide range of skills including to successfully assist veterans, Defence and ex-Defence members and their dependents[1] in their dealings with the Department of Veterans' Affairs and any other agency as required.

Few newcomers to Wellbeing Advocacy will have had much experience in this uniquely challenging field. This handbook has been written to support such newcomers and, in general terms, is designed to provide an easily assimilated description of the wellbeing support system as it affects an Advocate. Some information is of background interest only, while some is vital to the everyday performance of an Advocate.

**IMPORTANT NOTE**

Every effort has been made to ensure that the information contained in this Handbook was correct at the time of publication, and to keep it up to date. However, as legislation and DVA policies and procedures change, some information may become outdated.
Advocates are advised to check the currency of information before using, and to report any discrepancies to the Handbook Editor via the ATDP Homepage.

[1] Wellbeing Advocates may be assisting veterans, currently serving or transitioned full-time Defence members, currently serving or transitioned Reservists or dependants of any of these. For the sake of clarity, the term *'client'* will be used throughout this Handbook to include all of these groups, except where it is appropriate to refer to a particular group.

# LIST OF AMENDMENTS

| NO | AMENDMENT DETAILS | DATE |
|---|---|---|
| 1 | Complete update. Conversion of Welfare Repatriation Handbook to ATDP Wellbeing Advocate's Handbook. | May 2019 |
| 2 | Replacement of DVA Factsheet links with DVA web page links. | March 2020 |
| 3 | Expansion of Chapter 2 Part D in relation to retrospective consideration | May 2020 |
| 4 | Update to DVA telephone number | October 2020 |
| 5 | General review checking links, organisational names and updated terminology | March 2023 |

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# CHAPTER 1
# INTRODUCTION TO THE WELLBEING ADVOCATE'S HANDBOOK

# PART A - BACKGROUND

This Handbook has been prepared under the Department of Veterans' Affairs (DVA) Advocacy Training and Development Program (ATDP) in consultation with the ex-service community.

It covers wellbeing support available under veterans' and associated legislation and information on a range of health and community services and is designed to assist Ex-Service Organisation (ESO) representatives and others within the veteran and serving and ex-serving community to perform their support role within that community.

This Handbook is a national resource, and the focus is on national groups and organisations. It covers information on a range of health and community services based on the needs of ESOs. The Handbook does not refer to specific services offered by local councils, shires and regions. This would have made it unmanageable, given that much of the information from other local areas in Australia would not be relevant to the individual ESO representative.

However, bear in mind that lots of useful, accurate and detailed information on local services can be obtained from:

- Citizens' Advice Bureau;
- Community Health Centres;
- Local Councils/Shires;
- State Government Departments;
- Community organisations, e.g. Salvation Army;
- The internet e.g. Google search;
- local telephone books, especially the community services/emergency services pages in the front of the white pages; and
- local public hospitals.

## Acknowledgement

Little of the material in this handbook is original and comes from many sources. In particular, the following sources are acknowledged:

- The Vietnam Veterans' Association of Australia (VVAA) Handbook 1994
- The CCPS Research Library
- The DVA Consolidated Library of Information and Knowledge (CLIK)
- DVA National and State Offices

# PART B - TOOLS OF THE TRADE

It is imperative that Wellbeing Advocates have access to, study, understand and gain a competent working knowledge of the 'tools of the trade' that are discussed in the following paragraphs.

Everyone has a different capacity and therefore each will need different aids. Experience will show how to adapt these 'tools' to individual requirements.

## 1.B.1 Military Rehabilitation and Compensation Legislation

Some benefits and entitlements flow from acceptance of liability under one or more of the relevant Acts, namely:

- Veterans' Entitlements Act 1986 (VEA);
- Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988 (DRCA); and
- Military Rehabilitation and Compensation Act 2004 (MRCA).

Although detailed knowledge of these Acts falls primarily to Compensation Advocates, Wellbeing Advocates need a working knowledge of the benefits and entitlements available to clients through the legislation relevant to the client's service.

These are available from the DVA Legislation Library on CLIK.

## 1.B.2 Other Legislation

Other legislation an Advocate needs to be aware of include:

Defence Act 1903

Freedom of Information Act 1982

Privacy Act 1988

Aged Care Act 1997

## 1.B.3 Establishing Proof of Identity

Before benefits, entitlements and services provided by and through DVA can be accessed a person must first establish their bona fide identity. The process for establishing proof of identity (POI) is described on the DVA website here.

If the client has previously satisfied the POI requirements with DVA, it may not be necessary to provide all the same information a second time. In some cases, the client will only need to provide one document from Category B. If that document does not provide evidence of the client's current residential address, then he or she must also produce a document from Category C.

The ADF ID Card is an accepted form of ID.

## 1.B.4 Publications and On-Line References

Advocates need to be intimately familiar with the information provided by DVA about the Department's services and the range of forms used to apply for and access them. Please note: For those who may have previously relied upon the Department's range of Fact Sheets as

**DVA Forms.** The Forms system contains claim and application forms used within DVA. A list of Forms, searchable by form number, topic or keywords, is available here.

## 1.B.5 DVA Consolidated Library of Information and Knowledge (CLIK)

CLIK has been designed to assist departmental staff, ESO representatives and the general public to find relevant information. It comprises:

The CLIK home page has been designed for easier navigation and access to contents. A viewing window enables the user to explore the functionality and contents of CLIK without leaving the home page. Handy Hints and Internet links help the user learn how to better use CLIK and the information it contains. An alphabetical index on the home page enhances the ease of using CLIK.

The Legislation library contains the current version of the VEA, DRCA, MRCA and relevant regulations, the Defence Homes Act 1918 and Ministerial Determinations. It also contains links to the MRC and MRC(CTP) Acts.

The Service Eligibility Assistant (SEA) provides access to determinations and legislative instruments about service. It provides information about service categories and is used for determining eligibility for benefits under legislation administered by DVA.

The Compensation and Support Policy Library contains the formal policy guide for VEA Income Support and VEA Compensation.

The Compensation and Support Reference Library. Includes Departmental Instructions, Commission Guidelines, Advisories, the Overpayment Management Manual, the Deeming Exemptions Register and the Payment Rates.

The Rehabilitation Library is the resource and guide for rehabilitation policy, process and practice in DVA.

The Military Compensation MRCA Info Library includes the MRCA Policy Manual and the Actuary Tables used for Age Adjusting Lump Sum Payments.

The Military Compensation SRCA Info Library includes DRCA policy and procedural handbooks, and also the policies and procedures for processing F-111 Deseal/Reseal claims.

The Health Policy Library contains policy information related to health eligibility and treatment issues.

The SOPs information includes links to Statements of Principles on the RMA website.

The Reports and Studies Library contains links for research purposes to reports and studies relating to DVA and Defence matters.

The History Library contains a lengthy section on the history of Australian involvement in military conflicts, which incorporates maps, units deployed, military strategy and timelines along with a Repatriation History and a section on the Order of Battle for Army and Air Force.

## 1.B.6 Non-Liability Health Care Arrangements

While DVA normally only pays for treatment of medical conditions for which a client has proven a link to service and DVA has accepted liability, in certain circumstances DVA will pay for treatment of certain conditions without either being required. This is known as Non-Liability Health Care (NLHC).

All current and former members (both full-time and part-time) with any period of continuous full-time service (CFTS) may be eligible for treatment through NLHC arrangements.

HLHC arrangements currently provide treatment for:

- any mental health condition,
- Cancer (Malignant Neoplasm), and
- Pulmonary Tuberculosis.

### 1.B.6.1 Mental health and NLHC

Mental Health conditions addressed though NLHC arrangements include but are not limited to:

- Posttraumatic Stress Disorder (PTSD),
- Depressive Disorder,
- Anxiety Disorder,
- Alcohol Use Disorder, and
- Substance Use Disorder.

#### 1.B.6.1.1 Access to mental health support under NLHC for Reservists without CFTS

Reserve members without CFTS may be eligible for mental health treatment under NLHC if they rendered Reserve Service in the form of Disaster Relief Service (e.g. Operation Vic Fire Assist), or Border Protection Service (e.g. Operation RESOLUTE) or were involved in a serious service-related training incident.

In the case of a serious accident, this means an accident which occurred during a training exercise undertaken by Defence in which a member of the ADF dies or sustained a serious injury. The person would have needed immediate treatment as an inpatient in a hospital. Examples of serious injuries are:

- an injury that results in, or is likely to result in the loss of an eye, or total or partial loss of vision;
- a burn requiring intensive care or critical care;
- a spinal injury;
- deep or extensive cuts that cause muscle damage, tendon damage, or permanent impairment; or
- an injury that requires the amputation of a body part.

Treatment will be provided through a Veteran White Card. More information, including how to apply for NLHC for mental health conditions, is available here.

### 1.B.6.2 Cancer (Malignant Neoplasm) and Pulmonary Tuberculosis and NLHC

NLHC treatment of Cancer (Malignant Neoplasm) and Pulmonary Tuberculosis is available to those with the following types of service:

- eligible war service under the Veterans' Entitlements Act 1986 (VEA),
- operational service under the VEA,
- warlike and non-warlike service under the VEA or the Military Rehabilitation and Compensation Act 2004 (MRCA),
- peacekeeping service,
- hazardous service,
- British Nuclear Test defence service as defined in the VEA,
- completed 3 years CFTS between 7 December 1972 and 6 April 1994,
- were transitioned out of service on the grounds of invalidity or physical or mental incapacity to perform duties before completing 3 years CFTS between 7 December 1972 and 6 April 1994, but were engaged to serve not less than 3 years, or
- were a National Serviceman serving on 6 December 1972 and completed a contracted period of National Service.

Treatment is provided through a Veteran White Card. More information, including how to apply for treatment for cancer and tuberculosis, is available here.

Veteran White Cards for the treatment of mental health conditions are issued to those with any period of CFTS as a normal part of their transition process when they leave the ADF.

## 1.B.7 Record Keeping

It is important to maintain good records of relevant events, conversations, correspondence and other communications with the client and anyone else with whom you communicate about their case. Such documentation should include letters, faxes, memos, e-mail messages, notes taken during or after phone calls, and any other related information you have acquired. Proper documentation helps Advocates to keep track of their activities and demonstrates that they have followed proper procedures and have acted on the client's instructions.

Best practice procedures include:

- Taking notes recording relevant phone calls, meetings, conversations etc. relating to each case. These should include time and date, names of participants and outline of discussion.
- Sending a follow-up communication to confirm key facts, decisions etc. recorded in these notes. This ensures any misunderstandings get cleared up early, as well as providing the client with a written reminder of what he or she has agreed to provide or do.
- Making and keeping on file copies of all documentation, including emails. Clients have the right to access this information if they so choose.
- If a client changes representative, you should provide copies of all relevant documents as well as return all original documents provided by the client.
- Records must be kept by the ESO for a minimum of seven years.

## 1.B.8 Professional Indemnity Insurance

While providing services, assistance and support to clients Advocates may be provided with professional indemnity insurance coverage by their ESO through the Veterans' Indemnity and Training Association Inc (VITA). Currently there are over 35 organisations that are members of VITA. Advocates should check with the ESO regarding VITA coverage.

To be eligible for VITA coverage, you must:

- abide by the ATDP (or TIP) Code of Ethics;
- have an auditable trail of case work;
- be authorised in writing as an Advocate, by an ESO that is a financial member of VITA;
- be ATDP (or TIP) trained to the level at which you are authorised to operate by that organisation;
- keep up to date by undertaking ongoing professional development at that level.

VITA also requires that fees, including donations and gratuities, must not be charged or solicited for services to claimants. Expenses up to a maximum of $50 may be reimbursed by the claimant. If these requirements are not met, the insurance cover may be void.

More information on VITA is available here.

# PART C – TELEPHONE DIRECTORY

## Department of Veterans' Affairs Offices

General Enquiries 1800 VETERAN (1800 838 372)

## Veterans' Access Network (VAN)

Local VAN Office 1800 VETERAN (1800 838 372)

Other DVA and related contact details are available at https://www.dva.gov.au/contact

# CHAPTER 2

# ADF TRANSITION AND MILITARY EMPLOYMENT CLASSIFICATION SYSTEMS

# INTRODUCTION

Both Wellbeing and Compensation Advocates will find themselves assisting veterans and ADF members (and their dependants) at various stages of their life, from young currently serving Defence members to elderly veterans living in nursing homes.

Many Advocates with a Defence background will be familiar with terminology used during their own period of service or with which they have come into contact during their work as an Advocate. However, much of the terminology relating to types of ADF service has changed in recent years and it is this terminology that will most likely be used by younger members or those who have recently left Defence.

The information in this section has been provided to ensure that Advocates are aware of current terminology relating to ADF employment to help them better understand their clients.

While every effort will be made to ensure this information is kept current, the ADF personnel space is constantly evolving, particularly in relation to the transition process, so Advocates should endeavour to undertake their own research using the links provided in each section.

# PART A - ADF TOTAL WORKFORCE MODEL

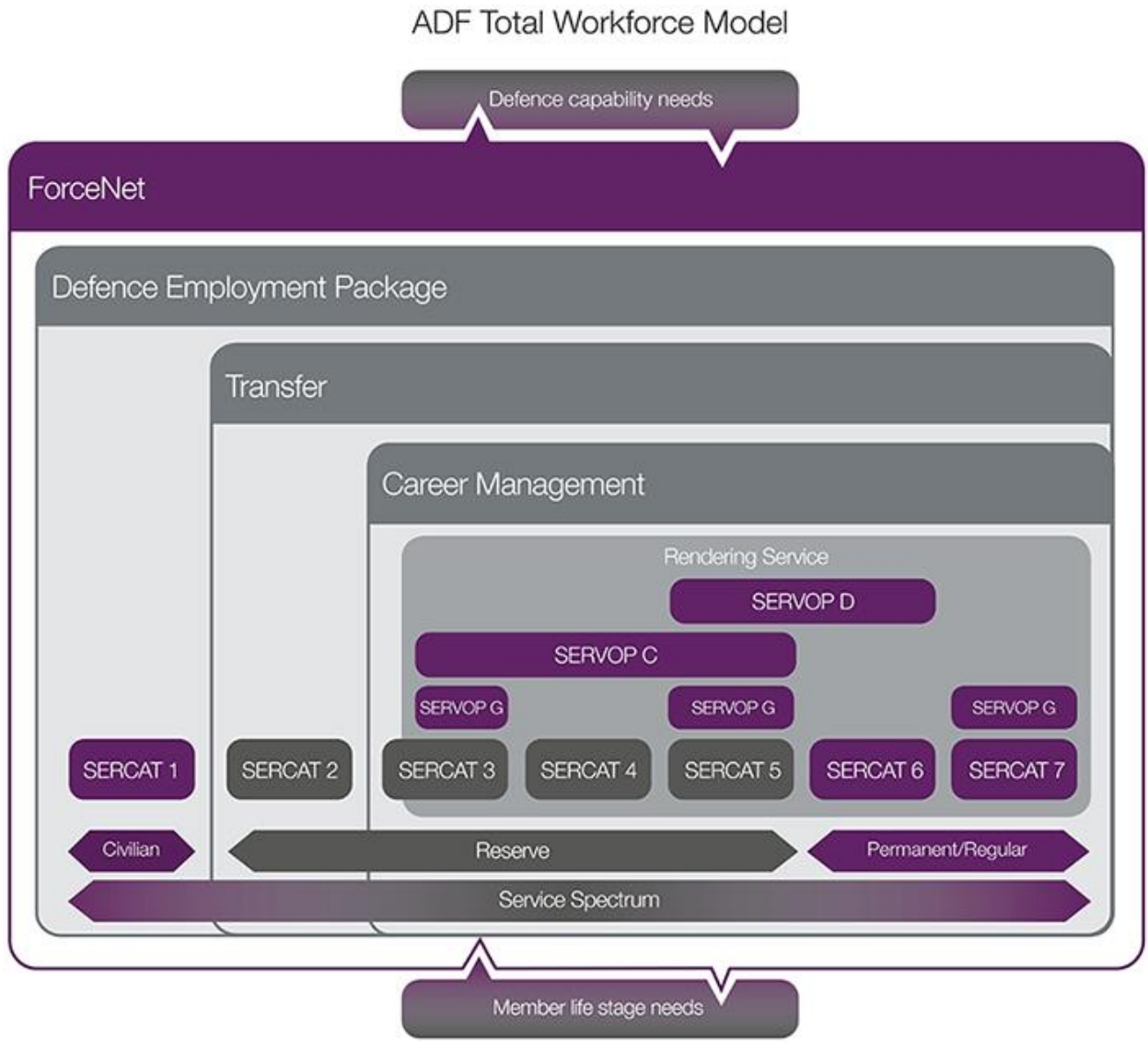
## 2.A.1 Background

The ADF Total Workforce Model (TWM) is a Defence-wide personnel employment model developed through Defence Project Suakin. The TWM was developed as a response to Australia-wide critical skill shortages and demands of ADF personnel for more flexible working arrangements.

While the ADF already had flexible work arrangements in place such as the ability to work from home, work from another location, or work in a different pattern to core work hours, a new flexible service arrangement under the provisions of the TWM is also available. The model contains flexible work options where, with approval from the respective Service (Navy, Army or Air Force) and subject to service capability requirements, ADF members may be able to work part-time such as days per fortnight or weeks per month. The TWM has been implemented, under single Service arrangements, from late 2016.

## 2.A.2 Service Spectrum

The ADF TWM features a new structure of Service Categories (SERCAT) and Service Options (SERVOP) in which members serve, while enabling the ADF to deliver capability. The TWM also offers members a range of ways to serve, giving them options for achieving a work-life balance.



## 2.A.3 Service Categories

SERCAT groups members into like service and duty arrangements that share mutual obligations and conditions of service. All members are categorised in a single SERCAT at all times, and these may be combined with SERVOPs. The seven SERCATs across the Spectrum described below.

- **SERCAT 7** - Permanent members rendering full-time service. More information is available here.
- **SERCAT 6** - Permanent members rendering a pattern of service other than full time, who are subject to the same service obligations as SERCAT 7. More information is available here.
- **SERCAT 5** - Members of the Reserves who provide a contribution to capability that extends across financial years and who have security of tenure for the duration of their approved commitment to serve. They are liable for call out. More information is available here.
- **SERCAT 4** - Members of the Reserves who provide capability at short notice, with their notice to move defined by their Service. They are liable for call out and available to be 'called for'. More information is available here.
- **SERCAT 3** - Members of the Reserves who provide a contingent contribution to capability by indicating their availability to serve, or who are rendering service to meet a specified task within a financial year. They are liable for call out. More information is available here.
- **SERCAT 2** - Members of the Reserves who do not render service and have no service obligation. They are liable for call out. More information is available here.
- **SERCAT 1** - Employees of the Defence Australian Public Service (APS) who are force assigned. More information is available here.

## 2.A.4 Service Options

SERVOP provide the ADF with the means to group members who provide needed capabilities where differentiated arrangements are required to achieve capability. The differentiated arrangements could include entry standards, skill levels, remuneration, duty patterns, or any other conditions that may be approved by a Service Chief, in addition to that offered in the Service Categories. A SERVOP may be applicable to more than one SERCAT and, when used, must be in conjunction with a SERCAT.

- **SERVOP C.** Reserve members serving in SERCATs 3, 4 or 5 who are rendering Continuous Full-Time Service (CFTS). More information is available here.
- **SERVOP D**. Permanent members in SERCAT 6 or Reserve members in SERCAT 5 who are serving part-time in the ADF while also working part-time for a civilian employer under a formal shared service/employment arrangement. More information is available here.
- **SERVOP G.** Permanent or Reserve members rendering full-time service in the ADF Gap Year Program. More information is available here

More information on Project Suakin and the ADF TWM is available here.

# PART B - DEFENCE MEDICAL EMPLOYMENT CLASSIFICATION SYSTEM (MEC)

## 2.B.1 Introduction

Medical classification systems, for the purpose of both selecting or rejecting prospective recruits on medical grounds, and for medically classifying service personnel on transition, have been in place in the ADF since World War 1. From World War 2, the systems of medical classifications were single service in nature, with different classifications related to the peculiarities of each services' requirements.

Details of these historical systems are contained here.

## 2.B.2 Medical Employment Classification System

The Medical Employment Classification System (MEC) was introduced in 2008. It is used across the ADF and describes a members' medical employment classification based on the requirements for their primary military occupation.

The individual's MEC assessment takes into account the skills and tasks (both mental and physical) required of an occupation, and the environment in which the member may be required to perform those skills and tasks when deployed, as well as general military tasks required of their service (such as maintaining physical fitness and weapons proficiency). The individual's MEC is reviewed regularly, usually at least every two years, or if there has been a change in the person's medical circumstances.

Each member's MEC is reviewed by a Medical Employment Classification Review Board (MECRB). A MECRB is a formal board convened by the relevant Service Career Management Agency or Personnel Management Agency to enable an employment review to be conducted that properly informs the MECRB Chair of the relevant matters to be considered when:

- Assessing the employability of a Defence member;
- Endorsing, amending or allocating a MEC as required;
- Endorsing, amending or allocating employment restrictions appropriate to a Defence member's MEC; or
- Determining whether to issue a termination notice on the basis that a Defence member is no longer employable on medical grounds.

## 2.B.3 Categories

The MEC System includes Categories and Sub-classifications. The categories are described in brief below.

- MEC 1 - Fully Employable and Deployable
- MEC 2 – Employable and deployable with restrictions
- MEC 3 – Restrictions
- MEC 4 – Employment Transition
- MEC 5 - Separation

A full description of the MEC system can be found here.

## 2.B.4 Applicability to Advocates

Although Advocates may be assisting Defence or ex-Defence members who have been

classified with any of the MEC categories, Advocates commonly assist members classified as MEC 5 (i.e. being medically transitioned). The MECRB will have determined that these members are to be medically transitioned from the ADF.

Members classified as J51 (See here) may return to work (normally on restricted duties) while undergoing the transition process, while members classified as J52 are deemed to be unable to perform any duties during this period.

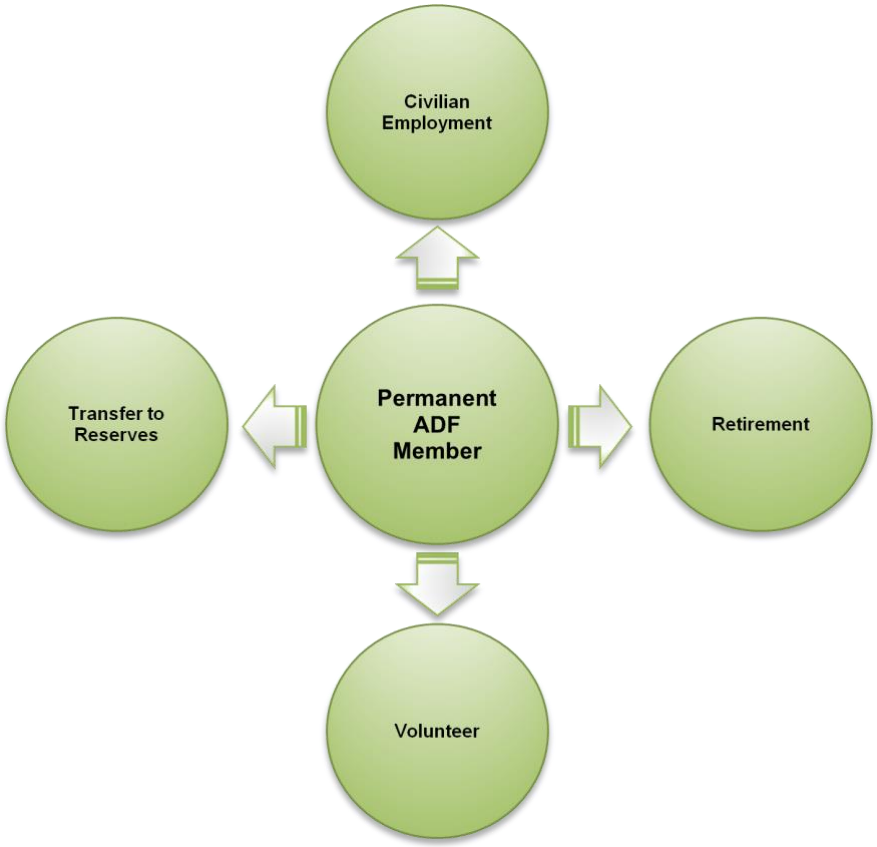
In assisting these members, two key requirements need to be considered by Advocates:

- The member's ADF pay and allowances will cease on the day of transition. If the member's transition is caused by an injury or disease related to their MRCA or DRCA service, they may be entitled to Incapacity Payments from the date of transition. It is vital that claims for liability be submitted to DVA as soon as possible to ensure that liability is accepted and entitlement to Incapacity Payments is determined prior to transition, to avoid financial hardship.
- Check that the member's Service Medical Centre has completed and forwarded a Form DM42 – Invalidity Retirement from the Defence Force Medical Information, and that the member has completed and submitted a Form M40 and/or D40 – Application for Invalidity Benefits, to the Commonwealth Superannuation Corporation (CSC). This will ensure that the member receives their superannuation benefits and avoid financial hardship on transition.

# PART C - TRANSITION FROM THE ADF

## 2.C.1 Voluntary Transition

Under the ADF Total Workforce Model, full-time ADF members have a number of options available to them when they decide it is time to leave. These choices are depicted in the following diagram:




The ADF Workforce Model (see Chapter 2 Part A) encourages Permanent Forces members to transfer to the Reserve Forces, to ensure that their skills and knowledge are retained as part of ADF capability.

Many members will transition to civilian employment. The ADF provides various forms of assistance to help members obtain and retain civilian employment. Of course, some members will choose both of these options – both a civilian job and Reserve service.

Older members may choose to transition straight to retirement. If a member is over 55 and retires from full time employment, they are able to access their superannuation entitlements and, combined with either a VEA Service Pension from age 60, or a Disability Compensation Payment or equivalent MRCA payment, can retire comfortably at a relatively young age.

Many may move into volunteer work (such as Military Advocacy).

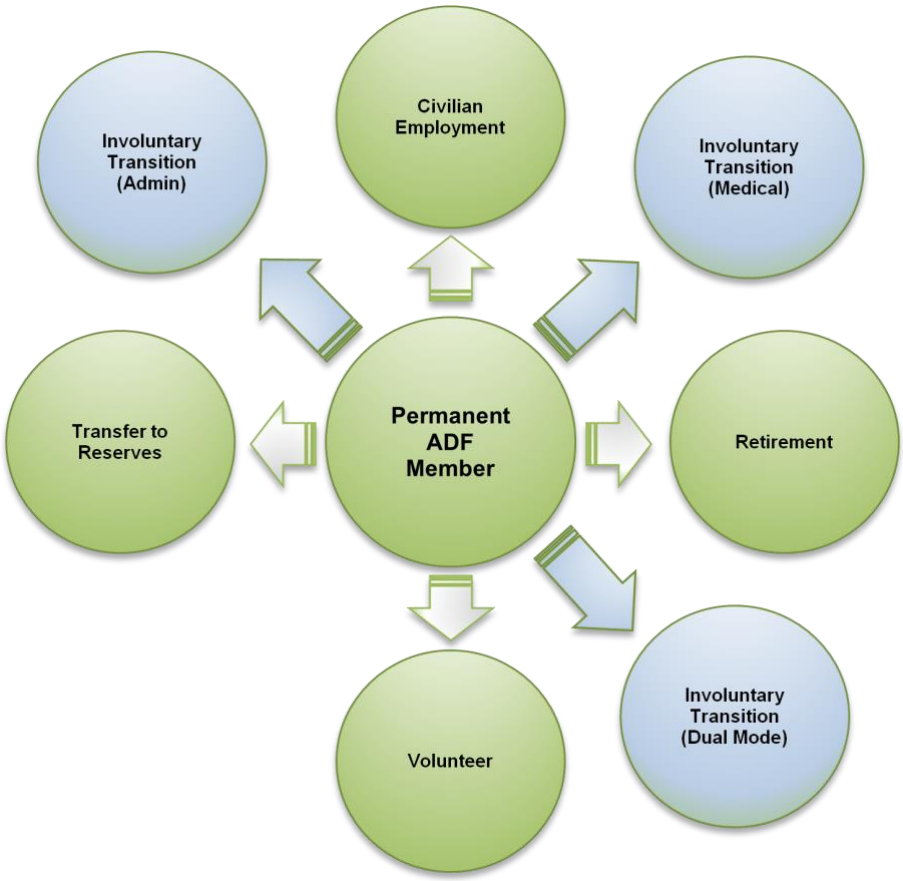
Note that these choices may also be available to those being medically transitioned, where they are medically unable to continue to serve in the Permanent Forces, but can still work, or can render Reserve service, or both. This is decided at their Military Employment Category Review Board (MECRB).

## 2.C.2 Involuntary Transition

The three categories of involuntary transition are:

- medically unfit for service,
- administrative transition, or

- dual mode.




Reasons for Administrative involuntary transition may include alcohol or drug misuse, psychologically unsuitable, or having been issued with a Protection Order or Domestic Violence Order.

Some may be considered a dual mode of transition. For example, a member is being transitioned for alcohol misuse, but is also subject to a MECRB due to a physical or mental injury. The MECRB may elect a dual mode of transition (both admin and medical) and that way the member may get some of the same benefits and entitlements that may get if they were being medically transitioned.

Lastly, a subset of this group is those who *should* have been medically transitioned but were instead administratively transitioned. This group may include many young soldiers who have returned from operational deployments with undiagnosed mental health issues and have had trouble settling back in to normal routine. Some may have started using drugs or alcohol to self-medicate their mental issues, often displaying anger and frustration, or alternatively depression and a lack of motivation, and end up in disciplinary trouble. Rather than wait for the long process of diagnosis, treatment, rehabilitation and medical transition, some elect the shorter and faster administrative transition route. The problem for this group is that they face all of the normal issues faced by newly-transitioned members but have none of the support mechanisms such as automatic Incapacity Payments and access to superannuation invalidity benefits that they should have received.

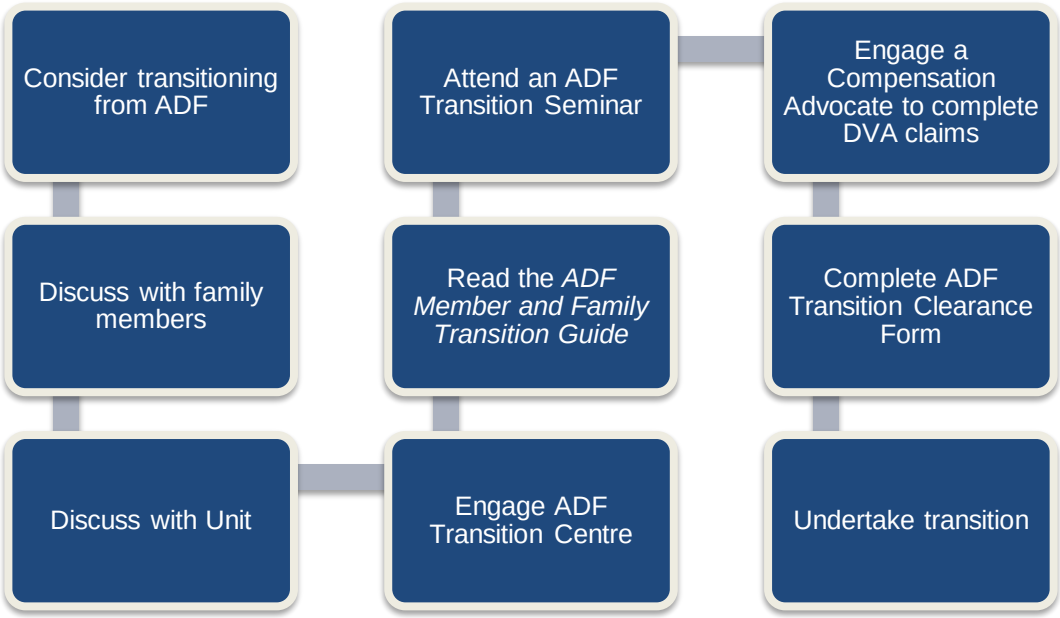
See Chapter 2 Part D for guidance on how Wellbeing and Compensation Advocates can assist these people. This might include proving they had a Service-related injury or illness which *should* have been the reason for their transition.

## 2.C.3 ADF Transition Process

The ADF transition policy and transition process are managed by ADF Transition Policy and Governance, a part of the ADF Members and Families group. Information about the ADF transition process and transition support mechanisms can be found here.

The following diagram is a representation of the recommended transition pathway for ADF members.

**ADF Transition Pathway**




It shows a straightforward linear process from the point where a member first considers separating from the Permanent Forces, through engaging with an ADF Transition Centre, attending a Transition Seminar to a nice, neat transition to life after the ADF.

As mentioned earlier, there will be many ADF members who follow this, or a very similar, pathway. The standard transition pathway is aimed at making transition as smooth as possible, setting the member and his or her dependants up with the skills and knowledge necessary to establish themselves in either a new career or retirement, depending on their circumstances.

Even where a member is being transitioned as medically unfit for service, the transition process can, if followed fully and correctly by both the member and the member's transition support agencies, result in as good a result as can be achieved, depending on the degree of medical issues faced by the member.

Unfortunately, for some members, their transition has been less than ideal, resulting in many of the issues currently the subject of high-level enquiries, including social isolation, financial difficulties, family /relationship breakdown, veteran homelessness, unemployment, alcohol and substance abuse and suicide (all of which are covered in later Chapters of this Handbook).

It is this group to whom Wellbeing and Compensation Advocates can provide the most assistance.

## 2.C.4 Support provided to Members during transition

The ADF has established a number of support mechanisms to assist members during their transition.

- **Support by the member's unit.** The member's unit has a major role to play in assisting a member to transition out of Defence. Not only will the unit be responsible for assisting the member with administrative requirements such as making medical and dental appointments and clearances but will also be involved in formally fare-welling the member and thanking them for their service.
- **ADF Transition Centres.** The Transition Centre network has been established to assist the transition process. ADF Transition Centres are located in every State

and Territory, and on most major Defence bases. Each transitioning member will be linked with a Transition Coach who will help the member and his or her family with services such as:

- an individual transition plan;
- career coaching during the member's transition and up to 12 months afterwards;
- help them meet their administrative requirements;
- helping them leave with all documentation like service, medical, and training records; and
- facilitating connections to Defence and government support services.

Contact details for Transition Centres can be found here.

- **ADF Transition Seminars.** ADF Transition Seminars are conducted nationally throughout the year. Members and their families can attend a Transition Seminar at any point in their career and can be attended on multiple occasions. Obviously, members are encouraged to attend at least one seminar, preferably a few months before their planned transition date, to ensure that they are fully informed and prepared for their transition. Transition seminars are now conducted expo-style, allowing attendees to choose the exhibits and presentations that are of interest to them. Topics shown here are indicative of the presentations and exhibits available at these seminars:
  - Transition support and administration,
  - Future employment,
  - Finance and superannuation,
  - Department of Veterans' Affairs,
  - Veteran and family support services,
  - ADF Reserves.

  More information on Transition Seminars can be found here.
- **ADF Transition Guide.** The ADF Member and Families organisation has developed a booklet titled the ADF Member and Family Transition Guide which contains detailed and valuable information on transition-related topics, as well as a Transition Checklist. A copy of this guide is available here.

# PART D - ASSISTANCE PROVIDED BY ADVOCATES

## 2.D.1 Assistance during Transition

There is a lot of assistance that both Wellbeing and Compensation Advocates can provide to transitioning members, especially those undergoing involuntary medical transition. This includes:

- When first contacted by a member who says that they are in the process of transitioning, ascertain their mode of transition – voluntary, medical, dual, or involuntary administrative.
- Using the Transition Checklist as a guide (it is as Annex to the Transition Guide) where they are up to in the transition process. Where necessary, assist them to submit claim forms to DVA and to CSC.
- Encourage the member to fully engage with their unit and Transition Centre to ensure that they are fully prepared and have availed themselves of all of the support available to them.
- Encourage them to attend a Transition Seminar, as these provide them with the latest information and details of the support available both before and after their date of transition.

## 2.D.2 Supporting Action to Gain Retrospective Consideration

Advocates may find some members who have, for a variety of reasons been transitioned in the incorrect mode. This is particularly important if they were transitioned on involuntary administrative grounds when they should have been transitioned on involuntary medical grounds.

An example could be members who have returned from operational deployments with undiagnosed mental health issues and have had trouble settling back into normal routine. Some may have started using drugs or alcohol to self-medicate their mental issues, often displaying anger and frustration, or alternatively depression and a lack of motivation, and end up in disciplinary trouble. Rather than wait for the long process of diagnosis, treatment, rehabilitation and eventual medical transition, some elect the shorter and faster administrative transition route. The problem for this group is that they face all the normal issues faced by medically transitioned members, but they have none of the support mechanisms such as automatic incapacity payments and access to superannuation benefits that they should have received. These veterans can apply to have their recorded mode of transition changed.

There are three main reasons why a member who was administratively transitioned may want to apply to retrospectively change their mode of transition. These are:

- **Superannuation.** A member who is transitioned on medical grounds may apply for invalidity benefits under their superannuation scheme.
- **Service record.** A member may wish to apply to alter their Service records to show that they were involuntarily transitioned due to medical conditions caused by their Defence service, and thus eligible for compensation and other benefits through DVA.
- **Eligibility for the Australian Defence Medal (ADM).** A member who been transitioned on medical grounds prior to completing the qualifying period for the ADM (the lesser of their initial engagement period or four years) is eligible for award of the medal. A member who did not complete the qualifying period but whose transition was primarily caused by mistreatment by Defence also retains eligibility. Transition on other grounds before completion of the qualifying period would make the member ineligible.

## 2.D.3 Superannuation

Depending on their period of Defence service, members may have invalidity benefits available through their superannuation. The most recent schemes are described below.

### 2.D.3.1 DFRB and DFRDB

Sub-section 51(6) of the Defence Forces Retirement Benefits Act 1948 (DFRB Act) and Section 37 of the Defence Force Retirement and Death Benefits Act 1973 (DFRDB Act) allows the Service Chiefs (or their authorised delegate) to consider whether former members who retired for reasons other than for medical reasons, may be treated as though they had transitioned medically for certain invalidity benefits under these Acts only.

The ADF Members and Families organisation administers this function on behalf of the CDF.

Guidelines and application forms for retrospective consideration under both DFRB and DFRDB are available here.

### 2.D.3.2 MSBS and ADF Cover

Rule 30 of the Military Superannuation and Benefits Act 1991 and section 31A of the Australian Defence Force Cover Act 2015 allow Commonwealth Superannuation Corporation (CSC) to consider whether former ADF members who retired for reasons other than invalidity or medical transition, may be treated as though they had retired from the Defence Force on invalidity grounds or had been medically transitioned, respectively.

If successful, this will allow the member to access invalidity benefits under their superannuation scheme. MSBS and ADF Cover members must apply directly to CSC.

A copy of the application form for retrospective consideration under both schemes is available on the CSC website here.

## 2.D.4 Seeking a change of reason for transition on a Service Record

Division 6 Section 26 of *Defence Regulation 2016* empowers the Chief of the Defence Force (CDF) to change the reason for end of service at the request of, or the agreement of, the member or member's family. The CDF must be satisfied the member could have been terminated for that reason.

A copy of the tri-Service application form (which includes the email addresses of the organisations to which applications should be submitted is available here.

## 2.D.5 Applying for the Australian Defence Medal

To be eligible for the ADM, have efficiently completed either:

- an initial enlistment period, or
- four years service,

whichever is the lesser, and all of the relevant service was after 3 September 1945.

Included are former Defence Force members who did not complete the qualifying period because they:

- died in service,
- were medically transitioned (based upon individual circumstances), or
- left the service due to a Defence workplace policy of the time. (For example, in the past a woman was required to resign on marriage.).

Members may apply directly to Honours and Awards for the award of the ADM once the reason for transition is changed on their service record.

Advocates can assist these members to apply for retrospective consideration. A guide to making an application for retrospective consideration is available here.

Information regarding the Australian Defence Medal can be found here.

# CHAPTER 3
## LOSS AND GRIEF

## 3.1 Introduction

Grief is a normal human response to loss. The more significant the loss is to an individual, the more acute the accompanying sense of grief. As will be discussed shortly, most individuals will move through stages of the grieving process to a point where they can accept the loss and move on with their lives.

Unfortunately for some individuals, this is not the case. An inability to cope with or accept the loss can lead to serious clinical disorders such as prolonged grief disorder or complicated grief disorder. In these cases, treatment by their GP or a psychiatrist is recommended.

Note also that loss and grief can lead to other conditions such as depression, substance or alcohol abuse or suicide. Again, Advocates should look for signs of these conditions and refer their client for medical or psychiatric assistance.

## 3.2 Causes of Grief

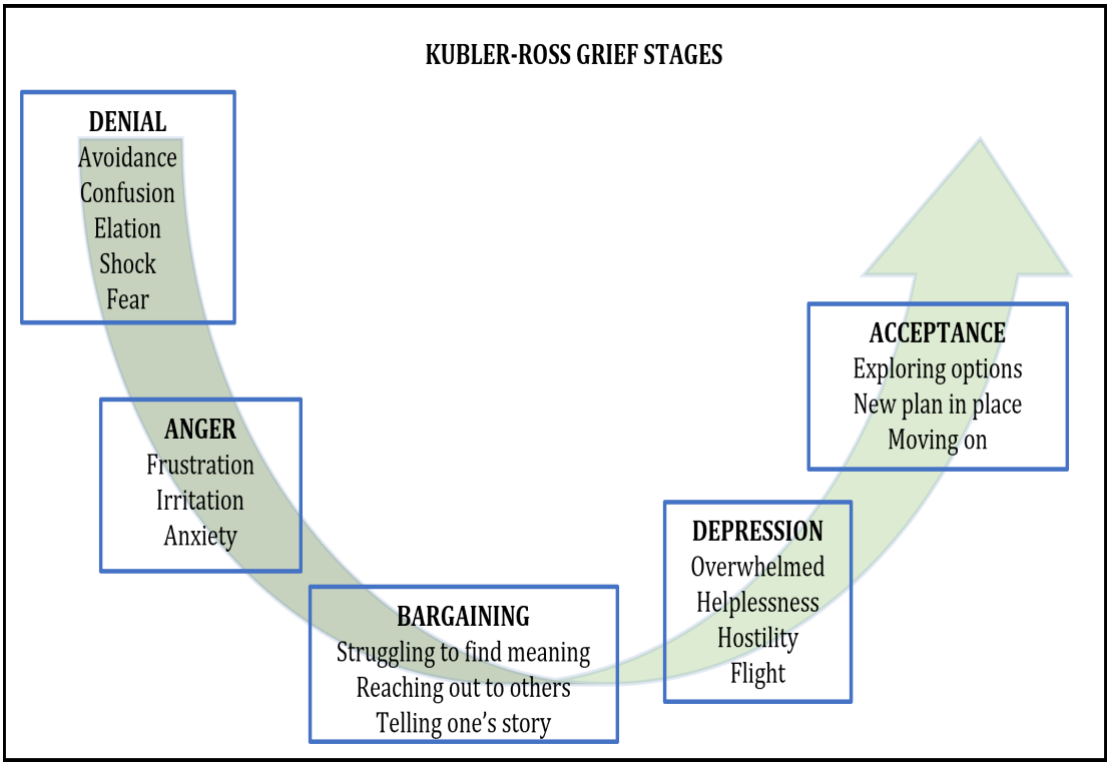
Grief is normally a response to some form of loss. Every individual is different, and the type of loss and subsequent degree of grief will be different for individual clients, however for many veterans and ex-Defence members the loss may be associated with:

- Transition from the ADF, including:
  - Loss of identity,
  - Loss of comradeship,
  - Loss of purpose,
  - Loss of job/employment,
  - Loss of financial security,
  - Loss of health, mobility or wellbeing.
- Transition or divorce;
- Death of someone close;
- Suicide of someone close;
- Posting, moving or relocating.

## 3.3 Stages of Grief

Although there are many books and webpages on the subject of loss and grief, one of the definitive texts is by American psychologist Elizabeth Kubler-Ross and grief expert David Kessler “On Grief and Grieving”. For those interested in further reading, a link to purchase this book is provided here.

Kubler-Ross and Kessler introduced the concept of grief having five stages, although they do point out that everyone’s experience of loss and grief is unique, some people may not experience all five stages, some may experience stages multiple times and some may experience them in a different order.




**Denial**. Denial helps individuals to survive the loss. In this stage, the world becomes meaningless and overwhelming. Life makes no sense. The person is in a state of shock and denial. They go numb. They wonder how we can go on, if we can go on, why we should go on. Denial and shock help them to cope and make survival possible. As they accept the reality of the loss and start to ask themselves questions, they are unknowingly beginning the healing process.

**Anger.** Anger is a necessary stage of the healing process. There are many other emotions under the anger, but the anger may seem to have no limits. It can extend to friends, doctors, family, their loved ones and themselves. Anger provides the individual with a focus for their frustration, anxiety and feeling of loss.

**Bargaining.** After a loss, particularly the loss of a loved one, bargaining may take the form of "What if I devote the rest of my life to helping others. Then can I wake up and realize this has all been a bad dream?" The individual become lost in a maze of "If only…" or "What if…" statements. They want life returned to what is was; they want whatever was lost to be restored. They want to go back in time: if only. Guilt is often associated with this bargaining stage. The "if onlys" cause them to find fault in themselves and what they think they could or should have done differently.

**Depression.** After bargaining, their attention moves squarely into the present. Empty feelings present themselves, and grief enters their lives on a deeper level. This depressive stage may feel as though it will last forever. It is important to understand that this depression is **not** a sign of mental illness. It is the appropriate response to a great loss. They may withdraw from life, be left in a fog of intense sadness, wondering, perhaps, if there is any point in going on alone? As grief is a process of healing, then depression is one of the many necessary steps along the way.

**Acceptance.** Acceptance is often confused with the notion of being "all right" or "OK" with what has happened. This is not the case. Most people don't ever feel OK or all right about the loss. This stage is about accepting the reality that what they have lost is gone and recognizing that this new reality is the permanent reality. They may never like this reality or make it OK, but eventually they accept it. They learn to live with it.

More information on Kubler-Ross and Kessler's five stages of grief is available here.

## 3.4 Signs and Symptoms of Grief

Individual experiencing loss and grief may not recognise what they are experiencing, or may not wish to discuss it, but there are a number of common signs and symptoms that may assist an Advocate to identify loss and grief as a possible issue.

**Emotional**

- Increased irritability
- Numbness
- Bitterness
- Detachment
- Preoccupation with loss
- Inability to show or experience joy
- Difficulty sleeping

**Physical**

- Crying
- Digestive problems
- Fatigue
- Headaches
- Chest pain
- Sore muscles

Of course, many of these signs and symptoms are common to other mental and physical conditions, so Advocates should seek medical and/or psychiatric advice where appropriate.

## 3.5 Strategies for providing support and assistance

In assisting a veteran or ex-Defence member experiencing loss and grief, Wellbeing Advocates can provide support and assistance by:

- Acknowledging that their loss and grief is important and that their feelings are normal.
- Letting them know that you care and that you are there for them.
- Listening. Simply being there to listen to their story and letting them express their feelings can be a big relief for them.
- Asking them what you can do for them. Do not assume what help they need, but do offer help.
- Letting them know it is good to share their feelings of loss and grief, so they do not feel so alone or isolated.
- Keeping in contact. Be available, check-in, keep them included in activities, and give them the option to contact you.
- Being understanding. Accept that they may act or say things differently.
- Looking out for signs that they are not coping. This includes signs of suicidal thoughts, self-harm, getting stuck in their grief, or giving up on life.
- Getting them help. Connect them with information, resources or professional help.

- Looking after yourself. Helping a grieving person can be a heavy burden. Take care of your own physical and emotional health and talk about your feelings with someone during this stressful time.

## 3.6 Resources

**Counselling:**

Open Arms

Beyond Blue

Lifeline

Australian Centre for Grief and Bereavement

**Information:**

Grief Australia

Beyond Blue

# CHAPTER 4
# VETERAN HOMELESSNESS

## 4.1 Introduction

Although not a new or even recent issue, the issue of veteran homelessness has been highlighted recently due to enquiries into the effects of mental health on veterans. Although not the only cause of homelessness, research has shown a direct link between individuals suffering from mental health issues and their ability to maintain stable and suitable accommodation.

Report to the Senate Foreign Affairs, Defence and Trade Reference Committee in Mar 2016 titled *'Mental Health of Australian Defence Force Members and Veterans'* noted that:

- veterans with PTSD and other mental health problems will be at greater risk of becoming homeless;
- the DVA estimate of the number of homeless veterans was 'likely to be in the order of 200-300 Australia-wide';
- the number was disputed by the RSL, noting that 'already this year the DVA has cut its own estimates of at least 3,000 homeless veterans in 2009 to 300 in 2015';
- the DVA response cited changes between 2009 and 2015 in the definitions of both 'homeless' and 'veteran'; and
- the submission from Homes for Heroes (RSL Lifecare) stated:

*'When we talk about homeless veterans, we are not talking about people who are living rough on the streets. Of the 71 veterans that we have housed, only a fraction of them had been living rough—perhaps half-a-dozen. I cannot remember the exact number. But many of them are living in cars, couch-surfing and things like that. So 'homeless' implies that they are without a home, not without a house. Our experience is that veterans will not access mainstream homelessness services, particularly when they are young, because in the main it is too much of an admission of how far they have fallen.'*

A copy of that report can be found here.

## 4.2 What is homelessness?

There is no single accepted definition of what constitutes someone being considered homeless. The Oxford Dictionary definition ('*the state of having no home*') is far too simplistic to be of use in understanding the concept of homelessness.

For the purpose of conducting the Australian Census, the Australian Bureau of Statistics (ABS) uses the following definition:

*'A person is considered homeless if their current living arrangement:*

- is in a dwelling that is inadequate; or
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations.'

In 2011, a review was conducted for the ABS by Mackenzie and Chamberlain titled *'ABS Review into Counting the Homeless Methodology'* in which an alternative definition was provided:

*'...three categories in recognition of the diversity of homelessness:*

***Primary homelessness** is experienced by people without conventional accommodation (e.g. sleeping rough or in improvised dwellings);*

***Secondary homelessness** is experienced by people who frequently move from one temporary shelter to another (e.g. emergency accommodation, youth refuges, "couch surfing");*

***Tertiary homelessness*** *is experienced by people staying in accommodation that falls below minimum community standards (e.g. boarding housing and caravan parks).'*

It is likely that Advocates will be assisting clients who fall into each of these categories. Although a client may not wish to divulge that they are homeless due to embarrassment, some signs of homelessness that an Advocate should look out for when interviewing clients, including:

- indicating that they have no fixed address to record on their file or claims;
- moving from one friend's house to another on a regular basis ("couch-surfing")
- sleeping in their car;
- sleeping in community shelters or other temporary accommodation; or
- sleeping rough (on the streets).

## 4.3 Reasons for Homelessness

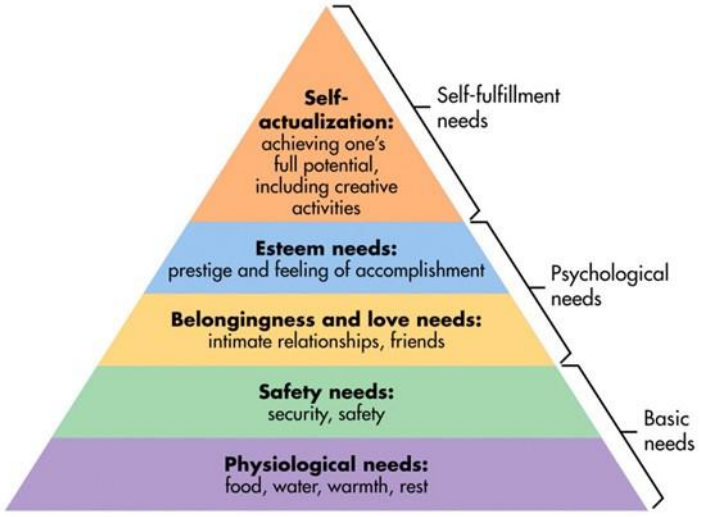
There are many reasons why a veteran or ex-Defence member may find themselves homeless, however the more common reasons are:

- mental health issues
- alcohol abuse
- substance abuse
- marriage breakdown
- gambling
- domestic violence
- transition from service
- unemployment
- financial problems

It is likely that homeless veterans may be experiencing a combination of any number of these issues.

## 4.4 Providing Assistance

Advocates should note that shelter and safety constitute some of the most basic human needs and should be provided ahead of any other forms of assistance. Maslow's hierarchy of needs is a theory in psychology proposed by American psychologist Abraham Maslow in his 1943 paper *"A Theory of Human Motivation"* in *Psychological Review*.



In meeting the needs of a client, Advocates should establish the client's (and, if applicable, the client's dependants) housing status. If the client is in fact homeless, Advocates must cater for their basic needs first (food, water, warmth, security and safety) before offering other forms of assistance. The client will be unable to think about accepting help for addictions, counselling for mental health issues or relationship problems if they are hungry, wet, cold and unsure of where they will sleep tonight.

### 4.4.1 Short Term Strategies

Advocates should look for crisis accommodation to help with the immediate problem. Crisis accommodation may be available specifically for veterans, or available for veterans as part of the wider homeless community. Advocates should identify crisis accommodation options in their home locality as this is a local issue which requires local solutions. Local options might include:

- Centrelink emergency accommodation,
- State Public Housing authorities,
- Local church groups,
- Local Councils,
- Service Clubs,
- Ex-Service Organisations, or
- Open Arms.

Links to some of these local resources are provided below, however Advocates should conduct their own local research to determine local availability of crisis accommodation:

Services Australia

NSW Government

QLD Government

In the ACT

VIC Government

Homelessness Australia

SA Government

WA Government Emergency Accommodation

Tasmania

NT Government Emergency Accommodation

Salvation Army

Crisis accommodation specifically for homeless veterans and ex-Service personnel have been established in several locations around Australia. Advocates should check if any of these options are available and keep themselves informed about any new facilities or crisis accommodation schemes have been formed in their areas.

Open Arms has been funded by DVA to provide a national co-ordination service for homeless veterans called Open Arms Crisis Accommodation Program. The program aims to provide crisis 'time-out' accommodation. This allows time to alleviate a crisis situation such as a potentially conflicting domestic situation or an immediate housing crisis.

Up to 5 nights crisis accommodation can be arranged, however in exceptional circumstances extensions may be granted.

More details are available on the Open Arms website here.

### 4.4.2 Longer Term Strategies

Homeless veterans and ex-Defence members, like other homeless people, most often have complex needs. Their problems are unlikely to be fixed if stable housing is only issue resolved. There will be a high probability of a relapse to homelessness unless the underlying issues that lead to homelessness in the first place are also resolved.

Many veterans or ex-Defence members who have become homeless will have complex needs and will require the help of a dedicated case worker to establish a structured program of support. This level of support is outside of the scope and capabilities of an ESO Wellbeing Advocate, so the client should be referred to Open Arms, the client's MD or medical specialist or the client's psychiatrist as appropriate.

Wellbeing Advocates should also ensure that the client has support from a Compensation Advocate so that claims for compensation (and NLHC if required) can be submitted or expedited.

## 4.5. Other Resources

DVA has a team dedicated to assisting veterans and ex-Defence who are, or at risk of becoming, homeless. They provide information and links to support services in each State and Territory and through the ESO community here.

# CHAPTER 5

# RESTORING WELLBEING (THE VETERAN OR DEPENDANTS IN CRISIS)

# PART A - TYPES OF CRISIS SITUATIONS

## 5.A.1 What is a Crisis?

There are many different definitions for a crisis or a crisis situation. In the context of this section we are referring to a personal or emotional crisis.

In his 1961 book *"An Approach to Community Mental Health"*, Professor Gerald Caplan of Harvard University defined a crisis as:

*"An obstacle that is, for a time, insurmountable by the use of customary methods of problem solving. A period of disorganisation ensues, a period of upset in which many abortive attempts at a solution are made".*

It is important to note here that a veteran or family will seldom come to an Advocate seeking help as their first resort. They will normally have tried to solve their issues themselves, but for a variety of reasons have been unable to. Advocates often only become aware of the issues when they have reached a crisis point.

A second definition, by James and Gilliland in their 2013 book *"Crisis Intervention Strategies"* says a crisis is:

*"A situation to which an individual cannot respond in an effective way, leaving the person in a state of emotional and psychological imbalance."*

In many cases the crisis has been caused in the first place by some emotional or psychological problem, with the result being that the crisis tends to put the person in a downward spiral, with the stress caused by the crisis exacerbating or worsening the underlying emotional or psychological problem.

Open Arms intimates that this downward spiral results in the person being unable to cope, and that the cause may be from internal sources (such as post-traumatic stress or depression) or external sources (such as being fired from a job or a relationship breakdown).

## 5.A.2 Causes of Crisis

Some of the common causes of crisis situations affecting veterans and their families are listed below.

- undiagnosed or poorly managed physical and mental health conditions,
- loss and grief,
- alcohol or drug misuse,
- relationship difficulties / breakdowns,
- social isolation, and
- a reluctance or unwillingness to address or acknowledge problems.

Service personnel have historically been reluctant to admit to physical, but particularly mental, injuries, especially where they believe this may end up affecting their career. Some have become very adept at hiding their post-traumatic stress or major depression from their workplace, their families and often even themselves. But because the person is already in a state of inner turmoil and emotional instability, it does not need much of an external stressor to tip them over the edge into a crisis situation.

This feeling of being overwhelmed and unable to cope can precipitate abuse of alcohol, medication or drugs or other risky behaviours to 'take the edge off', although it must be said that substance abuse can precipitate a crisis all by itself.

Other common causes of a crisis situation include a relationship breakdown, feeling socially and emotionally isolated from others and a reluctance or unwillingness to acknowledge and

deal with problems when they arise; allowing these problems to escalate and multiply until they reach seemingly overwhelming proportions.

## 5.A.3 Types of Crisis

There are many types of crisis situations involving veterans or their families that an Advocate may find themselves dealing with. These include:

- financial crisis,
- homelessness,
- risky behaviours, and
- thoughts of suicide.

Veterans or veteran's families may come to see an Advocate when they are in a financial crisis. There are a number of common causes of this, including unemployment or under-employment, poor financial management or budgeting skills or money wasted feeding drug, alcohol or gambling addictions. While Advocates may be able to access ESO Welfare funds to partially alleviate the immediate financial issue, such as feeding the family or paying the rent, this is a band-aid solution only. The client needs to be referred to a support agency such as Open Arms to address the underlying problem or problems.

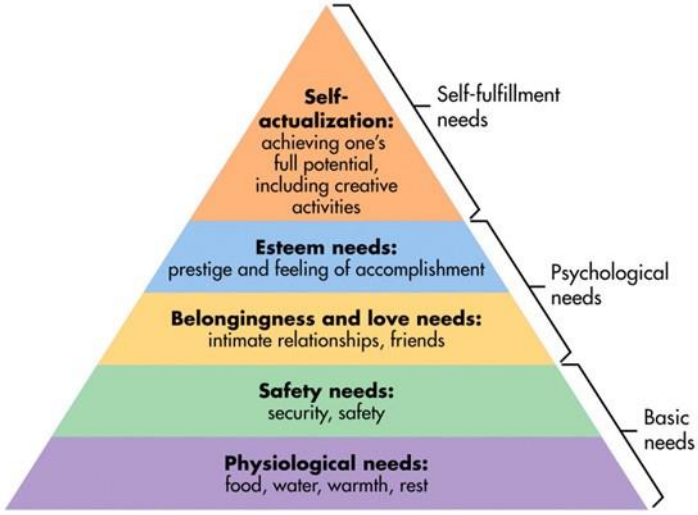
Risky behaviours include those already mentioned – drug, alcohol and gambling addictions - but also other activities such as inappropriate internet use, excessive risk-taking while driving, drunk or drug driving, thrill seeking, violent or destructive behaviour, undertaking self-harm, and unsafe sexual practices. Again, an Advocate is not in a position to address these issues, and the client needs to be referred to a support agency such as Open Arms to address the underlying problem or problems causing the behaviours.

Veteran homelessness and veteran suicide are particular types of crisis situations that will require Advocates to react quickly.

# PART B - RESPONDING TO A CRISIS SITUATION

## 5.B.1 Prioritising the Response

Maslow's hierarchy of needs is a theory in psychology proposed by American psychologist Abraham Maslow in his 1943 paper *"A Theory of Human Motivation"* in *Psychological Review*.




The basis of this hierarchy of needs is that the most basic needs, what Maslow referred to a Physiological Needs shown here at the bottom of the diagram, are needed to sustain life – air, water, food, warmth. These basic needs are the strongest drivers of behaviour, as an inability to meet these needs will result in death.

The next level, called Safety Needs, include personal safety, security and shelter from the elements – again life sustaining needs, but not as immediate as the bottom level.

Further up the levels, the needs become less about life and more about quality of life – a sense of belonging (relationships and friendships), self-esteem or self-worth and the highest level, self-actualisation or achieving one's full potential or life goals.

Maslow's theory is that a person's lower level needs must be met first, before the person can look at fulfilling their higher-level needs. When we are referring to a person in crisis, we are referring almost exclusively to the bottom two levels. The definitions (section A.1) for a crisis generally involve immediate threats to life or the physical and mental wellbeing of a veteran or the veteran's family, which are associated with Physiological Needs and Safety Needs.

## 5.B.2 Advocate Immediate Responses

The veteran or his or her family may be feeling socially isolated, may be unemployed, may have low self-esteem and feeling adrift and directionless and these needs must be addressed.

An Advocate's first priority must be dealing with any threat to life or personal safety. If the veteran is signalling thoughts of suicide, self-harm or harm to others, that requires an immediate response.

Then, in applying Maslow's theory, Advocates needs to address the veteran's basic needs - ensure the veteran and his or her family have food, water and warmth (or perhaps cooling, depending on their location in Australia).

Once these needs are met, Advocates can move on to safety needs – accommodation (together or separately, depending on the family situation) and physical safety.

It is only when these basic needs have been met can the veteran or family unit start to think about addressing the underlying problems that precipitated the crisis situation. In simple

terms, deal with the crisis first, then deal with the causes. A person cannot think about accepting help for addictions, or counselling, or finding a job, if they are hungry, wet, cold and have nowhere to sleep tonight.

Note that all or most of the assistance needed to deal with both the crisis itself (immediate assistance) and underlying issues (long term assistance) should be provided by support agencies such as Open Arms, or specialists such as psychiatrists, counsellors, or therapists.

The first thing you should do when confronted with a situation is to determine whether or not it constitutes a crisis. Questions to yourself here might be:

- Is there a threat of harm to self or others?
- Are alcohol or drugs involved?
- Does the situation need an immediate response (e.g. emergency housing)?

If you believe there is a threat of violence in any form, contact the police by calling 000.

If there is any other threat of harm, if someone already needs medical attention, or if the person is affected by drugs or alcohol, call an ambulance by calling 000, or contact Open Arms to arrange a trained counsellor or health professional to intervene. Alternatively, contact the person's GP.

If the crisis is not life threatening or potentially so, still respond appropriately by contacting Open Arms during business hours, or Open Arm's Veterans Line after-hours number, or an alternative local community support agency, depending on the nature of the crisis.

If there is a need for arranging crisis accommodation for the veteran or dependants (together or separately), make those arrangements. (see Veteran Homelessness)

## 5.B.3 Responding to Thoughts of Suicide

Unfortunately for some people, when faced with a crisis and unable to see a way out or a way forward, their thoughts turn to suicide. When responding to a crisis, Advocates need to first establish whether there is a threat of self-harm or harm to others. Suicide is the ultimate form of self-harm, so whether or not thoughts of suicide are involved in the situation must be established.

Historically, suicide has been the subject of cultural and religious taboos, and until fairly recently was illegal. For these reasons, someone contemplating suicide often found it very difficult to talk about – and the people they might want to tell also find it difficult to respond to, so both tend to avoid the subject.

The best way to broach the subject is openly and clearly, something like:

"Sometimes people in your situation think about suicide. Are you thinking about suicide?"

If Advocates have not already done so, they should attend suicide awareness training through a program called safeTALK – Suicide Awareness for Everyone. The program being conducted as part of Level 1 Consolidation Training for both Wellbeing and Compensation Advocates[2], and is also available through the ATDP network and through Open Arms.

Level 2 Advocates are encouraged to attend a two-day program called ASIST – Applied Suicide Intervention Skills Training, or another program called Mental Health First Aid. Both of these programs will provide Advocates the skills and knowledge to handle situations involving thoughts of suicide appropriately.

[2] Please note that this program is only available during programs that are presented face to face'.

## 5.B.4 The Veteran Suicide Issue

A Parliamentary Inquiry Report into this issue was released in August 2017, titled "*The Constant Battle – Suicide by Veterans"*. Advocates are encouraged to read this report, so they understand the issues. The report is available on the Australian Parliament House website here.

An extract of some of the facts from the report are shown here:

- The inquiry studied a period of 14 years (2001-2015).
- During that period, there were 325 deaths where the cause of death was recorded as suicide, and the person was recorded as having at least one day of Defence service.
- 90 were currently serving full-time members.
- 69 were currently serving Reserve members.
- 166 were from the ex-serving community.
- 303 were males, 22 were females.
- Over the study period, the figures fluctuated but averaged 23 suicides per year.
- In 2017, there were 86 certified deaths by suicide.

And these figures are considered conservative. Firstly, not all suicide deaths are linked to service, particularly where some time has elapsed since the member transitioned or the time in service was short. Secondly, the figures only reflect where the death certificate records suicide. Many single vehicle accidents, 'accidental overdoses' or 'accidental drowning' may in fact have been suicides.

In January 2018, an Australian Government research organisation, the Australian Institute of Health and Wellbeing, released a report into the incidence of suicide in serving and ex-serving ADF personnel. A copy of this report is available here.

## 5.B.5 Suicide Intervention Resources

Suicide ideation must be taken seriously. If the person states, or hints at, or an Advocate otherwise suspects suicide may be involved, action must be taken.

If the person says they already have the means (e.g. a weapon) or have taken some action (e.g. swallowed pills), call 000 and have emergency services respond.

If the person says or indicates they are just having suicidal thoughts, the Advocate should immediately refer them to someone equipped to assist them. There may be an ASIST trained person in the ESO, or contact Open Arms and tell them the details, or use one of the many suicide assistance resources available. The Advocate must ensure they follow up with them later to check if the person is now safe from suicide. A small sample of available community resources are shown here:

| **Suicide Resources** | **Contact** |
|---|---|
| **Emergency** – Police, Fire, Ambulance | 000 |
| Open Arms Help Line (24 hours) | 1800 011 046 |
| Lifeline | 13 11 14 |
| Lifeline Suicide Call Back Service | 1300 659 467 |
| Kid's Helpline (5-25) | 1800 55 1800 |

| | |
|---|---|
| Mensline | 1300 789 978 |
| Beyond Blue | 1300 224 636 |
| Open Arms Resources | Getting Support |

Advocates should identify and prioritise suicide intervention resources available to them in their ESO and community and keep them handy.

## 5.B.6 Duty of Care

Advocates should acknowledge that they have a Duty of Care while dealing with a crisis situation. Obviously Advocates want to provide the best assistance that they can to the veteran and their families. However, Advocates also need to acknowledge that they are not a counsellor, doctor or financial advisor. They need to be aware of their limitations in knowledge, skills and resources and work within them. Of course, if the Advocate is a trained professional in some related field they can work within those boundaries as well.

The basic rule is to take all reasonable steps to not cause any further harm to the veteran or family. And, in dealing with the situation, ensure that they do not put themselves in danger.

Advocates also need to be very aware of their own health and wellbeing. Dealing with someone else's crisis can be draining both physically and emotionally. When they have dealt with the crisis, they should consider whether they need to seek some support themselves to deal with the stress and any reactions they may have. Just talking to someone else, perhaps their mentor or another Advocate may help, but they also have access to counselling services through Open Arms or other agencies if required.

# CHAPTER 6

# MENTAL AND EMOTIONAL WELLBEING

## 6.1 Understanding Mental Health

Mental health and wellbeing are more than simply an absence of mental health conditions or disorders. A person with good mental health and a strong sense of wellbeing recognises their strengths and abilities, can cope well, is keen to make a contribution within their family and community, and will take part in enjoyable activities.

Wellbeing Advocates can assist veterans, ex-Defence members and their dependants by understanding the basic concepts of mental good health and wellbeing, recognising the signs and symptoms of mental and emotional problems and knowing the forms of assistance and resources that can be provided to clients.

The World Health Organisation (WHO) defines 'health' as:

*"… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*

The WHO defines 'mental health' as:

*" … a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."*

It is easy to see from this definition the reason for the priority being placed on mental health of veterans by both the Government, DVA, Defence and the wider ex-Service community.

To gain a broader understanding of mental health issues relating to younger veterans, it is recommended that Advocates read the 2017 report published jointly by Phoenix Australia (Centre for Posttraumatic Mental Health) and Orygen Australia (The National Centre of Excellence for Youth Mental Health) titled 'The Next Post – Young people transitioning from military service and their mental health.' A copy of this report can be found here.

## 6.2 Signs of Mental Ill-health

The following list is not designed to help Advocates diagnose a client with mental health issues, but to provide a guide to when Advocates might decide to seek further help for a client. There is often not a single sign, but a combination of a number of them, and the key is noticing a change in a person's behaviours or feelings, not just a pre-disposition for them.

Signs include:

- Withdrawing completely from family, friends and others.
- Sleeping poorly – for example, sleeping during the day and staying awake all night.
- Becoming very preoccupied with a particular topic – for example, death, politics or religion.
- Uncharacteristically neglecting responsibilities, personal hygiene or appearance; eating poorly.
- Deteriorating performance at school or work.
- Having difficulty concentrating, following conversation or remembering things.
- Panicking, becoming anxious, depressed, or talking about suicide.
- Having extreme changes in mood for no real reason.
- Hearing voices that no-one else can hear.
- Believing, without reason, that others are plotting against or spying on them, and feeling fearful or angry about this.
- Believing they are being harmed or influenced to do things against their will.
- Believing they have special powers or influence.

- Believing their thoughts are being interfered with, or that they can influence the thoughts of others.
- Spending extravagant and unrealistic sums of money.
- Common behaviours of clients suffering mental health conditions include:
- abusive behaviour, including violence towards their spouse, children, friends and others;
- addictive behaviour, including alcohol or substance misuse, gambling and excessive internet use;
- social isolation, such as cutting off ties with loved ones, family and friends;
- risky behaviour, including drink- or drug-driving, speeding and high-adrenalin activities; and
- threats or acts of self-harm or suicide.

## 6.3 Mental Health Conditions common among Veterans

A mental health condition occurs when a set of distressing symptoms (thoughts, feelings and behaviours) has a severe impact on a person's psychological, social (including relationships) and vocational functioning. This is not to say that it is always easy to recognise or diagnose a mental health condition, as the nature and severity of symptoms can vary from one person to the next. Personal characteristics and the environment in which a person is living influence how he or she will experience a mental health condition. For example, high-stress environments can trigger symptoms.

If mental health conditions are not recognised and treated, they usually become worse over time, and can cause major problems and disability in other areas of the client's life. The good news is that most commonly occurring mental health conditions can be successfully treated by psychological treatments. Sometimes medications will also help when used along with psychological treatments.

The earlier a condition is treated the more quickly it will respond to therapy. The support of families and friends is important, and the client's living situation needs to be stable and relatively low stress to get the best outcomes.

Advocates should encourage clients to seek counselling as soon as possible to properly diagnose and treat possible mental health conditions, and to use the resources listed at the end of this section to help prevent them.

**Depression.** Depression is not simply feeling low from time to time, which is very common and quite normal. Depression is a persistent state of low mood and a loss of interest or pleasure in activities that were previously enjoyable. Life becomes flat and grey, and nothing seems fun, exciting, or enjoyable anymore. In more severe cases, the client may believe that life is no longer worth living. Depression is often associated with guilt. Ex-serving members who have experienced war may feel guilty that they survived while others did not; it may be about what they had to do to survive; it may be related to things they did in combat about which they now
feel ashamed. The nature of military operations can be such that there may be no acceptable or 'good' options in some situations.

**Anxiety.** Anxiety is best described as a state of apprehension and worry that something unpleasant is about to happen. Some anxiety from time to time is absolutely normal. In fact, it has a protective value in alerting people to potential threat and putting them in a state of readiness. Anxiety requires treatment when it is a frequent and dominant feature in a client's life. Anxiety can also be a problem if it comes in very intense bursts (panic attacks) in response to specific situations such as crowded places or public transport. Social anxiety (a fear of embarrassment or performance-related anxiety) can result in a very narrow life without much enjoyment if social events are avoided. Anxiety can lead to social withdrawal

and being house-bound (agoraphobia) in order to avoid a wide array of threatening situations, which is also a major risk factor for developing depression.

**Posttraumatic Stress Disorder (PTSD).** PTSD is a psychological response to the experience of intense traumatic events, particularly those that threaten life. The client may have experienced a threatening event that has caused them to respond with intense fear, helplessness, or horror. For military veterans, the trauma may relate to direct combat duties, being in a dangerous war zone, or taking part in peacekeeping missions under difficult and stressful conditions. It is normal to experience distress when confronted with trauma, and most people recover over the first week or two, particularly with the help of caring family members and friends. However, for some people the symptoms do not seem to resolve quickly. It is also common for symptoms to vary in intensity over time. Some people go for long periods without any significant problems, only to relapse when they have to deal with other major life stresses. In rare cases, the symptoms may not appear for months, or even years, after the trauma. The reasons for this are not fully understood, but a common observation is of a veteran who, when busily immersed in a successful career and family life appears to cope quite well, only to begin to exhibit symptoms when they retire from work.

The following are considered mental conditions in their own right, however for veterans are often link to or are a consequence of one or more of the conditions mentioned above:

**Traumatic Grief.** After the loss of a friend in battle or an accident, the grief associated with trauma may be unresolved over many years and lead to social withdrawal. Clients with traumatic grief may be unwilling to get emotionally close to someone again. They may have feelings of anger because the death was ‘unfair’, or feelings of powerlessness or guilt about the circumstances of the death.

**Sleep Disorders.** Disturbed sleep is common for a variety of reasons and can be harmful to a person’s wellbeing. Sometimes it is just a consequence of poor sleep habits (e.g., too much alcohol or caffeine before sleep, too much physical or mental stimulation before going to bed). Sleep problems can develop as a consequence of disrupted sleep patterns in operational zones (somewhat like the disrupted sleep patterns of shift workers or parents getting up to settle young children). However, sleep problems can also be a sign of poor mental health. Depression can result in too much or too little sleep. Anxious thoughts replaying over and over can keep people awake. Frequent nightmares will disrupt sleep patterns.

**Alcohol and Drug Use.** In an attempt to cope with unpleasant symptoms of mental health conditions, clients may turn to alcohol or other drugs. Many veterans with chronic PTSD also have major problems with alcohol and other drugs. In Australia, the most common drug problem, leaving aside tobacco, (which is the biggest killer in the long run) is alcohol, but many people also use other drugs (e.g., cannabis or prescription medications) to excess. Excessive alcohol and drug use impair the ability to function effectively and to relate to other people. It can cause great difficulties in areas such as physical health (liver and brain damage, and increased risk of many types of cancer), relationships, work, and finances. Alcohol binges are associated with explosive anger and violence and impulsive decisions to suicide.

**Gambling**. Problems arise when losses exceed what can be afforded and when the over-riding motive is to win money or to escape from boredom and depression. It is then very easy for things to go horribly wrong with massive repercussions for bank balances and debt. Fraud is common when problem gamblers desperately ‘chase’ their losses to try and repair the damage. Families are ripped apart; it is very difficult to regain the trust of family members and friends when it is discovered that many assets have gone, or bankruptcy is being faced. Problem gamblers often become depressed and anxious as a result of their gambling and have high rates of suicide.

**Excessive or Inappropriate Internet Use.** Excessive use of the Internet (sometimes called ‘cyber-addiction’ or ‘Internet Addiction Disorder’) can be very damaging to our relationships. Regardless of the preferred activity engaged in over the Internet, the issue is whether it is consuming most of the client’s time and energy to the detriment of other aspects of their life.

**Pain and Other Physical Symptoms.** Chronic stress is associated with a wide range of physical symptoms such as skin complaints and general aches and pains. Pain related to injuries sustained while serving can greatly undermine a client's sense of wellbeing (e.g., chronic back pain is associated with general disability, emotional distress and depression). When a mental health condition occurs along with chronic pain, the pain may be felt more intensely and be more distressing. Untreated pain impacts very negatively on occupational, social and recreational functioning. Not surprisingly, this can induce a sense of hopelessness and worthlessness and lead to social isolation and severe depression. It is common for people to self-medicate with alcohol or other drugs when struggling with chronic pain. The presence of chronic pain carries an increased risk of suicide in veterans.

**Self-harm and Suicide.** The risk of self-harm, either intentionally or by accident, is much higher if a client has a mental health condition. Accidents are more likely when risks are being taken, such as drink-driving or handling machinery when intoxicated. A fatalistic attitude ('what will be, will be') about life may result from war experiences, if the client feels they had little control over outcomes, and when feeling hopeless and helpless about their future. This approach to risk- taking also puts other people at risk.

An information booklet with more information about these common mental health conditions, their symptoms and treatment options was produced in 2011 by Phoenix Australia (Centre for Posttraumatic Mental Health) in conjunction with DVA. It is available here.

## 6.4 Other Mental Health Disorders

Although not as common among the veteran and ex-Service community, as part of the normal population clients may suffer from a variety of other mental conditions. These are discussed below.

**Adjustment Disorder.** Adjustment disorder is a short-term condition that occurs when a person has great difficulty coping with, or adjusting to, a particular source of stress, such as a major life change, loss, or event. In 2013, the mental health diagnostic system technically changed the name of "adjustment disorder" to "stress response syndrome."

**Personality Disorders.** When someone's personality causes major problems in their life, such as serious upheaval and distress, problems with relationships and perhaps self-harm, they may have a personality disorder. This behaviour may have been happening since teenage years or early adulthood and disrupting most parts of their life. While much is still not known about personality disorders, the most common is borderline personality disorder (BPD). Symptoms include a fear of being abandoned, insecurity, volatile emotions, reckless behaviour, paranoia, and self-harm. Major contributing factors in the development of BPD could include traumatic events in childhood, such as abuse, neglect and transition from caregivers or loved ones.

**Eating Disorders.** Eating disorders are often a way that people deal with psychological problems such as low self-esteem or intense distress. They are more common among adolescent girls and young women but can also affect boys and men. Types of eating disorders include:

- **Anorexia nervosa**– not eating enough, to the point of starvation at worst, yet still feeling overweight.
- **Bulimia nervosa**– feeling unable to control the urge to eat and eating too much, then feeling guilty and purging what you've eaten in different ways, including vomiting, the use of laxatives or excessive exercise.
- **Binge eating**– eating excessively, even if you're not hungry, and feeling guilty afterwards. Bingeing often masks other feelings, such as anxiety, loneliness or depression.

**Schizophrenia.** People with schizophrenia have disturbed thoughts, behaviour and emotions, with psychotic symptoms which vary from person to person. They may see things or hear voices that others don't (hallucinations), which can be very distressing, and they may

have delusions and talk in a way that others can't understand. A person may lose their ability to take care of themselves and perform daily tasks; or they may not show their usual range of emotions and become so disorganised in their thinking that working or studying is impossible.

**Psychosis.** Psychosis is often associated with schizophrenia, bipolar disorder or schizoaffective disorder (in which people experience symptoms of schizophrenia such as hallucinations as well as those of bipolar disorder such as mania), but it can occur on its own. It can also be triggered by stress, trauma and alcohol or other drug misuse. Other causes may include genetic inheritance and chronic lack of sleep.

**Bipolar Disorder.** Bipolar disorder (previously called manic depression) is a condition that can severely change a person's mood. With bipolar disorder, a person can swing from feeling very high, which is called being manic or hypomanic, to being extremely low. At times, they may lose contact with reality.

## 6.5 Resilience Building

A series applications and online resources have been developed to help veterans, current and ex-Defence members and their dependants build their resilience. These are located on the Open Arms website here.

## 6.6 Support by the Wellbeing Advocate

Advocates are not mental health professionals and are not expected to (or should attempt to) diagnose or treat clients with suspected mental health issues. However, there are some simple steps the Advocate can take to assist their clients:

- Ensure that the client has applied for treatment for mental health conditions under Non-Liability Health Care.(see Chapter 1.B.6).
- Encourage the client or their dependants to speak, in the first instance, to their normal GP about their concerns and symptoms.
- Refer the client or their dependants to Open Arms for counselling and/or group programs.
- Encourage the veteran to access DVA-funded group programs.
- Refer the veteran or dependants to on-line resources and support groups.
- Attend a Mental Health First Aid Course. See here.

## 6.7 Resources

Open Arms

Beyond Blue

Lifeline

Beyondblue

Phoenix Australia

RedSix

Australian Veterans Support Program

# CHAPTER 7
# PHYSICAL WELLBEING

# PART A - PHYSICAL ACTIVITY

## 7.A.1 Introduction

Health promotion is the process of enabling people to increase control over, and to improve, their health. The intention is to help people improve their wellbeing, not just avoid illness, by controlling some of the determinants of health. Wellbeing Advocates can do more to promote the health of their clients through participation and inclusion than by direction. "Do as I say, not as I do" does not inspire change.

The aim of Wellbeing Advocacy is to promote and assist clients with achieving a "Healthy Veteran, Healthy Family". This can best be achieved by taking a holistic approach to health – that is, promoting mental health, physical health and social/relationship health.

While members of the ADF, most clients will have been encouraged to, in fact required to, remain fit and healthy. This is mainly conducted through organised physical training and team sports, as well as the intense physical nature of many military employment categories. Combined with regular medical and dental examinations, this encourages many ex-Defence members to adopt a lifelong commitment to maintaining physical fitness.

Modern lifestyle encourages sedentary behaviour through watching television, use of computers, on-line gaming, driving vehicles, use of mobile phones and other electronic devices. Unfortunately, many clients adopt this sedentary lifestyle once they leave the ADF, and greatly reduce their physical activity or even cease it all together.

Clients will have many reasons (or excuses) for this, including:

- too busy;
- too tired;
- just having a break – I will start exercising again soon; or
- no one can tell me what to do anymore.

Of course, some clients will have more valid reasons to reduce or cease their physical activity:

- a medical condition that makes exercise difficult or painful, or
- a mental condition that makes the thought of exercise difficult or painful.

## 7.A.2 Benefits of Physical Activity

Undertaking physical activity and exercise has many benefits, both physical and emotional. These include:

- Gives you more energy,
- Helps you sleep better,
- Helps you to relax (reduces anxiety and stress),
- Increases sensual awareness and enjoyment,
- Helps you meet new people and make new friends,
- Allows you to live longer and more independently,
- Improves self-confidence and sense of wellbeing,
- Lifts your mood, reduces feelings of sadness and depression,
- Helps control weight, body fat, blood pressure, cholesterol, diabetes and bone and joint problems,
- Reduces the risk of heart disease, stroke and some cancers,

- Helps manage pain,
- Helps to maintain and increase joint movement.

## 7.A.3 How Much Physical Activity?

Undertaking any physical activity is better than none. Factors such as age, medical conditions and the time elapsed since last undertaking exercise need to be considered. Clients should be encouraged to speak to their GP or specialist before undertaking physical activity.

As a rough guide, clients should be encouraged to accumulate 2.5 to 5 hours of moderate intensity activity, or 1.5 to 2.5 hours of vigorous intensity activity, per week. They should be encouraged to undertake some activity on most, preferably all days each week rather than undertake all activity on one day. A combination of aerobic and muscle-building activities is most beneficial.

## 7.A.4 Ways Advocates can Encourage Clients to be Active

As indicated, Advocates can help promote a healthy lifestyle in their clients by being active and health themselves (within their own physical and medical limitations). Asking clients to participate in healthy activities with them works far better than telling them they should exercise more.

Clients should be encouraged to:

- Join an exercise group or a gym;
- Make a plan: what, when, who, where to exercise;
- Set goals;
- Get into a routine, but include variety;
- Use a diary, wrist monitor or app to monitor progress;
- Expect setbacks; and
- Measure the changes.

## 7.A.5 Resources

There are a wide variety of resources available, including obvious ones like local parks, cycle and walking paths and gyms. A simple Google search for ‘exercise class’, ‘fitness activities’ or ‘healthy living’ in your local area will provide with numerous options to provide clients (and Advocates themselves).

Physical Activity and Exercise Guideline

Choose Health – Be Active - A physical activity guide for older Australians.

Heart Foundation – Physical Activity and your heart

Lift for Life

DVA Heart Health Program

DVA Exercise Physiology Services

DVA Wellbeing and Support Program

# PART B - HEALTHY EATING

## 7.B.1 Introduction

Combined with exercise, eating health and eating smart will promote a longer and better life. Heathy eating has many benefits, especially for older clients, including:

- having more energy,
- feeling good,
- less falls, fractures and illnesses,
- less cognitive decline and dementia
- healthy independence,
- better and faster wound healing, and
- better sleep.

## 7.B.2 Balanced Diet

Like exercise, clients should be encouraged to speak to their GP or specialist before embarking on a major change of diet. Most medical practitioners, however, agree that 'going on a diet' can be counterproductive and in fact cause problems, whereas 'changing to a better, balanced diet' can be very beneficial for the reasons shown above.

The guidelines shown here are general in nature and are drawn from the resources detailed at the end of this Part of Chapter 7. Clients will have individual needs depending on age, gender, physical and medical condition and amount of exercise undertaken, so should seek guidance from their GP or dietician.

The human body needs a variety of nutritional inputs to maintain itself in a health state. The basic components are shown in the following table:

| Type | Benefit |
|---|---|
| Protein | Growth and repair |
| Carbohydrates (starches and sugars) | Energy |
| Fats | Protection, absorption, hormones |
| Fibre | Filling, laxative, healthy bowel |
| Vitamins and minerals | Growth, development, health |
| Water | Required to absorb above and prevent dehydration |

Modern lifestyles mean that many clients eat a variety of highly processed foods (which often include a lot of added salt, sugar and preservatives) and fast foods (which often also include a lot of added salt, sugar and preservative as well as being fried in high cholesterol oil or trans fats).

The following table provides a guide to what foods should be consumed more, and what foods should be consumed less, to achieve a healthy, balanced diet:

| Eat More | Eat Less |
|---|---|
| Vegetables and legumes | Starchy vegetables (potatoes) |
| Fruits | Refined cereals |
| Wholegrain cereals | High- and medium-fat dairy foods |
| Low fat milk, yoghurt and cheese | Red meats (men only) |
| Fish and seafood | Fried foods |
| Poultry | Takeaway fast foods |
| Nuts and seeds | Cakes and biscuits |
| | Chocolate and confectionery |
| | Sweetened drinks |

Nutritionists recommend the following daily intake of the various food groups to achieve a balanced, healthy diet:

| Type | Serves per Day |
|---|---|
| Vegetables and legumes | 5 serves |
| Fruit | 2 serves |
| Grains/cereals (wholegrain) | 6 serves |
| Lean protein | 3 serves |
| Dairy foods (soy equivalent) (low fat) | 2.5 serves |
| Water | 1.5 litres |

Foods to limit or avoid altogether include:

- saturated and trans fats, and moderate amounts only of mono- and polyunsaturated fats;
- salt/sodium, both in processed food and added;
- sugars, both in processed food/drink and added;
- alcohol – no more than two standard drinks per day.

## 7.B.3 Resources

Some other resources that Advocates might find useful include:

DVA Cooking for 1 or 2 Program

The Food Coach

Better Health Channel

# PART C - SLEEP

## 7.C.1 Importance of Sleep

There is no agreed medical reason why we need to sleep. The exact reason remains a mystery. What is agreed, however, is that we perform better with it, and poorly without it. Sleep is an active period in which a lot of important processing, restoration, and strengthening occurs. Our bodies all require long periods of sleep in order to restore and rejuvenate, to grow muscle, repair tissue, and synthesize hormones. Sleep helps us to solidify and consolidate memories.

## 7.C.2 Causes of Sleeplessness

There are many reasons why clients may be suffering from sleeplessness. These include:

- Medical causes.
  - Obstructive sleep apnoea,
  - Asthma. or
  - Pain.
- Environmental causes
  - Noise,
  - Light, or
  - Temperature.
- Psycho - Physiological causes
  - Reduced or lack of sleep drive,
  - Biological clock, or
  - Stress and anxiety.

## 7.C.3 Strategies for a Healthy Sleep

Sleeplessness may relate to medical conditions, and prolonged sleeplessness can cause medical problems, so Advocates should advise clients to see their GP if sleeplessness is a problem. The GP may recommend the client see a specialist, or attend a sleep study, to ascertain the cause of sleeplessness relates to a medical problem such as blocked airways or deviated septum.

Advocates can also use the following as a guide to helping clients achieve a good night's sleep.

**During the day.**

- Exercise regularly;
- Get out in the sunlight;
- Nap for no longer than 30 mins, and not late in the day;
- Stay out of bed until ready to sleep; and
- Deal with worries and stress before going to bed.

**In the evening.**

- Avoid caffeine for at least 4 hours before bed;
- Avoid alcohol late in the evening;
- Do not smoke before bed (or in bed!);

- Time dinner so neither full nor hungry;
- Turn off TV or computer early; and
- Have a warm milk or herbal tea.

**Immediately before bed**

- Go to the toilet immediately before retiring to bed
- Try to go to bed at the same time
- Try going to bed later if waking too early
- Turn down clock brightness, or remove altogether
- Make sure bedroom is dark

**In bed**

- Have a comfortable bed, mattress and pillow
- Do not watch TV, use laptop or other screen devices
- Try reading, if that helps relax you
- Make sure temperature is comfortable
- Close your eyes - tell your brain it is sleep time

## 7.C.4 Resources

The Sleep Health Foundation

The Better Health Channel

Open Arms – Sleeping Better group program

Veterans' Mates – Good Sleep Guide

# PART D - HEALTHY HOUSEHOLD

## 7.D.1 Healthy Household

In promoting physical health to clients and their dependants, Advocates should also consider the environment in which their clients live. Good exercise and a good diet go part of the way to a healthy lifestyle, but a health household environment is also important.

Poor indoor air quality may produce a range of health effects, including:

- mild and generally non-specific symptoms such as headaches, tiredness or lethargy
- more severe effects such as aggravation of asthma and allergic responses.

Common sources of indoor air pollutants include:

- building operations and construction materials
- household products
- various human indoor activities
- external factors (from outdoors).

## 7.D.2 Hazards

The following is a list of potential health hazards in the household, the major sources of those hazards and their potential health effects:

| Pollutant | Major Source(s) | Health Effects |
|---|---|---|
| Nitrogen dioxide | Gas combustion | Chronic respiratory disease |
| Carbon monoxide | Kerosene, gas and solid fuel combustion, cars idling in enclosed garage, cigarette smoke | Aggravation of cardiovascular disease, poor foetal development |
| Formaldehyde | Pressed wood products, consumer products, hobby, crafts | Eye, nose and throat irritation |
| Volatile organic compounds (VOCs) | New building products, cleaning products, office equipment, consumer products | Eye, nose and throat irritation, headache, lethargy |
| Passive smoke | Tobacco smoking | Eye, nose and throat irritation, aggravation of asthma, chronic respiratory disease, lung cancer |
| House dust mite allergens | Dust mites in bedding, carpets, furniture | Aggravation of asthma, nasal inflammation, eczema |
| Mould spores | Bathrooms, damp rooms, window sills, indoor plants, poorly ventilated areas | Aggravation of asthma, nasal irritation and inflammation |

| | | |
|---|---|---|
| Lead in indoor dust | Pre-1970s paint, hobbies and renovations | Poor childhood intellectual development |
| Pet dander | Cats and dogs | Aggravation of asthma and hay fever |

## 7.D.3 Other Hazards

Other hazards that may be present in some houses, particularly older houses are discussed below.

**Asbestos.** Asbestos was used widely in the construction, car and textile industries because of its strength and ability to resist heat and acid. It is no longer allowed to be used in building products for the home. Asbestos-containing products were rarely labelled. Products like cement sheet, roofing sheet, some textured paints, vinyl floor tiles, pipe lagging and fire- resistant boards and blankets used in the home before the mid-1980s may contain asbestos. Generally, home building products containing asbestos are not a health risk but if asbestos is disturbed to produce fibres or dust, asbestos fibres may be released into the air and inhaled.

**Lead.** Lead is a concern when small particles or fumes are swallowed or inhaled. Many older building and household products contain lead, but newer products no longer do. Items such as old paint, flashing, old plastic pipe and fittings, electrical cabling and glazed pottery can contain variable amounts of lead. Contact with lead can arise from home renovation activities, particularly when stripping old paint, through some hobbies (e.g. lead-lighting, making fish sinkers or pottery glazing) or coming into contact with contaminated soil.

**Combustion Products.** Combustion products include smoke (small soot particles), ash and gases that can get inside your home from fireplaces and heaters burning wood, coal, gas or kerosene, gas cooking appliances, tobacco smoking, outdoor air, exhaust from cars in garages, and hobbies such as welding and soldering. Combustion particles are so small they behave almost like a gas — they can enter or leave a home very easily. When you breathe them in, they travel into the deepest part of the lungs. Under certain circumstances these particles and gases may cause ill health or, in extreme cases, even death.

**Volatile Organic Compounds.** Volatile organic compounds (VOCs) are chemicals containing carbon that evaporate into the atmosphere at room temperature. They often have an odour and are present in a wide range of household products, construction materials and new furnishings. Household products that contain VOCs include paints, varnishes, adhesives, synthetic fabrics, cleaning agents, scents and sprays. VOCs can also result from personal activities, such as smoking. When used in building products or other indoor items VOCs slowly make their way to the surface and 'off-gas' into the surrounding air. Most off-gassing occurs when products are new and/or freshly installed, after which it lessens dramatically over time. Only a few specific VOCs have been studied in detail and little is known about the health hazards when VOCs mix with each other and other pollutants. The level of VOCs in the home can vary greatly, not only over time but also from room to room, especially if new VOC-containing products are frequently introduced.

## 7.D.4 Four Steps to Better Air Quality

Clients can reduce the hazards associated with air quality in their households by following four simple steps:

- **Step One - Eliminate.** Identify the source of air problems and wherever possible eliminate through better product selection and design.
- **Step Two - Ventilate.** If too little fresh air enters a home, pollutants can accumulate to levels that can pose health and comfort problems. Ventilate the home to remove these.
- **Step Three - Separate.** Separate problem materials from occupants by using air barriers or sealers such as coatings.

- **Step Four Absorb.** Indoor plants can be used to improve the quality of the indoor environment, as well as add beauty.

## 7.D.5 Resource

Australian Government Your Home website

# CHAPTER 8
# FINANCIAL WELLBEING

# PARTA – SOURCES OF FINANCIAL SUPPORT AND ASSISTANCE

## 8.A.1 Sources of Finance

Wellbeing Advocates should never give clients financial advice, but an understanding of the various income streams that clients might have, or might be entitled to but not accessing, will put them in a better position to provide assistance in a variety of areas. If a client is having financial difficulties, Advocates can provide them with information on forms of financial assistance available and how they can apply for that assistance. Clients should be advised to seek independent financial advice.

Clients may have a number of sources of finance available to them, depending on their age, physical and mental health, family structure and employment history. These sources may include:

- Wages from employment
- Income from self-employment
- Superannuation benefits
- Age or Service Pension
- Dividends from shares / investments
- Disability Compensation Payment
- Incapacity Payments
- Permanent Impairment Payments
- Carer's Payment or Carer's Allowance

## 8.A.2 Support from the Department of Veterans' Affairs

There are a variety of sources of finance available from the DVA to which a client may be entitled. These include:

### 8.A.2.1 Veterans' Entitlements Act 1986

**Service Pension.** A Service Pension is a means- and asset-tested income support payment that provides a regular income for people with limited means, payable to veterans with qualifying service under the Veterans' Entitlements Act 1986 (VEA). It is equivalent to the age pension available from Centrelink, but have a number of advantages over the age pension, including:

- is payable from age 60, and
- Australian veterans in receipt of a Service Pension may have more beneficial health care entitlements.

**Invalidity Service Pension.** An Invalidity Service Pension is another type of income support payment, equivalent to the Disability Support Pension available from Centrelink. Eligibility requirements include:

- is a veteran who has rendered qualifying service under the VEA,
- is permanently incapacitated for work, and
- meets additional residency requirements if a Commonwealth or Allied veteran or Allied mariner.

The veteran does not need to be pension age and the invalidity does not need to be service related. Eligibility ceases when veteran reaches age pension age, although at age 60 becomes eligible for a Service Pension.

Information on the Age Service Pension and Invalidity Service pension is available here.

**NOTE**

The following information is a summary only. Compensation legislation is very complex, and Wellbeing Advocates should advise clients to consult with a qualified Compensation Advocate with regard to benefits available under the VEA, DRCA and MRCA

**Disability Compensation Payment.** A Disability Compensation Payment (DCP) is paid under the VEA to compensate a veteran, member of the Forces, member of a Peacekeeping Force or Australian mariner for injuries or diseases caused or aggravated by war service or certain Defence service on behalf of Australia. Section 13 of the VEA draws a distinction between 'injury or disease' and 'incapacity'. Diagnosis of an injury or disease does not in itself entitle a veteran to a DCP - the veteran must suffer an incapacity as a result of the injury or disease to be eligible. The injury or disease causing the incapacity must also be causally linked to eligible VEA service.

The amount of DCP paid is dependent on the degree of incapacity caused. A DCP is:

- paid fortnightly for life,
- not income or assets tested,
- not based on age, and
- tax free.

The four categories of DCP are:

**General Rate.** The General Rate (GR) is a scale of compensation that takes into account the degree of medical impairment and lifestyle effects of an accepted condition or conditions. It does not have regard to whether or not a veteran is employed. The scale is based on a percentage of the 100% GR DCP (which is adjusted bi-annually) from 0% to 100% in 10% increments.

**Extreme Disablement Adjustment.** The Extreme Disability Adjustment (EDA) compensates a person who is extremely disabled (70+ impairment points and lifestyle rating at least 6) and in receipt of the 100% GR DCP, but whose accepted disabilities have further degenerated after age 65. EDA is a 50% increment to the 100% GR DCP. EDA does not have regard to whether or not a veteran is employed nor any regard to income and assets.

**Intermediate Rate.** The Intermediate Rate (IR) is paid to compensate a veteran, member of the Forces, member of a Peacekeeping Force, or Australian mariner, who, because of incapacity resulting from eligible service, is unable to resume or continue in paid work for 50% or more of their normal work time, or 20 hours or more per week. The IR provides a rate of pension to bridge the gap between the GR and the Special Rate for veterans capable of part-time or intermittent work only.

**Special Rate.** Special Rate (SR) is the highest level of DCP available to an injured veteran, member of the Forces, member of a Peacekeeping Force or Australian mariner under the VEA. Incapacity must be due to eligible VEA service. SR is designed to provide non-economic loss compensation to veterans incapacitated by war- or Defence-caused conditions with higher rates of pension when the veteran is severely incapacitated and is unable to work or to earn a normal wage because of the effects of his or her accepted conditions. SR Is not income or asset tested, nor is it taxable income.

**Temporary Special Rate.** To receive Temporary Special Rate (TSR), the veteran must meet the same criteria as SR, however the medical opinion is that the incapacity for work is not permanent. TSR is only granted for a specific time period (based on medical advice) and will

automatically revert to General Rate at the end of the time period. If the incapacity becomes permanent, the veteran will need to submit an Application for Increase (AFI) to receive the SR.

**Additional Disability Compensation Payment.** An increased rate of DCP is payable for amputations and blindness in one eye, where the veteran receives the DCP at less than the Special Rate. The additional amount depends on the type of amputation; however, the combination of the additional amount and the rate of DCP cannot exceed the Special Rate.

More information on Disability Compensation Payments is available here.

**War Widow's/Widower's Pension.** The War Widow's/Widower's Pension (WWP) is compensation for the widow or widower (including a partner) of:

- an Australian veteran (this includes an Australian mariner),
- a member of the Forces, or
- a member of a Peacekeeping Force,

whose eligible VEA service has caused or contributed to their death. An application may be made by a widow or a widower of a person who has eligible service covered by the VEA.

**Orphan's Pension.** The Orphan's Pension (OP) is compensation for dependent children of deceased:

- Australian veterans (this includes an Australian mariner),
- members of the Forces.

The child must be the natural or adopted child of the veteran, or a child who was wholly or substantially dependent on the veteran, immediately prior to the veteran's death. If the child is between 16 and 25 years old, he or she must be:

- receiving full-time education,
- not receiving benefits under the Veterans' Children Education Scheme (VCES), Youth Allowance or other education assistance from the Australian Government, and
- not receiving a disability support pension from Centrelink or another Australian Government pension or allowance.

Information on the WWP and OP is available here.

### 8.A.2.2 Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988 (DRCA) and the Military Rehabilitation and Compensation Act 2004 (MRCA)

**Incapacity Payments.** Incapacity payments are payments made to top up or replace income lost due to an accepted injury or disease. Incapacity payments are payable to age pension eligibility age.

- **For transitioned MRCA clients**, incapacity payments are based on ADF salary for rank and pay level and any allowances at the date of transition but accord with ADF pay and allowance rates during the period of incapacity (that is, the current pay and allowance rates).
- **For transitioned DRCA clients**, incapacity payments are based on ADF salary for rank **and** pay level and any allowances at the date of transition but are indexed annually on 1 July in accordance with the Wage Price Index.

All periods of incapacity for work must be supported by medical evidence showing that the cause of the incapacity was an accepted service-related injury or disease.

More information with regard to how incapacity payments under DRCA and MRCA are calculated can be found here.

**Permanent Impairment.** Permanent Impairment (PI) compensation is paid under DRCA and MRCA where an accepted condition is considered to be likely to continue indefinitely and has stabilised. PI is a tax-free payment for the non-economic effects of a service-related injury or disease.

- **For MRCA clients**, PI payments may be taken as periodic payments (paid fortnightly), a lump sum or a combination of both. More information with regard to MRCA PI payments can be found here.
- **For DRCA clients**, PI payments can only be taken as a lump sum. More information with regard to DRCA PI payments can be found here.
- **Provisional Access to Medical Treatment (PAMT).** Under both DRCA and MRCA DVA provides pays for treatment of certain conditions while a person is awaiting the outcome of a claim for compensation. When DVA receives a claim the person is sent an acknowledgement letter that includes a PAMT Medical Treatment Form. To access paid medical treatment a person must have their GP or treating medical professional complete the Form and return it to DVA. More about PAMT can be found here

## 8.A.3 Military Superannuation Schemes

Depending on their age, years of military service, enlistment and transition dates and, in some cases, personal choice, ex-Defence members will have been members of one of the ADF superannuation schemes which are administered by the Commonwealth Superannuation Corporation (ComSuper). The military superannuation schemes are:

- Defence Force Retirement Benefits Scheme (DFRB);
- Defence Force Retirement and Death Benefit Scheme (DFRDB);
- Military Superannuation Benefits Scheme (MSBS); and
- ADF Super and ADF Cover.

Each scheme closed to new members on introduction of replacement scheme, and members of the previous scheme were generally given a one-off option to transfer to the new scheme or remain in their existing scheme.

Under DRFDB, members who retire after 20 years or more effective service are eligible to receive retirement benefits in the form of a fortnightly pension for life regardless of age at retirement. For MSBS and ADF Super members, a retirement benefits are only payable once the member reaches a minimum of 55 years and retires from full time employment.

Each scheme also includes an invalidity pension if the member is medically transitioned. Invalidity pensions are classed as Class A or Class B invalidity pensions, depending on the degree of invalidity of the individual.

More information on all of the military superannuation schemes are available from CSC here.

# PART B - EMERGENCY FINANCIAL ASSISTANCE

## 8.B.1 Sources of Crisis Funds

Wellbeing Advocates have access to a ranges of sources that provide assistance to clients in financial difficulty. Advocates should consider referring the client to DVA and/or the Services Australia (a part of the Department of Social Services (DSS)) to access emergency funds under a number of Government schemes. If the client is ineligible or needs funds before these schemes can be accessed, emergency financial assistance through their ESO should be considered.

### 8.B.1.1 DVA

**Financial Hardship**. DVA can provide relief to clients who are facing financial hardship through the application of a set of hardship rules related to personal assets. To be eligible for such consideration clients must meet the eligibility criteria for a service pension, ISS or veteran payment . more information is available here.

**Crisis Payment**. A crisis payment is a non-taxable, "one off" payment to financially assist eligible people following a range of defined circumstances. There are a number of criteria relating to eligibility for receipt of a crisis payment. Information regarding the crisis payment can be found here.

### 8.B.1.2 Services Australia

**Crisis Payment.** Crisis Payment is a one-off payment for people in severe financial hardship and extreme circumstances. Eligibility criteria include:

- be eligible for an income support payment from us, and
- have severe financial hardship, and
- have an extreme life change such as leaving a violent relationship, getting out of jail or being a refugee, or
- go through a natural disaster not covered by the specific Disaster Recovery Payment.

**Carer Adjustment Payment.** The Carer Adjustment Payment is a one-off payment if the person's child under 7 years old gets a severe illness or major disability. The illness or disability must be because of a catastrophic event.

**Pension Loan Scheme.** The Pension Loan Scheme is a voluntary reverse equity mortgage that offers older Australians an income stream to supplement their retirement income.

**Advance Lump Sum Payment.** Clients who are already in receipt of Services Australia income support payments may be eligible to receive a lump sum advance payment. They will be required to pay it back later out of their income support payments.

More information on the DSS crisis payment options is available here.

### 8.B.1.3 Ex-Service Organisations.

**ESO Emergency Welfare Funds.** Many ESO maintain Welfare Funds which can be accessed by Wellbeing Advocates to assist clients in emergency situations. In most cases, the funds are used to purchase food, pay for accommodation or pay bills, rather than as a cash hand-out to clients.

**RSL Crisis Funding.**

RSL DefenceCare Financial Assistance (NSW).

RSL Queensland Crisis Funding

RSL Victoria Financial Assistance.

Legacy Financial Relief Payments

**Bravery Trust.** Bravery Trust's main purpose is to provide urgent financial assistance to veterans and their families in their time of need.

https://braverytrust.org.au/

## 8.B.2 Financial Planning

Financial planning advice is available to veterans and dependants when they are offered a lump sum payment under the DRCA or MRCA. Financial planning will also help veterans with budgeting, business planning and retirement planning.

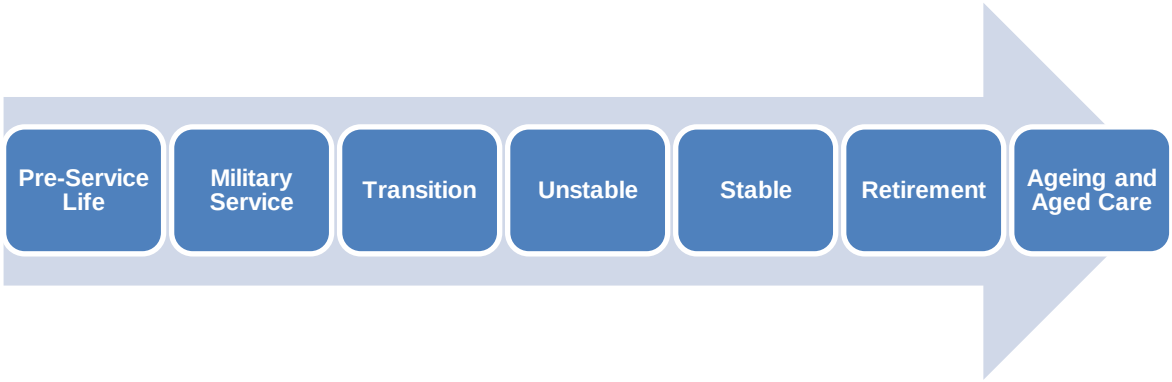
Wellbeing Advocates should identify reliable local licensed financial planners who work for a fee, not on commission.

# CHAPTER 9
# VETERAN LIFE STAGES

# PART A - LIFE STAGES OF A VETERAN

## 9.A.1 Life Stages

Although every person's life experience is different and there will be many variations to the life stages of veterans discussed in this Chapter, the majority of people with a military service history tend to follow a generic pattern, depicted in the diagram below:




Military Advocates will generally have no or little contact with members in their pre-service life, and limited contact while they are still in military service. It is normally as members approach their transition point that they engage with Advocates for assistance with either Compensation or Wellbeing matters, or both.

Many members have a smooth, well-planned transition to life after military service. The standard ADF transition pathway is aimed at making transition as smooth as possible, setting the member and his or her dependants up with the skills and knowledge necessary to establish themselves in either a new career or retirement, depending on their circumstances. This means that their period of instability is reasonably short, and they reach a point of stability with few problems.

Even where a member is being transitioned as medically unfit for service, the transition process can, if followed fully and correctly by both the member and the member's transition support agencies, result in as good a result as can be achieved, depending on the degree of medical issues faced by the member. They may remain in a state of instability for longer due to ongoing medical issues (physical, mental or both) but most are able to establish themselves in a stable post-Service life.

The majority of Wellbeing Advocate's efforts are aimed at those members who, for a variety of reasons, get 'stuck' in the *Unstable* stage. It is this group who are most at risk of the issues already covered in pervious Chapters, including:

- poor physical and mental health,
- ongoing feelings of loss and grief,
- alcohol or drug misuse,
- relationship difficulties / breakdowns,
- social isolation,
- homelessness, and
- suicide.

Wellbeing Advocates also assist many veterans as they approach retirement and during their later years where they require more ongoing care and support.

The assistance that can be provided to veterans in the *Retirement* and *Aging and Aged Care* stages are covered in Chapter 11.

# PART B - TRANSITION SUCCESS TRAJECTORY

## 9.B.1 Introduction

The diagram depicted below is extracted from a resource called *Veteran's Transition Map and Action Plan*, produced by an American ex-service organisation called Purple Stars Veterans and Families. While it was produced for US ex-service personnel, the same issues and challenges are face by our own veterans, ex-Defence members and their dependants.

The full Veteran's Transition Map and Action Plan is available here.

## 9.B.2 Transition Success Trajectory

The Transition Success Trajectory works on the premise that transitioning from military services requires each individual to redefine who they are and who they want to be in their new life – their identity, mission, meaning and purpose.


The x axis at the bottom of the chart depicts the passage of time, from the time that a Defence member first contemplates leaving Defence, through until that person is fully established in their new life following their service. Note that the diagram does not try to depict a set elapsed period in weeks, months or years, as each member's circumstances will be different, and the time taken will vary markedly. Instead, the elapsed time is divided into stages – End of Service, Readjustment, Transition, Transformation and New Normal. While these are shown diagrammatically as being equal in elapsed time, in reality the time taken for each stage will also vary markedly.

The y axis on the left depicts emotions, with negative emotions at the bottom of the axis and positive emotions at the top.

Note that many Defence members who voluntarily separate will undertake a planned and structured transition, the preferred pathway shown as the green arrow. This may include taking advantage of the support available through the ADF Transition process, including attending Transition Seminars, accessing training through the Career Transition Assistance Scheme, and transition coaching include job search and CV writing skills. While the individual will still go through the stages of Readjustment, Transition and so on and will face some uncertainty and worry, negative emotions are generally kept in check by having clear goals and a planned strategy.

Some members being involuntarily medically or involuntarily administratively transitioned can also adopt this pathway – they have access to the same transition support and can quickly adapt to their New Normal.

Unfortunately for many Defence members, especially those being involuntarily transitioned on medical or administrative grounds, their pathway may look more like the blue line. Because their transition is unplanned and beyond their control, they have often given no thought to what they will do post-service. For some, their whole identity, meaning and purpose is wrapped up tightly in the military ethos. Unplanned transition often leads to heightened worry, stress, confusion and disorientation, both during the last period of their service, and in the early stages of transition. Where the individual's reason for transition is based on mental health problems such as post-traumatic stress, anxiety or depression, these emotions tend to exacerbate the underlying issues.

### 9.B.2.1 End of Service Stage

The events, decisions, degrees of planning and thought processes that lead up to the point of transition from Defence are as varied as the Defence personnel themselves. This can range from a senior officer or non-commissioned officer retiring after a long and distinguished career, to a young person who was injured in the first couple of weeks of their recruit training undergoing involuntarily medical transition.

What makes each person's transition 'journey' different are include:

- their age - so whether they intend to retire from the workforce or look for another job or another career;
- their relationship status – single, married, in a relationship, transitioned, divorced, with or without dependent children;
- their length of service, and whether or not that was their plan; and
- their reason and mode of transition – was it voluntary or involuntary, medical, disciplinary, not suitable for service.

Regardless of the reason or mode, most people leaving the Services experience feelings of uncertainty, fear, loss, worry, confusion and disorientation. The degree and persistence of these feelings most often relate directly the issues discussed above. A transition that was involuntary, unplanned and at short notice will generally heighten these feelings.

### 9.B.2.2 Readjustment Stage

The readjustment stage predominately relates to the individual and their extended family realising that their life has changed and will never be the same. This often comes after a period of denial, confusion and disorientation.

For many people, their Service life provides them with a clear personal identity – "I am a soldier" or "I am a Navy Officer" – and now, they are not sure what they are or how to answer that question if asked, other that "I was a soldier" or "I used to be a Navy Officer". Service life generally provides structure and purpose – service personnel usually know what they are doing tomorrow, next week and next month. In some cases, their careers are mapped out with pre-determined time in rank and predictable career progression.

It is this loss of structure, the lack of clear short term and long terms goals and a lack of a clear purpose to their life that many ex-service personnel struggle with during this readjustment period.

Research into the experiences of service personnel who have undergone both voluntary and involuntary transition have identified some common themes. The predominate feeling in this early post-transition stage is loss and grief. Some of these losses we have already mentioned – loss of identity, purpose and structure. Others are shown in the following table.

| LOSS OF: | SENSE OF BEING: | COMMON RESULTS INCLUDE: |
|---|---|---|
| Purpose | Powerless | Personal isolation |
| Identity | Unprepared | Mood swings |
| Structure | Overwhelmed | Depression |
| Camaraderie | Used and discarded | Emotional outbursts |
| Community | Abandoned | Erratic behaviour |
| Belonging | Forgotten | Abusive behaviour |
| Public status | Rejected | Financial difficulties |
| Self esteem | Disrespected | Marital/family difficulties |
| Self confidence | Shunned | Relationship difficulties |
| Trust in others | Insecurity | Risky behaviours |
| Sense of being 'invincible' | Depressed | Alcohol or drug abuse |
| Health | Embarrassed | Gambling problems |
| Wellbeing | Lost | Thoughts of suicide |

For some, most especially those in elite or special forces, include a loss of status and the sense of being 'special' or 'invincible'. Loss is often linked to feelings of grief – mourning the losses and wishing things could return to what they were before.

The other common theme, especially for those involuntarily medically transitioned, is a sense of being rejected, shunned, abandoned or forgotten – used and discarded when they are no longer part of the 'team'. Many feel embarrassed, insecure and lost.

These feelings of loss and grief, and the sense of rejection and abandonment, can lead to some very undesirable results. Some socially isolate themselves from family and friends; some undergo periods of depression, others have periods of emotional outbursts, abusive behaviour or mood swings. Some turn to drugs, alcohol, gambling or other risky behaviours to dull these negative feelings. Any of these can lead to marital or relationship difficulties, which in turn lead to more feelings of rejection, abandonment and depression. Any of these can lead to thoughts of suicide, or at worst, actual suicide. Chapter 3 covers this issue in more detail.

### 9.B.2.3 Transition Stage

Luckily, for the vast majority of people, they reach a turning point. Some will reach 'rock bottom' or a crisis point (such as a suicide attempt) before they can let go of the past and look towards the future. And many will see the warning signs well before the crisis or point of despair and either seek help or undertake this turning point themselves. Help can come from family or mates, from Wellbeing Advocates, or from trained professional like their doctor, counsellor or psychiatrist.

It is the ones who reach the crisis point or point of despair and remain at this low point that are of most concern. It is this group who are at risk of homelessness, social isolation, increasing drug or alcohol misuse and at greatest risk of suicide. It is this group that is the subject of much current scrutiny, with high-level investigations into veteran suicides, veteran homelessness and reviews into ADF transition assistance. Again, pointers on how Wellbeing Advocates can support these people are provided in previous Chapters.

So, this turning point or transition point, which is normally linked to the individuals lowest emotional ebb, represents a significant milestone in the journey. It signifies a change from holding on to the past, letting go, and moving on. A change from looking back to looking forward. A change from being inwardly focussed on what was lost, to externally focussed on what is to come.

#### 9.B.2.4 Transformation Stage

This turning point leads to a transformation. An acceptance that the change is real and happening, with a growing feeling of progress and emerging clarity. A number of possible solutions generally present themselves, which allows the individual to choose what their future will look like. This leads to a sense of hope and commitment to success in their new endeavours.

#### 9.B.2.5 New Normal Stage

What the vast majority of ex-Defence members find is that they can use their Service experience and training to their advantage. Their sense of disciple, commitment, courage and teamwork are all traits valued in the civilian workforce in whatever field they explore. They forge a new identity, a new mission and a renewed sense of purpose.

This then becomes their new normal.

### 9.B.3 Considerations for Wellbeing Advocates

It is important to note that interactions between Advocates, veterans or ex-service members and their dependants can occur at any stage in their transition process. Hopefully, the majority seek out an Advocate early on, although from a historical perspective this has probably been more seeking out a Compensation Advocate to submit claims to DVA before or soon after transition. Many would not have sought assistance from a traditional ESO Welfare Officer unless they had some problem, such as have financial difficulties while waiting for their claims or superannuation to be finalised. In fact, it was more likely that the person or family had reached a crisis point or the point of despair before they sought some assistance.

The role of the Wellbeing Advocate has to change to meet the needs and expectations of contemporary veterans. The aim should be to engage early and provide support throughout the process. In fact, Compensation and Wellbeing Advocates should work in tandem – one ensuring the person receives all of the benefits to which they might be entitled, the other helping set the veteran and family up for success in their new life. Of course, some will need more guidance and support than others, and it is these that will benefit the most from assistance provided by willing Advocates. Advocacy support could range from simple life-skills like providing advice on how to open up bank accounts or how to apply for a Medicare Card, to providing referrals to counsellors or therapists to help with relationship issues, addictions or abusive behaviour.

Being aware of the issues faced by transitioning members, and having access to information, resources and support agencies to provide assistance as required will be invaluable. But, just as important, being a willing listener and providing a safe and supportive environment will help overcome those common feelings of isolation, loneliness and abandonment.

### 9.B.4 Resources

Wellbeing Advocates may find the following resources useful in assisting clients during their transition to civilian life.

The Mental Health and Wellbeing After Military Service booklet available here.

The DVA Transition to Civilian Life web page available here.

# CHAPTER10

# FAMILY AND EXTENDED FAMILY RELATIONSHIPS

# PART A - THE DEFENCE FAMILY

## 10.A.1 The Defence Family

Historically speaking (World War I through to Vietnam) a 'normal' Defence family usually consisted of the Defence member (usually male) his wife and a number of children. While of course this is a generalisation and there were many variations to this, the majority of Defence family support services and arrangements catered for this family configuration.

For example, single members were provided with living-in accommodation on Defence bases, while married members were provided married quarters either on or off base. There was little flexibility provided to meet more complex or non-traditional family makeups.

Additionally, most Defence forms in this era provided Defence members with only two choices – 'Single' or 'Married'. Personnel were categorised as either a 'single member' or a 'married member'. This dichotomy of choice did not allow much in the way of diversity in the Defence population.

Over time, what constitutes a Defence family has evolved, as a reflection of the broader Australian society. Some of this has resulted from changes in societal norms (such as recognition of de facto relationships) and some from legislative changes (such as anti-discrimination, equality and same-sex marriage legislation).

This means that the modern 'Defence family' seeking support from Advocates is a much more diverse and multi-faceted group.

## 10.A.2 Definitions

The work of Advocates is often tied in to support available to veterans and their families through legislation. Each Act has its own list of definitions that apply to the provisions of that Act. Most legislation administered by DVA tend to refer to 'dependants' rather than 'families' and provide definitions of different classes of dependants.

For example, s15(1) of the Military Rehabilitation and Compensation Act 2004 (MRCA) defines a **dependant** as:

*"a related person of the member:*

- who is wholly or partly dependent on the member; or
- who would be wholly or partly dependent on the member but for an incapacity of the member that resulted from an injury or disease or an aggravation of an injury or disease."
- Additionally, s15(2) goes on to define a related person as:
- the member's partner;
- a parent or step-parent of the member;
- a parent or step-parent of the member's partner;
- a grandparent of the member;
- a child or stepchild of the member;
- a child or stepchild of the member's partner;
- a grandchild of the member;
- the member's brother, sister, half-brother or half-sister;
- a person in respect of whom the member stands in the position of a parent;
- a person who stands in the position of a parent to the member.

MRCA s5(1) further defines a partner as:

- "if the member is a member of the Aboriginal race of Australia or a descendant of Indigenous inhabitants of the Torres Strait Islands—the person is recognised as the member's husband, wife or spouse by the custom prevailing in the tribe or group to which the member belongs;
- the person is legally married to the member;
- a relationship between the person and the member (whether the person and the member are the same sex or different sexes) is registered under a law of a State or Territory prescribed for the purposes of section 2E of the Acts Interpretation Act 1901 as a kind of relationship prescribed for the purposes of that section;
- the person (whether of the same sex or a different sex to the member):
  - is, in the Commission's opinion (see subsection (2)), in a de facto relationship with the member; and
  - is not an ancestor, descendant, brother, sister, half-brother or half-sister of the member (see subsection (3)).".

### 10.A.2.1 Implications for Advocates.

Supporting a Defence or ex-Defence 'family' has broader implications than supporting the veteran or ex-Defence member alone. The success or failure of any plan to assist a veteran or ex-Defence member often relies on the involvement and support of their extended family. The extended family may be geographically disbursed which may complicate communication and consultation. However, the focus of the Wellbeing Advocate's role – "Healthy Veteran - Healthy Family" – means that the involvement of the extended family should be considered in any wellbeing support provided.

## 10.A.3 Importance of Good Relationships

The importance of good relationships to the health and wellbeing of veterans and their families cannot be overstated. Some of the reasons for this include:

- People in supportive, loving relationships are more likely to feel healthy, happy and satisfied with their lives.
- They are less likely to have mental or physical health problems or do things that affect their health.
- People in good relationships help each other practically as well as emotionally.
- They share the good times and help each other through the tough ones.
- The relationship between parents greatly affects children as they grow up and become adults.

Good relationships generally involve:

- respect, honesty and trust;
- love, companionship and shared activities;
- mutual emotional support and intimacy;
- communication;
- agreement about finances, child raising and other important matters; and
- shared dreams for the future.

## 10.A.4 Reasons Relationships Fail

Relationships fail for a wide variety of reasons. Common reasons include:

- trust issues,

- compatibility issues,
- communication issues,
- relational abuse,
- life habit abuse, and
- finance issues.

### 10.A.4.1 Issues for Defence Families

Defence families are affected by the same relationship stressors and issues that affect the rest of the Australian population, however the unique nature of Defence service places some additional pressures.

- Deployments and exercises can take veterans away from loved ones for extended periods of time.
- The experience of combat conditions during deployment can contribute to long-term mental health consequences after return.
- Great strains are placed on relationships when a partner is left behind to carry on, often with young children and few supports.
- Sometimes partners learn to manage very well in the absence of the ADF member and the returning members feel un-needed or excluded.
- The nature of military training encourages a decisive, assertive style of thinking and communication that isn't always well suited to civilian and domestic situations.

## 10.A.5 Resources

There are many resources available to Wellbeing Advocates to help them assist veterans and families with relationship issues. These include:

**For current Defence Members.**

ADF Members and Families

ADF Members and Families SMART Programs.

The Defence Family Helpline 1800 624 608

Open Arms

**For Ex-Defence Members.**

Open Arms.

Relationships Australia courses.

Lifeline

# CHAPTER 11

## DVA AND OTHER AGENCIES WELLBEING SERVICES AND RESOURCES

# PART A - COUNSELLING

## 11.A.1 Open Arms – Veterans and Families Counselling

Open Arms – Veterans and Families Counselling is Australia's leading provider of high-quality mental health assessment and clinical counselling services for Australian veterans and their families.

Open Arms are focused on meeting client needs through a combination of proven clinical practices and new and emerging evidence-based approaches.

Open Arms – Veterans and Veterans Family was founded by Australia's Vietnam veterans. The Vietnam War was a difficult chapter in Australia's history. For those who served, the experience forged strong bonds and a commitment to look out for each other. This deep sense of mateship led Vietnam veterans to lobby for a specialised counselling and support service for veterans and their families.

The result was the Vietnam Veterans' Counselling Service (VVCS). VVCS was established by the Australian Government in 1982.

Since then, access to VVCS has been extended to veterans of all conflicts, their families, and other members of the ADF and ex-service community. In 2007 the service was renamed VVCS – Veterans and Veterans Families Counselling Service. Eligibility has further expanded and, in 2018, VVCS became Open Arms.

Open Arms represents Australian soldiers standing in a field with open arms signalling for helicopters to land and the family welcoming home serving members after deployment.

Through Open Arms, Australia's Vietnam veterans have ensured that future generations of serving men and women have access to the specialised mental health and wellbeing support they first pioneered in Australian in 1982.

### 11.A.1.1 Services provided by Open Arms

In addition to one-on-one and family counselling services, Open Arms provides a number of group programs for eligible persons. These are listed below.

- Beating the Blues
- Building Better Relationships
- Doing Anger Differently
- Managing Pain
- Managing Pain: Half day education workshop
- Mental Health First Aid
- Operation Life: Applied Suicide Intervention Skills Training (ASIST)
- Operation Life: Suicide alertness for everyone (safeTALK)
- Parenting Programs
- Recovery from Trauma
- Recovery from Trauma: Half day education workshop
- Relaxation and Stress Management
- Residential Lifestyle Management Program
- Sleeping Better
- Stepping Out
- Understanding Anxiety

Open Arms will also provide case management for clients with complex needs and has also developed a Peer Support Program for veterans.

Contact details for Open Arms are:

1800 011 046 (24 hours)

www.openarms.gov.au

## 11.A.2 Mental Health Support

Through Open Arms DVA has provided a variety of applications, tools and resources to assist veterans and their dependants with mental health concerns. Information about these is available here and through Open Arms here.

# PART B - EMPLOYMENT SCHEMES

## 11.B.1 Veteran's Vocational Rehabilitation Scheme (VVRS)

The VVRS is a voluntary scheme operated by DVA to help veterans with certain service under the VEA who need assistance to obtain or hold suitable paid employment.

A range of VVRS services are available to help eligible veterans find or keep a job, including:

- vocational assessment to determine transferrable skills and employment opportunities;
- advice on job-seeking including with finding work;
- assistance with updating or upgrading skills including to gain recognition for on-the-job training where this is essential for gaining or keeping employment;
- advice or support if a job is at risk;
- group social skills training;
- assistance in accessing support groups;
- anger management training;
- financial counselling, and
- medication adherence training support in managing a medical condition.

Details on eligibility criteria, effect on VEA Disability Compensation Payment and applications are available here.

## 11.B.2 Vocational Rehabilitation

Vocational rehabilitation under the DRCA and MRCA provides assistance to help veterans and former members to become job ready to support a suitable and sustainable return to work. Activities may include vocational assessment and guidance, assessments to determine what their employment options might be, work preparation activities, work trials, job seeking assistance, provision of workplace aids and appliances, and vocational retraining.

Retraining and further education can be an important part of the vocational rehabilitation process and may be provided by on-the-job training or by short- or long-term courses through a variety of educational institutions.

More information of vocational rehabilitation is available here and in the DVA CLIK Rehabilitation Policy Library here.

# PART C - EDUCATION SCHEMES

## 11.C.1 Education Schemes

The Veterans' Children Education Scheme (VCES) is established under the Veterans' Entitlements Act 1986 (VEA).

The Military Rehabilitation and Compensation Act Education and Training Scheme (MRCAETS) is established under the Military Rehabilitation and Compensation Act 2004 (MRCA). While the benefits provided under each scheme are mostly the same, eligibility rules differ slightly under the different pieces of legislation.

The VEA defines an eligible child of a veteran as the veteran's natural or adopted child, or any other child who is, or was immediately before the death of the veteran, wholly or substantially dependent on the veteran.

The MRCA defines an eligible young person as a dependant who was wholly, mainly or partly dependent on the member and includes any person for whom the member stands in the position of a parent.

Benefits available to eligible students may include:

- education allowance;
- special assistance;
- fares allowance;
- rent assistance;
- additional tuition;
- guidance and counselling;
- tertiary Student Start-up and Relocation Scholarships;
- Energy Supplement;
- Income Support Bonus.

More information about the DVA Education Schemes is available here.

More information about the DVA Student Start-up and Relocation Scholarships is available here.

## 11.C.2 The Long Tan Bursary

The Long Tan Bursary (LTB) is named after the Battle of Long Tan, the best-known battle fought by Australians during the Vietnam War.

The LTB provides funding to help the children of Australian Vietnam veterans' meet the cost of post-secondary education and help them obtain formal qualifications and skills needed to pursue their chosen career.

Thirty-seven (37) bursaries are available annually across Australia. Each bursary has a total value of up to $12,000 over three years and can be used to help cover costs such as enrolment, course fees and textbooks.

The LTB is administered on DVA's behalf by the Australian Veterans' Children Assistance Trust (AVCAT).

Details on eligibility, benefits and application process for the Long Tan Bursary are available here.

## 11.C.3 Education Entry Payment

The Education Entry Payment is a payment designed to assist eligible persons, receiving certain payments under the *Veterans' Entitlements Act 1986* (VEA), with the costs of enrolling in a course of study to develop their skills, obtain a qualification, or to improve their employment prospects.

Only one payment is made in each calendar year. The payment is available to both new and existing students. The annual rate of payment is $208.00 and is taxable.

Details on eligibility and application process are available here.

## 11.C.4 Income Support Bonus

The Income Support Bonus is paid every six months to assist eligible students with the cost of living pressures.

DVA clients entitled to the Income Support Bonus are those in receipt of an education allowance under the Veterans' Children Education Scheme (VCES) or the Military Rehabilitation and Compensation Act Education and Training Scheme (MRCAETS), where the student is in secondary or tertiary education and:

- 16 years old or over; or
- under 16 years old and receiving the education allowance rate of double orphan, homeless or living away from home.

They must be in receipt of an education allowance on 20 March or 20 September to be eligible.

Details on eligibility and application process are available here.

# PART D - HEALTH CARE

## 11.D.1 Health Services for the Veteran Community

Members of the veteran community are entitled to health services and treatment under the VEA, DRCA, MRCA or the *Australian Participants in British Nuclear Tests (Treatment) Act 2006* (APBNT(T)A).

DVA provides a wide range of health services for eligible veterans, war widows/widowers, and dependants, where clinically required. These are listed below.

- acupuncture performed by Local Medical Officers (LMOs) or General Practitioners (GPs) who are registered with Medicare Australia to provide this treatment
- chiropractic services
- community nursing services
- convalescent care
- diabetes education
- dental services
- dietetic services
- exercise physiology services
- hearing services
- medical consultations and procedures available through Medicare and listed on the Medicare Benefits Schedule (MBS)
- medical specialist services listed on the MBS
- medication reviews
- occupational therapy services
- optometric services, including visual aids
- orthoptics
- osteopathic services
- oxygen
- palliative care
- pathology services
- pharmaceutical items prescribed by your doctor
- physiotherapy services
- podiatry services and medical grade footwear
- psychology including hypnotherapy
- radiology
- rehabilitation aids and appliances
- social work
- speech pathology services
- transport including ambulance and travel assistance to obtain health care
- Open Arms - Veterans and Families Counselling

- Veterans' Home Care (VHC) including domestic assistance, personal care, safety related home and garden maintenance and respite care
- X-rays, nuclear medicine imaging, ultrasound and computerised tomography.

Details on eligibility for health services are available at the following links.

Health services

Chiropractic services

Osteopathic services.

Community nursing

Dental services

Optical services

Physiotherapy services

Podiatry services

Dietetic services

Hearing services

Occupational therapy

Speech pathology services

Diabetes educator services

Exercise physiology services

When we will pay for your hospital

Ambulance transport

Alternative therapies

Orthotic services

## 11.D.2 Veteran Healthcare Cards

There are three different types of DVA Veteran Healthcare Cards that may be issued to veterans or dependants, depending on their eligibility. There are:

- Veteran Gold Card
- Veteran White Card
- Veteran Orange Card

### 11.D.2.1 Veteran Gold Card

Gold Cards holders are eligible for treatment and care within Australia for ***all*** clinically required health care treatment at DVA expense.

Details of eligibility and instructions for use of the Veteran Gold Card are available here.

### 11.D.2.2 Veteran White Card

A Veteran White Card is issued to:

- Australian veterans or mariners under the VEA with an accepted war or service-caused injury or disease;
- former members of the ADF under the DRCA with an accepted condition and ongoing treatment needs;

- former members of the ADF, current part-time Reservists, cadets and, in limited circumstances, to full-time members under the MRCA with a medical condition accepted as service related under the MRCA;
- eligible former members of the ADF for the purpose of treatment under Non-Liability Health Care for:
  - malignant cancer (neoplasia)
  - pulmonary tuberculosis, or
  - any mental health condition.

he Veteran White Card can only be used to pay for treatment and/or pharmaceuticals related to accepted conditions.

Details of eligibility and instructions for use of the Veteran White Card are available here.

#### 11.D.2.3 Veteran Orange Card

A Veteran Orange Card is issued to Commonwealth and allied veterans and mariners who:

- have qualifying service from World War I or II
- are aged 70 years or over; and
- have been resident in Australia for 10 years or more.

The Veteran Orange Card is for pharmaceuticals only and cannot be used for any medical or other health care treatment. It gives access to the subsidised pharmaceuticals and medicines under the Repatriation Pharmaceuticals Benefits Scheme (RPBS).

Details of eligibility and instructions for use of the Veteran Orange Card are available here.

## 11.D.3 Repatriation Pharmaceutical Benefits Scheme (RPBS)

The RPBS provides a wide range of pharmaceuticals and wound dressings at a concessional rate for the treatment of eligible veterans, war widows/widowers, and their dependants.

The RPBS allows access to all pharmaceutical items available to the general community under the Pharmaceutical Benefits Scheme (PBS), and also an additional list contained in the Repatriation Schedule of Pharmaceutical Benefits (RSPB) which is available only to veterans.

Details of the RPBS are available here.

## 11.D.4 Health Care for F-111 Workers and Families

A variety of benefits and services are available to eligible F-111 deseal/reseal and other fuel tank maintenance workers, family members and other personnel who worked at RAAF Base Amberley at the time of the F-111 deseal/reseal programs.

The Study of Health Outcomes in Aircraft Maintenance Personnel (SHOAMP) Health Care Scheme is a health care program that covers treatment costs (for certain conditions) and counselling services to serving and ex-serving Australian Defence Force and civilian personnel who were involved in F-111 deseal/reseal and other fuel tank maintenance programs between 1973 and 2000 (Group 1 participants).

Counselling services are available, generally, to partners and children of Group 1 participants as well as other personnel employed at RAAF Base Amberley at the time of the F-111 deseal/reseal programs (Group 2 participants).

Details of the program and other benefits are available here.

## 11.D.5 Coordinated Veterans' Care Program

The Coordinated Veteran's Care (CVC) Program is a team-based program designed to increase support for Gold Card holders with one or more targeted chronic conditions. The CVC Program focuses on improving the management of chronic conditions and quality of life for eligible Gold Card holders who are most at risk of unplanned hospitalisation.

The Program aims to assist you to better understand your health and provide support in self-managing your conditions using a Comprehensive Care Plan (Care Plan). (The Care Plan is also referred to as a General Practitioner Management Plan (GPMP)).

The CVC Program is for Veteran Gold Card holders who meet the CVC Program criteria, including:

- living in the community (not in a Residential Aged Care Facility)
- have been diagnosed with one or more of the following chronic conditions:
- congestive heart failure
- coronary artery disease
- pneumonia
- chronic obstructive pulmonary disease
- diabetes, or
- some other chronic condition
- have complex care needs, and/or
- are at risk of unplanned hospitalisation.

Details of the CVC program are available here.

## 11.D.6 Rehabilitation Appliance Program (RAP)

RAP provides eligible DVA clients with aids and appliances to be as independent and self-reliant as possible at home and in the community. Aids and appliances through RAP can help minimise the impact of disabilities, illnesses or injuries helping the client maximise their quality of life, independence and participation in the community.

Clients are eligible if they are:

- a Veteran Gold Card holder; or
- a Veteran White Card holder (only for conditions accepted by DVA as related to service), including Commonwealth and other allied veterans who hold a Veteran White Card; and
- assessed by a general practitioner (GP) or medical specialist as requiring an aid or appliance to meet a clinical health care need.

The items listed on the Schedule include (but are not limited to) the following categories:

- mobility and functional support;
- continence;
- oxygen and continuous positive airways pressure (CPAP);
- cognitive, dementia and memory assistive technology;
- personal response systems (PRS);
- falls prevention;
- low vision;

- prostheses;
- orthoses;
- hearing appliances;
- speech pathology appliances;
- diabetes; and
- home modifications and household adaptive appliances.

More details on the RAP are available here and here (Electric Scooters).

## 11.D.7 Local Medical Officers and Specialists

Eligible clients can access Department of Veterans' Affairs (DVA) funded medical services from Local Medical Officer (LMO) / General Practitioner (GP) and medical specialists.

For clients with a DVA Health Card - All Conditions (Gold) or Totally & Permanently Incapacitated (Gold), DVA will pay for medical services, available through DVA arrangements, to meet their clinical needs.

For clients with a DVA Health Card - Specific Conditions (White), DVA will pay for medical services provided through DVA arrangements, if they are required because of an accepted war or service caused injury or disease.

More details are available here.

# PART E - TRANSPORT AND TRAVEL

## 11.E.1 DVA Arranged Transport

Eligible VEA veterans and war widows/widowers (entitled persons) can access arranged transport under the DVA Repatriation Transport Scheme (RTS) when attending a health provider for approved medical treatment.

Details of eligibility, forms of transport and booking arrangements are available here.

## 11.E.2 Claiming Reimbursement for Travel Expenses

Eligible VEA veterans, war widows/widowers (entitled persons) can claim for travelling expenses, (transport/meals/accommodation) relating to travel for treatment purposes under the DVA Repatriation Transport Scheme (RTS).

Those who hold a Veteran Gold Card under the MRCA, or a Veteran White Card under the MRCA or DRCA can claim travelling expenses for:

- attending treatment for any condition (MRCA Gold Card holders)
- attending treatment for accepted conditions only (White Card holders)
- attending a rehabilitation assessment
- attending a medical examination at the request of DVA
- travelling to attend or obtain medical evidence for a Veterans' Review Board (VRB) hearing (applicable to MRCA clients only); and
- in specific circumstances, transporting a person for treatment immediately after they have sustained a service injury or disease.

Details of eligibility and instructions for claiming reimbursement under the RTS are available here.

## 11.E.3 Recreation Transport Allowance

Recreation transport allowance is a fortnightly amount that may be paid to VEA veterans suffering from severe war or defence-caused disabilities (such as multiple amputations and blindness) that affect mobility.

This allowance aims to assist a veteran with the cost of travel to attend recreational activities, such as sporting events, social outings, or visiting friends and family. It can be used to pay for transportation costs (such as bus, train or taxi fares, or paying a friend or family member to drive) so that the veteran can participate in their recreational activities.

Details are available here.

## 11.E.4 Transport Concessions

State and Territory Governments offer a variety of subsidised or concessional travel schemes to veterans, War Widows/Widowers and/or former Defence members. As each State/Territory scheme is different, Wellbeing Advocates should refer to the appropriate Factsheet for details applicable to their clients.

New South Wales

Victoria

Queensland.

South Australia

Western Australia

Tasmania

Northern Territory

Australian Capital Territory.

# PART F - AGEING AND AGED CARE

## 11.F.1 Introduction to Aged Care

Information about Australian Government services and support available to older people has been assembled into a single website here.

The website provides information on:

- the types of aged care services available
- eligibility criteria for services
- service providers available by area
- costs the person may need to pay
- quality in aged care
- advocacy services
- how to make a complaint.
- Links are provided to further information for:
- Aboriginal and Torres Strait Islander people
- Carers
- LGBTI people
- People who speak other languages
- People in rural and remote areas
- Veterans
- People with other diverse needs

Information on aged care services specifically for the veteran community is available here.

## 11.F.2 Residential Aged Care

Residential aged care homes provide care and support to older people who can no longer live independently in their home. Many residential aged care homes receive subsidies from the Commonwealth Government to assist in providing appropriate care and support to older people. These homes are required to meet a set of standards set by the Commonwealth Government in regard to care, lifestyle, safety and building conditions.

Residential aged care homes that do not attract Commonwealth Government subsidies may be subject to different arrangements.

The Department of Health and Aged Care is responsible for the administration of all health and aged care services governed by the *Aged Care Act 1997* for all Australians, including veterans and war widow/ers. The *Aged Care Act 1997* covers residential aged care services.

Details on residential aged care are available here.

## 11.F.3 Veteran's Home Care

Veterans' Home Care (VHC) is a DVA program designed to assist eligible DVA clients who need a small amount of practical help to continue living independently in their own home. Services include Domestic Assistance, Personal Care, Respite Care, and safety-related Home and Garden Maintenance. VHC is not designed to meet complex or high-level care needs. The VHC Program also assists carers in recognition of the vital role they play in the veteran and defence community.

Details of VHC are available here.

Information about help if you cannot pay for home care services is available here.

> **Note:** VHC is available to eligible VEA clients. Similar services are available to eligible DRCA and MRCA clients as Household Services and Attendant Care. Details of these schemes are contained in the relevant chapters of the ATDP Rehabilitation and Compensation Handbook and in the following links.
>
> Household Services
>
> Attendant Care

## 11.F.4 Respite Care

Respite care gives a break to a carer by temporarily relieving them of their caring responsibilities.

A carer can be a friend, partner or family member who provides ongoing care to a person who is severely incapacitated or frail. A carer is not required to live with the care recipient. A carer is someone who provides unpaid support and may receive the Carer Payment or Carer Allowance from Centrelink.

Respite services are provided through the Veterans' Home Care (VHC) Program. Respite can may be provided as either in-home or residential respite care.

Details on respite care and carer support is available here.

## 11.F.5 Veterans' Supplement in Home Care

The Veterans' Supplement provides additional funding to Home Care Package providers in recognition of the additional costs that may be required to deliver appropriate care to veterans with accepted, service-related mental health conditions. The Supplement is paid directly to the Home Care Package provider on a veteran's behalf.

Any veteran in a Commonwealth-subsidised Home Care Package who has a mental health condition accepted by the DVA as related to their service is eligible. Payment may only occur if a veteran or their nominated representative(s) have consented to certain information being disclosed to the DSS and their Home Care Package provider.

There is no need for veterans to apply or undergo an assessment for the Supplement to be paid to Home Care Package providers. War widow/ers and dependants are not eligible to receive this supplement.

Details on the Veterans' Supplement in Home Care is available here.

## 11.F.6 Veterans' Supplement in Residential Care

The Veterans' Supplement in Residential Care (Supplement) is available to residential aged care providers who care for veterans with service-related mental health conditions. The Supplement is designed to ensure a veteran's mental health condition does not act as a barrier to accessing appropriate care and is paid directly to a residential aged care facility, on behalf of an eligible veteran.

Any veteran in a Commonwealth-subsidised residential aged care facility who has a mental health condition accepted by the DVA as related to their service may have the Supplement paid on their behalf. Payment may only occur if a veteran or their nominated representative(s) have consented to certain information being disclosed to the DSS and their residential aged care provider.

There is no need for eligible veterans to apply or undergo an assessment for the Supplement to be paid to residential aged care facilities. War widow/ers and dependants are not eligible for the Supplement.

Further details on the Veterans' Supplement in Residential Care is available here.

## 11.F.7 Financial Effects of Aged Care

All care recipients are assessed by the Aged Care Assessment Team (ACAT), or Aged Care Assessment Service (ACAS) in Victoria, which determines what care the veteran requires. They will recommend the type of aged care services that are the most appropriate.

Once the veteran commences care, the level of Government subsidy payable to the care provider will be determined. Reductions may be made to the amount of Government subsidy if the veteran has the means to contribute to their care and accommodation. An approved provider will be able to recoup this reduction by asking the veteran to contribute to the costs of care and accommodation.

Some aged care fees are the same for everyone, while some are determined by an individual's care needs and the level of their income and assets, capped at maximum rates.

A veteran's income support pension (service pension, age pension, veteran payment and the income support supplement) or the veteran payment may be affected if the veteran moves into residential aged care.

Information about Aged Care arrangements and costs is available here.

Information about Residential aged care and the support payment is available here.

## 11.F.8 Commonwealth Seniors Health Card

The CSHC may entitle eligible persons to the following concessions:

- pharmaceuticals (prescription medicines) at concessional rate through the Pharmaceutical Benefits Scheme (PBS);
- PBS Safety Net threshold at concession cardholder rate;
- additional concessions from state and local government authorities (for more information contact the relevant department in the relevant state or territory);
- the Medicare Safety Net threshold available to Commonwealth concession card holders; and
- bulk billed GP appointments.

DVA provides a CSHC to:

- Australian, Commonwealth or allied veterans with qualifying service;
- Australian, Commonwealth or allied mariners of World War 2 with qualifying service;
- partners (including widows or widowers) of veterans or mariners with qualifying service; and
- war widows or widowers including wholly dependent partners under the Military Rehabilitation and Compensation Act 2004 (MRCA).

To qualify the individual must also:

- be 60 years of age if a veteran with qualifying service; or
- be pension age if a partner of a veteran with qualifying service;
- be 60 years of age if a war widow or a war widower;
- be an Australian resident and in Australia at the time of lodging a CSHC claim;
- not be receiving an age pension, service pension or income support supplement from DVA;

- not be receiving a pension or benefit from Centrelink;
- meet the seniors health card income test; and
- not already hold a CSHC issued by Centrelink.

More information on the CSHC is available here.

# PART G - ACCOMMODATION AND HOUSING

## 11.G.1 Defence Service Home Loan

The DSH subsidised home loan is a subsidised loan of up to $25,000.00 available to eligible veterans and their surviving partners and dependent parents.

To qualify for a DSH, a person must:

- have first enlisted with the Australian Defence Force before 15 May 1985, or were allotted for service in Namibia between 18 February 1989 and 10 April 1990, and completed a specified period of service;
- have been part of the British Commonwealth forces or, in certain circumstances, were part of the merchant marine or welfare organisations attached to Defence operations; or
- be a surviving partner or dependent parent of a person qualified under the criteria above.
- A DSH loan can be used to:
- buy or build a house or unit;
- complete, enlarge, modify and/or repair your house or unit;
- buy the right of entry into a retirement village;
- re-finance an existing mortgage, charge or encumbrance on a house or unit owned by the eligible person;
- build, complete, enlarge, modify or repair your retirement village accommodation in certain circumstances or transition a debt in relation to it; or
- obtain granny flat accommodation on another person's property (in this situation, you must assign the loan to the owner of the accommodation, so you also need to apply for a Certificate of Assignment).

The DSH loan can be transferred from one home to another.

Details of the scheme are available here.

## 11.G.2 Defence Service Homes Insurance Scheme

The Defence Service Homes Insurance Scheme (commonly referred to as DSH Insurance) provides home building insurance to all current and former members of the Australian Defence Force (ADF) with at least one day of service regardless of their type of service.

DSH Insurance also provides access to a range of other insurance products including, for example, contents, landlord and car insurance. These products are available to anyone in the Defence community.

Details are available here.

## 11.G.3 Renting and Rent Assistance

Rent assistance is a non-taxable allowance to help meet the cost of private rented accommodation.

Rent is an amount paid by a person on a regular basis for occupying a residence, and includes:

- rent for private rental accommodation;
- fees for the hire, rental or leasing of a caravan site or to moor a boat;

- lodging;
- board and lodging (if you cannot identify the amount paid for lodging, 2/3rds of the total amount you pay is taken to be rent);
- fees paid to a non-government-funded residential care facility;
- fees for nursing-home type accommodation in a facility that is not subsidised by Government;
- fees paid for services in a self-care retirement village; and
- site fees for relocatable homes.

A veteran may also be eligible for rent assistance if they have sold their principal residence and are paying rent while you wait to buy or build another.

The be eligible to receive rent assistance, the veteran must:

- be eligible for service pension, income support supplement or veteran payment;
- pay rent other than Government (public housing) rent;
- pay a minimum amount of rent known as the rent threshold.
- live in Australia.

Details are available here.

# PART H - WAR GRAVES

## 11.H.1 Office of Australian War Graves

The Office of Australian War Graves (OAWG):

- Provides and maintains official commemorations of veterans of the Australian armed forces who have died in war or conflict, and of eligible veterans who have died after war or conflict of causes related to their service in that war or conflict.
- Provides permission, on behalf of the Department of Defence, to use the Service emblem on the graves of all veterans.
- Provides historical information in respect of those who have died in war or conflict.
- Provides and maintains official Australian memorials overseas.

## 11.H.2 Official Commemoration

Official commemoration consists of provision of an official memorial at either the site of interment or by placement of a plaque only in an official Office of Australian War Graves (OAWG) Garden of Remembrance. The memorial is provided and maintained in perpetuity by the OAWG for veterans of the Australian armed forces who die in war or conflict, or eligible veterans who die after a war or conflict of causes related to their service in that war or conflict. In this context war or conflict means service in a World War or Operational, Peacekeeping, 'Warlike' or 'Non-Warlike' service after World War II.

More details on war graves is available here.

Information about official commemoration activities and services is available here.

# PART I - BEREAVEMENT PAYMENTS AND FUNERAL EXPENSES

## 11.I.1 Bereavement Payments under the MRCA

A wholly dependent partner of a deceased serving or former member is entitled to a bereavement payment where the serving or former member was receiving, or was entitled to receive, incapacity payments, permanent impairment periodic payments or the Special Rate Disability Compensation Payment (SRDP) under the MRCA at the time of his or her death.

If more than one partner was dependent on the serving or former member at the time of his or her death, the bereavement payment will be split between the partners having regard to the relative loss of financial support each has suffered as a result of the serving or former member's death.

If there is no wholly dependent partner, the bereavement payment can be made to a dependent child or dependent children of the deceased.

The payment is equal to 12 instalments of the:

- weekly amount of incapacity payment;
- permanent impairment periodic payment; and/or
- SRDP payments;

that the deceased member was either receiving, or was entitled to receive, at the time of his or her death.

More details on bereavement payments under the MRCA are available here.

## 11.I.2 Bereavement Payments under the VEA

A bereavement payment is a one-off, non-taxable payment designed to help with the costs that may follow the death of a pensioner. Where the deceased pensioner was a member of a couple, the bereavement payment will assist the surviving partner to adjust their finances following the cessation of the pensioner's payments.

There are two types of bereavement payment under the VEA:

- those made after the death of a person who was receiving Disability Compensation Payment, and
- those made after the death of a person who was in receipt of an income support payment.

If the deceased was receiving both a disability compensation payment and an income support payment, it is possible for bereavement payments to be payable in respect of both payments.

More information on bereavement payments under the VEA is available here.re available at:

## 11.I.3 Funeral Expenses under the MRCA

Compensation can be awarded for the cost(s) of the funeral of a deceased member if:

- liability for the deceased member or former member's death has been accepted under the MRCA;
- the deceased member received the Special Rate Disability Compensation Payment (SRDP) or was eligible to receive the SRDP during some period of his or her life; or

- the deceased member was entitled to the maximum rate of permanent impairment compensation for accepted conditions immediately before his or her death (i.e. assessed at 80 or more impairment points).

The ADF currently meets all costs of a military funeral of ADF members who die while still serving. If the cost of a member's funeral is met by the ADF, no funeral expenses are payable under the MRCA.

Funeral expenses can be paid under the MRCA directly to the person who made the claim (including the deceased's dependant or legal personal representative). If the funeral expenses have not been paid, the MRCA provides that funeral expenses up to the maximum amount payable can be awarded to the person or company which is conducting, or which conducted, the funeral.

More information on funeral expenses under the MRCA and the form to make such a claim is available here.

## 11.I.4 Funeral Expenses under the VEA

A funeral benefit is a one-off payment, up to a maximum of $2,000 to assist with the funeral costs of an eligible veteran or dependant and may also assist with the costs of transporting the veteran's body from the place of death to the normal place of residence. Where eligibility for a funeral benefit arises due to a posthumous grant or an increase to the rate of Disability Compensation Payment, the amount payable as a funeral benefit is the rate applicable at the date of death.

More information on funeral expenses under the VEA and the form to make such a claim is available here.

## 11.I.5 Funeral Expenses under the DRCA

Section 18 of the DRCA provides that in cases of a compensable death, the Commonwealth is liable to pay or contribute to the cost of the funeral.

The amount payable is, 'as the MRCC considers reasonable' but up to a maximum amount which is also indexed on 1 July each year.

More information on funeral benefits under the DRCA is available here.

# CHAPTER 12
## SERVICES IN THE COMMUNITY

# PART A - AGING ADVOCACY AND SUPPORT

## 12.A.1 Council on the Ageing (COTA)

COTA Australia's role is to promote, improve and protect the wellbeing of older people in Australia as citizens and consumers. It seeks to be recognised by government, the general community and media as representing, advocating for and serving all older Australians.

COTA Australia promotes the interests of Australians as they age at the highest level of government and key national organisations.

COTA Australia speaks to Federal Government Ministers and advisors, Shadow Ministers and other Parties, and the most senior levels of the public service on key issues of relevance. They make submissions to Government and Parliamentary Inquiries. COTA Australia is a federation of COTA branches in each State and Territory.

COTA Australia speaks out on matters of concern to Australians as they age and is widely recognised and sought out by media to comment on the issues of the day.

More information on COTA Australia, and links to State and Territory branches is available here.

## 12.A.2 Combined Pensioners and Superannuants Association (CPSA)

CPSA is a non-profit, non-party-political membership association founded in 1931 which serves pensioners of all ages, superannuants and low-income retirees. CPSA's aim is to improve the standard of living and well-being of its members and constituents. Membership is open to those who agree with the objectives and core policies of CPSA and is comprised of individual members and affiliated organisations.

CPSA is well informed of the needs, aspirations and concerns of its members and constituents. CPSA through its Executive, Area Council, Branches and staff liaises with governments at all levels, community organisations and the media to promote its objectives, policies, activities and services.

Branches give members access to affordable social activities and the opportunity to participate in local community events, as well as personal support in times of need.

More information on CPSA is available here.

## 12.A.3 National Aged Care Advocacy Program (NACAP)

The National Aged Care Advocacy Program (NACAP) is funded by the Australian Government under the Aged Care Act 1997. It provides free, independent and confidential advocacy support and information to older people (and their representatives) receiving, or seeking to receive, Australian Government funded aged care services.

Advocacy services ensure that the rights of consumers are supported, and that they are empowered to make informed decisions about their care.

The Older Persons Advocacy Network (OPAN) provides NACAP services across Australia through its network of nine service delivery organisations. Each provides a nationally consistent model of independent advocacy, information and education focused on the rights of older Australians in need of care.

More information on OPAN is available here.

OPAN can be contacted on 800 700 600 (free call)

**NOTE:**

There are also a number of aged and aged care advocacy services in States and Territories, so Wellbeing Advocates should check local directories or do a web search by State or Territory.

# PART B - CARER SUPPORT

## 12.B.1 Carers Australia

Carers Australia is the national peak body representing Australia's unpaid carers, advocating on their behalf to influence policies and services at a national level. It works collaboratively with partners and its member organisations, the Network of state and territory Carers Associations, to deliver a range of essential national carer services.

Carers Australia work to improve the health, wellbeing, resilience and financial security of carers and to ensure that caring is a shared responsibility of family, community and government.

Contact details for Carers Australia and State/Territory Carer Associations listed below.

Ph: 1800 242 636

Email caa@carersaustralia.com.au

Carers Australia website here.

## 12.B.2 Financial Support to Carers

A number of allowances and payments are available from the Australian Government Department of Social Services.

### 12.B.2.1 Carer Payment.

The Carer Payment is an income support payment that provides financial help to people who are unable to engage in substantial paid employment because they are giving constant care to someone who has a severe disability, illness, or an adult who is frail and old. Eligibility criteria for the Carer Payment include:

- must be caring for one or more people with care needs which score high enough on the Adult Disability Assessment Tool (ADAT) or Disability Care Load Assessment (Child) (DCLA);
- the care receiver will have these needs for at least 6 months or the rest of their life;
- must meet the pension income and assets test limits; and
- the carer and care receiver must both be residing in Australia.

### 12.B.2.2 Carer Allowance.

The Carer Allowance is an income supplement for parents or carers providing extra daily care for either:

- an adult or dependent child with disability or a medical condition, or
- someone who is frail aged.

The Carer Allowance is a fortnightly payment. There is an annual income test, but no assets test. Carer Allowance is not taxable. It can be paid it in addition to:

- wages;
- Carer Payment;
- any other income support payment.

### 12.B.2.3 Carer Supplement

The Carer Supplement is an annual lump sum payment. It helps with the costs of caring for a person with a disability or a medical condition. It is paid to anyone the Carer Payment or Carer Allowance.

### 12.B.2.4 Carer Adjustment Payment

The Carer Adjustment Payment is a one-off payment. It helps families deal with the increased costs of caring for a child that:

- is 7 years of age or younger
- has had a sudden and severe illness or accident.

### 12.B.2.5 Child Disability Assistance Payment

The Child Disability Assistance Payment is an annual lump sum payment. It helps parents with the costs of caring for a child with disability.

# PART C - FAMILY ASSISTANCE AND CHILD SUPPORT

## 12.C.1 Financial Assistance for Parents

A number of allowances and payments are available from the Australian Government Department of Social Services to financially assist families and parents. These include:

- Family Tax Benefit
- Parental Leave Pay
- Dad and Partner Pay
- Child Care Subsidy / Additional Child Care Subsidy
- Parenting Payment
- Rent Assistance
- Single Income Family Supplement

## 12.C.2 Child Support

The Department of Social Services has a variety of information for parents seeking or required to pay child support. The topics on their website include:

- Parents' Guide to Child Support
- Child Support Options
- Child Support Assessment
- Paying Child Support
- Living Overseas
- Support for Non-parent Carers
- Paying Child Support
- Child Support Estimator

Links to all of these topics and further information on child support is available on the Services Australia website here.

# PART D - FAMILY AND DOMESTIC VIOLENCE

## 12.D.1 Family and Domestic Violence

Family and domestic violence includes any behaviour that is violent, threatening, controlling or intended to make someone feel scared and unsafe. Forms of family and domestic violence are discussed below.

**Physical violence.** Includes any violent behaviour or threats of violence. It can be directed at you, or your children, pets or property. It might be:

- punching
- hitting
- kicking
- pushing, or
- choking

**Sexual assault.** Any unwanted sexual behaviour or sexual activity.

**Verbal or emotional abuse.** Behaviour that makes you feel worthless and put down. This can include yelling, insulting, name-calling and swearing.

**Controlling behaviour**. Controlling behaviour that makes you do or believe things you wouldn't normally. It may stop you from seeing people or leaving the house. You may be stopped from spiritual or cultural participation that is important to you.

**Stalking.** Behaviour that makes a person feel harassed or intimidated. This could be:

- repeated phone calls or messages
- unwanted or obsessive attention
- being followed or monitored.

**Technology facilitated abuse.** When someone monitors what a person does online. This may include:

- checking the person's computer and phone use
- using tracking spyware on a person's phone
- publishing intimate photos without consent

**Financial abuse.** Behaviour limiting access to money. Warning signs might be:

- not being able to have money of your own
- being stopped from working
- having to account for how money is spent.

**Elder abuse.** Harmful behaviour in a relationship of trust with an older person. It could be:

- emotional
- psychological
- financial
- physical
- sexual, or
- neglect

More information of family and domestic violence and available Government support is available on the Services Australia website here.

## 12.D.2 Community Organisations Providing Assistance

A variety of community organisations can provide assistance and support during instances of family and domestic violence. These are discussed below.

**1800RESPECT.** 1800RESPECT is a national family violence and sexual assault counselling service available 24 hours a day, 7 days a week. It is confidential and free to call. They can also help with advice about online safety if the caller thinks someone is watching your online activities. Contact options are:

**1800 737 732** at any time to speak with a professional counsellor

The 1800RESPECT website here.

**Family Relationship Advice Line.** The Family Relationship Advice Line can help with family issues and assist individuals through transition. They can also refer individuals to local services for more help. Contact options are:

call 1800 050 321 (Monday to Friday 8am - 8pm, Saturday 10am - 4pm)

Family Relationship Advice Line website here.

**Kids Helpline.** A free 24-hours advice line for young persons aged 5 to 25. Contact details are:

Ph 1800 551 800 (24 hours)

Kids Helpline website

**Lifeline.** Lifeline can provide personal crisis support services to anyone affected by family and domestic violence. Contact details are:

131 114 (24 hours)

Lifeline website

**MensLine Australia.** MensLine Australia is a phone and online support service. They provide specialist help to people affected by family and domestic violence. They also offer support to people using violence. Contact details are:

1300 789 978 (24 hours)

MensLine Australia website

**Men's Referral Service.** The Men's Referral Service is a free phone counselling, information and referral service. They can help men end their use of violence and abuse against their family members. Contact details are:

1300 766 491

NSW and TAS – 24 hours

Other States/Territories – Mon - Fri 8am – 9 pm; Weekends 9am – 5 pm

No to Violence website

**White Ribbon Australia.** White Ribbon Australia is a national program aimed at preventing violence by men against women and assisting women subject to domestic violence. They provide a national database of national and local domestic violence hotlines here and local domestic violence support resources here.

# PART E - COUNSELLING

***NOTE:*** *The organisations offering welfare services detailed in this Section provide assistance regardless of any religious affiliation.*

## Centacare Catholic Family Services

Centacare provides a range of services, one of which is counselling.

Centacare specialises in providing counselling assistance to families and couples. They offer family therapy, group therapy, marriage guidance counselling and mediation sessions for couples, adolescents and families.

Information on these and other services are available on the Centacare website here.

## Lifeline

Lifeline is a Christian organisation, which provides a range of services to people, regardless of religious belief. The services Lifeline offer include:

- Crisis Telephone Counselling
- Face to Face Counselling
- Financial Counselling
- Youth Counselling
- emergency financial relief
- marriage and family counselling
- TTY service for hearing impaired people
- rural crisis counselling
- grief and loss counselling
- alcohol and substance addiction counselling
- gambling addiction counselling.

Services available may vary from region to region.

The Lifeline number is 13 11 14 (24 hours) and more information regarding their services is available here.

## Relationships Australia

Relationships Australia is a national community organisation which provides a range of relationship support services. It is a non-profit organisation, partly funded by federal, state and local governments across Australia.

Clients pay a fee on a sliding scale, according to their ability to contribute.

Among the services offered by Relationships Australia are:

- education for relationships;
- couple and family counselling;
- domestic violence prevention services;
- marriage enrichment courses;
- transition counselling;
- mediation for couples seeking a divorce settlement;
- youth and family mediation;
- re-building courses after transition;

- communication skills and family skills courses;
- gambling counselling (some States); and
- counselling for sexual difficulties.

Services offered by Relationships Australia may differ between Centres. More information on services available, and contact details for State/Territory and local offices is available here.

### The Salvation Army

The Salvation Army provides a range of services one of which includes counselling services. Counselling/Support services include:

- telephone counselling lines (Salvo Careline and Salvo Youthline);
- face-to-face counselling;
- drug and alcohol treatment programs, including counselling;
- marriage and relationship enrichment groups; and
- survivors of suicide groups.

More information on services available, and contact details for State/Territory and local offices is available here.

# PART F - DISABILITY SERVICES

## The National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is Australia's first national Scheme for people with disability. It moves away from the previous system of providing block funding to agencies and community organisations, to direct funding for individuals.

There are around 4.3 million Australians who have a disability. When it is fully rolled out, the NDIS will provide about 460,000 Australians aged under 65, who have **permanent and significant disability** with funding for **supports and services**. For many people, it will be the first time they receive the disability support they need.

The NDIS can provide all people with disability with information and connections to services in their communities such as doctors, sporting clubs, support groups, libraries and schools, as well as information about what support is provided by each state and territory government.

More information on the NDIS, including eligibility, application procedures and services providers by region is available here.

## Independent Living Centres Australia

Independent Living Centres Australia (ILCA) is a collective network with member ILC's from each Australian state. Their mission is to:

- advance Assistive Technology policy and systems innovation with the Australian Government.
- encourage development of evidence for practice in understanding the economic benefits, social benefits and effectiveness of Assistive Technology.
- seek and identify emerging trends in Assistive Technology and advise of its application within the Australian context.

Assistive Technology is defined as:

- any device, system or design, that allows an individual to perform a task that they would otherwise be unable to do, or increase the ease and safety with which a task can be performed, or
- anything that assists individuals to carry-out daily activities.

More information on the ILCA, including eligibility, application procedures and State/Territory member ILCs is available here.

The number for ILCA is 1300 885 886

# PART G - HEALTH PROMOTION/SUPPORT GROUPS

## Heart Foundation

The Heart Foundation is a national organisation that funds life-saving heart research and work to improve heart disease prevention and care for all Australians.

More than 620,000 Australians are living with heart disease and each year approximately 54,000 Australians suffer a heart attack.

The Heart Foundation is dedicated to making a real difference to the heart health of Australians. Every day, their work includes:

- funding world-class cardiovascular research
- guiding health professionals on preventing and treating heart disease
- educating Australians about making healthy choices
- supporting people living with heart conditions
- advocating to government and industry to improve heart health in Australia.

More information of the Heart Foundation, heart care and maintaining heart health is available here.

The Heart Foundation General Enquiries number is 13 11 12.

Email: contactus@heartfoundation.org.au

## Alzheimer's Association

The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support and research. Their mission is to eliminate Alzheimer's disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health.

The Alzheimer's Association website provides information on Alzheimer's and dementia, warning signs, diagnosis and treatments. It also provides information on help and support, for both sufferers of Alzheimer's or dementia and for their families/carers.

More information is available here.

The contact number for the association is 800 272 3900

## Arthritis Foundation

The Arthritis Foundation of Australia provides information and resources on all aspects of arthritis care. The Foundation can also conduct arthritis self-management courses to help people manage pain and stress and exercise programs. Each State has a network of support groups.

The Arthritis Foundation publishes a large number of information leaflets, covering all aspects of Arthritis.

More information is available here.

The contact number is 1800 011 041

## Diabetes Australia

Diabetes Australia is a community-based organisation dedicated to servicing the needs of people with diabetes. Diabetes Australia was established in 1984 and is the national body for people affected by all types of diabetes and those at risk. Through leadership, prevention, management and research, Diabetes Australia is committed to reducing the impact of diabetes. They work in partnership with diabetes health professionals and educators, researchers and healthcare providers to minimise the impact of diabetes on the Australian community.

In collaboration with state and territory diabetes organisations and through assisting with the administration of the National Diabetes Services Scheme (NDSS), Diabetes Australia provides practical assistance, information and subsidised products to almost 1.1 million Australians diagnosed with diabetes.

Diabetes Australia works to raise the awareness about the seriousness of diabetes, promoting prevention and early detection strategies and advocating for better standards of care. Diabetes Australia is also a significant financial contributor to research into better treatments for diabetes and the search for a cure.

Diabetes Australia consists of member organisations, each falling into one (at least) of the following categories:

- Specialist – medical, educational, scientific
- Community - state and territory diabetes organisations
- Research - Diabetes Australia Research Trust, Kellion Research Foundation, Diabetes Research Foundation - Western Australia.

More information on diabetes, prevention and living with the disease is available here.

The NDSS National Enquiry Line is 1300 136 588.

### Cancer Australia

Cancer Australia was established by the Australian Government in 2006 to benefit all Australians affected by cancer, and their families and carers. Cancer Australia aims to reduce the impact of cancer, address disparities and improve outcomes for people affected by cancer by leading and coordinating national, evidence-based interventions across the continuum of care.

Cancer Australia works collaboratively and liaises with a wide range of groups, including those affected by cancer, key stakeholders and service providers with an interest in cancer control. The agency also focuses on populations who experience poorer health outcomes, including Aboriginal and Torres Strait Islander peoples and people living in rural and remote Australia.

As the lead national cancer control agency, Cancer Australia also makes recommendations to the Australian Government about cancer policy and priorities.

Email enquiries@canceraustralia.gov.au

More information is available here.

### Cancer Council Australia

Cancer Council Australia commenced in 1961 as the Australian Cancer Society, when the six state Cancer Councils, which then varied in name and brand, agreed to establish a federal body to promote cancer control at the national level. Cancer organisations in the ACT and the Northern Territory were subsequently formed and signed on as members of the society.

While state and territory Cancer Councils continued to undertake most of the organisation's research, patient support and education programs, the federal body's primary role was to develop independent national cancer control policy, albeit on a comparatively modest scale.

In 1997 the eight jurisdictional members agreed to expand the Society, renaming it The Cancer Council Australia and appointing an expert Chief Executive Officer, Professor Alan Coates, to lead the organisation's push for improved national cancer control policy and build its profile. Specialist staff in communications, advocacy, business management, marketing and other professional roles were recruited to promote the organisation's mission.

Over the ensuing decade, member organisations uniformly adopted the name Cancer Council and together took on the daffodil, a global symbol of hope, as our common logo.

The activities of Cancer Council Australia include:

- **Support.** A range of services to support anyone affected by cancer. In 2017 they helped thousands of Australians get the support they need, answering over 41,000 calls through our 13 11 20 information and support line.
- **Research.** Funding for more cancer research than any other non-government organisation in Australia. In 2017, thanks to the support of the community, they directed almost $60 million along with our research partners in cancer across Australia.
- **Prevention.** Development of programs that encourage and empower people to lead healthier lifestyles to help reduce their cancer risk.
- **Advocacy.** Working with the community to change laws and policies to reduce cancer risks and improve cancer care.

**Ph** 02 8256 4100

**Email:** info@cancer.org.au

More information on Cancer Council Australia, including contact details for State/Territory offices, are available here.

# PART H - LEGAL AID

## 12.H.1 Legal Aid Commissions

The Australian Government is committed to providing legal assistance to the most vulnerable members of the community to help them resolve their legal problems. The = National Partnership Agreement on Legal Assistance Services provides Australian Government funding to Legal Aid Commissions and Community Legal Centres to deliver this assistance.

Legal Aid Commissions provide a range of services, including information, legal advice and representation in courts and tribunals. Information and services including telephone advice are often free of charge. However, to be eligible for representation through a grant of aid, applicants must satisfy means and merits tests set by Legal Aid Commissions.

There is a legal aid commission in each state and territory. Links to these are provided below.

Legal Aid Australian Capital Territory

Legal Aid New South Wales

Northern Territory Legal Aid Commission

Legal Aid Queensland

Legal Aid Commission of South Australia

Legal Aid Commission of Tasmania

Victoria Legal Aid

Legal Aid Western Australia

## 12.H.2 Community Legal Centres

Community Legal Centres are independent, community managed, non-profit services that provide a range of assistance on legal and related matters to those disadvantaged and with special needs.

Community Legal Centres are a key component of Australia's legal assistance system. They complement and extend the services provided by legal aid commissions and the private profession.

To find a community legal centre near you look here.

## 12.H.3 Legal Aid for Veteran for Appeals

Legal aid may be available at the AAT for a review of a DVA decision. Legal aid applications by DVA clients are exempt from means testing but are subject to a merits test and decision by the state/territory Legal Aid Commissions (see 12.H.1).

In addition to representation in the AAT, Legal Aid Commissions may also provide advice and/or legal task assistance for people preparing an application to the VRB, including any alternative dispute resolution processes. However, a lawyer is not able to appear before a VRB hearing.

More information about Legal Aid Commissions and the types of services they provide can be found on each commission's website (see 12.H.1)

Please note that legal aid is not available to MRCA clients who select the reconsiderations pathway, either at the reconsiderations stage or at the AAT. However, legal or associated costs may be awarded by the AAT in certain circumstances (see below).

Financial assistance for people appearing before the AAT may be provided by the Attorney-General's Department Information related to that is available on the AGs website here.

# PART I - OTHER WELLBEING SUPPORT AGENCIES

**NOTE**: The religious organisations offering welfare services detailed in this Section provide assistance regardless of any religious affiliation.

## 12.I.1 St Vincent de Paul Society

The Society of St Vincent de Paul is a Catholic organisation providing assistance to the needy, regardless of religious affiliation. The Society is a volunteer organisation that also runs a wide range of professional services across Australia. While all services will not be available in all areas they are described below.

**Housing and Homelessness Services.** From WA to SA in the west to NT and QLD in the Top End, across Australia Vinnies provides accommodation and a variety of services for single men and women, women and children, two parent families, men with children and young men and women to become homeless or at risk of homelessness.

**Food.** Vinnies provides all kinds of nourishment. We provide food and friendship to people in their homes and also operate soup vans in some states and territories in Australia. We do so with the generous support of our many volunteers, sponsors, donors and suppliers.

**Addiction.** In certain states we have services for people experiencing multiple types of disadvantage, including addiction. Addiction refers to a range of behaviours, from substance misuse to gambling.

**Aged Care.** The Society has a strong commitment to supporting people as they grow older. Aged care accommodation or services for seniors are offered by the Society in NSW, TAS, QLD and more.

**Disability Employment.** Our services operating in VIC, TAS and NSW provide opportunities for people living with a disability to integrate and socialise with the broader community.

**Finances.** Financial counselling and related services are offered by the Society in NSW and QLD but people experiencing financial stress can contact the Society regardless of where they live in Australia.

**Health and Wellbeing**. In most States the Society offers services such as family and children's activities. A friendship program, called Compeer also operates in VIC, QLD, ACT and NSW.

**General Support**. As part of our general support services to the most vulnerable among us, Vinnies has a number of programs that we call our Special Works

More information on Vinnies, and links to State/Territory and local Vinnie facilities is available at:

1300 VINNIES (13 18 12) nationally (will redirect to local office)

St Vincent de Paul Society website here (including links to State/Territory offices)

## 12.I.2 The Smith Family

The Smith Family was founded in 1922 by a small group of businessmen, who set out to provide support to disadvantaged Australians. They now concentrate on empowering Australian children in need to create a better future for themselves through education. The Smith Family is a children's charity helping disadvantaged Australian children to get the most out of their education, so they can create better futures for themselves

In 2018 they supported more than 174,823 Australian children in need (and their families) through our Learning for Life and other support programs.

Learning for Life support is provided in three main ways:

1. Through Learning for Life Workers who connect students and their families to opportunities in their local community.

2. By facilitating access to The Smith Family's education and mentoring programs;

3. Through sponsorships that match a disadvantaged student with a sponsor who provides both financial assistance to help with the cost of essential education items, and emotional support that encourages students to stay motivated at school.

More information on The Smith Family and their programs is available at:

1300 326 359 (general enquiries, business hours)

The Smith Family website here (including links to State/Territory offices)

## 12.I.3 Wesley Mission

The Wesley Mission is national charity organisation operated by the Uniting Church. It provides a wide range of services in the community, including programs and services for:

4. families and children
5. youth and young adults
6. foster care
7. mental health and hospitals
8. seniors and aged care
9. housing and accommodation
10. home care
11. training and jobs

Information on Wesley Mission services, and links to State/Territory/local offices is available here.

## 12.I.5 Anglicare

Anglicare is national charity organisation operated by the Anglican Church. It provides a wide range of programs and services in the community, including:

12. Home care
13. Residential aged care
14. Retirement living
15. Aged care services
16. Food and financial assistance
17. Family, parenting and youth support
18. Foster care and adoption services
19. Counselling
20. Dementia care
21. Support for carers
22. Cross-cultural services

Information on Anglicare services, and links to State/Territory/local offices is available here.

# CHAPTER 13
# ABBREVIATIONS AND MEDICAL CLASSIFICATIONS

# PART A – SERVICE ABBREVIATIONS

| A | |
|---|---|
| AA | Anti-Aircraft |
| AA | Army Act |
| AAF | Australian Army Form |
| AAMC | Australian Medical Corps |
| AAMWS | Australian Army Medical Women's Service |
| AANS | Australian Army Nursing Service |
| AAOC | Australian Army Ordinance Corps |
| AAPC | Australian Army Pay Corps |
| AASC | Australian Army Service Corps |
| AAT | War Pensions Assessment Appeals Tribunal (Defunct) |
| AATTV | Australian Army Training Team Vietnam |
| AB | Apex Beat or Able Seaman |
| AC(A) | Assistant Commissioner (Appeals) (Defunct) |
| ACD | Australian Convalescent Depot |
| ADC | Assistant Deputy Commissioner |
| ADMS | Assistant Director Medical Services |
| ADS | Advanced Dressing Station |
| AFC | Australian Flying Corps (1914 War) |
| AFH1 | Australian Field Hospital (First) |
| AFPD | Application for Pensionable Degree |
| AFSR | Application for Special Rate |
| AFU | Advanced Flying Unit |
| AGH | Australian General Hospital |
| AGX | Act of Grace—1939 War |
| AIF | Australian Imperial Forces |
| Alb +/- | Albumen present/absent |
| AJ +/- | Ankle Jerks present/absent |
| AJ ++ | Ankle Jerks increased |
| AJ +++ | Ankle Jerks markedly increased |
| AMD | Army Medical Directorate |
| AME | Aero Medical Evacuation Squadron (RAAF) |
| AMES | Aero Medical Evacuation Squadron (USAF) |

| | |
|---|---|
| AMF | Australian Military Forces |
| AMR&O | Australian Military Regulations and Orders |
| AMS | Adequate means of support |
| ANGAU | Australian New Guinea Administrative Unit |
| ANMEF | Australian Naval and Military Expeditionary Force, New Guinea |
| ANZAC | Australia and New Zealand Army Corps |
| ANZUK | Australia, New Zealand and United Kingdom |
| AOiC | Assistant Officer-in-Charge |
| ARL | Annual Recreation Leave |
| Art | Arteries |
| ARVN | Army of the Republic of Vietnam |
| A&SD | Administrative and Special Duties—RAAF (normally ground staff) |
| AS(A) | Assistant Secretary (Appeals) |
| ASH | Australian Special Hospital |
| AV MED | Aviation Medicine (RAAF) |
| ASH | Australian Special Hospital |
| AV MED | Aviation Medicine (RAAF) |
| AWAS | Australian Women's Army Service |
| AWL | Absent Without Leave |
| AWOL | Absent Without Leave (Army and RAAF) |

**B**

| | |
|---|---|
| Ba | Barium |
| BAGS | Bombing and Gunnery School (RAAF) |
| BCOF | British Commonwealth Occupation Forces |
| Board | Repatriation Board for a State |
| BO | Branch Office |
| BP | Blood pressure |
| BP 140/90 | BP Systolic 140 millimetres Mercury & Diastolic 90mm Mercury |
| BPX | British pension—1939 War |
| BS | Breath Sounds |
| B&T | In Boots and Trousers |
| BMH | British Military Hospital |
| BPX | British pension—1939 War |
| BMH | British Military Hospital |

| | |
|---|---|
| BTM | Benign Tertian Malaria |
| BU | Bring up |
| BW | Bullet (or Bomb) Wound |

**C**

| | |
|---|---|
| Ca | Carcinoma |
| CAN | Canada |
| CARO | Central Army Records Office |
| CB | Confined to Barracks (punishment) |
| CCOM | Chronic Catarrhal Otitis Media |
| CCP | Casualty Collecting Post |
| CCS | Casualty Clearing Station (medical) |
| CDMS | Chief Director, Medical Services |
| CDS | Camp Dressing Station (medical) |
| CFTS | Continuous Full Time Service |
| CH | Camp Hospital |
| $C_2H_{60}$ or $C_2H_5OH$ | Alcohol |
| CiC | Clerk-in-Charge |
| CMF | Citizens Military Forces |
| CMO | Commonwealth Medical Officer |
| CMR | Central Medical Records (Service Documents) |
| CO | Central Office, Veterans' Affairs |
| CO | Complains of |
| CO | Commanding Officer (Army and Air Force) |
| CPO | Command Pay Office (Army) |
| Creps | Crepitations |
| CSF | Cerebrospinal Fluid |
| CSS | Cerebrospinal Syphilis |
| CZ | Combat Zone |
| C&V off | Coat and Vest off |

**D**

| | |
|---|---|
| DA | Domestic Allowance |
| DAH | Disorderly Action of the Heart |
| DAPU | Discharged as Permanently Unfit |
| D&R | Diagnosis and Report |

| | |
|---|---|
| D or BC | Defaulter or Bestial Conduct (referred to on some 1914 War Attestation Papers) |
| DCM | District Court Martial (a Military Court) |
| DCM | Distinguished Conduct Medal (an award for gallantry) |
| DCDMS | Deputy Chief Director, Medical Services |
| DCP | Deputy Commissioner of Pensions, London |
| Del | Delegate of the Repatriation Commission |
| Div 10 | Division 10 |
| DMO | Departmental Medical Officer |
| DMS | Director, Medical Services |
| DMU | Discharged Medically Unfit |
| DMZ | Demilitarised Zone |
| DRCA | Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988 |
| DRO | District Records Office (or Officer) |
| DR&Q | Discipline Rations and Quarters |
| DSO | Distinguished Service Order |
| DWS | Due to War Service |

**E**

| | |
|---|---|
| EA | Education Allowance |
| EAT | War Pension Entitlement Appeal Tribunal (Defunct) |
| EATS | Empire Air Training Scheme |
| ECG | Electro-cardiogram |
| ECT | Electro-convulsive Therapy |
| ED | Embarkation Depot (RAAF) |
| EEG | Electro-encephalogram |
| EFTS | Elementary Flying Training School (RAAF) |
| EMS | Emergency Medical Services |
| ENT | Ear, Nose and Throat |
| ETA | Evacuate to Australia |
| ETM | Evacuate to Mainland |

**F**

| | |
|---|---|
| FDS | Field Dressing Station |
| FESR | Far East Strategic Reserve |
| FGCM | Field General Court Martial (a Military Court) |

| | |
|---|---|
| Field | (eg. in the field) - indicates that at the time the soldier was not in hospital, GDD, LTD etc |
| FMB | Final Medical Board |
| FND | Flinders Naval Depot |
| FP | Field Punishment |
| FSU | Field Surgical Unit |
| FTD | Full Time Duty |

**G**

| | |
|---|---|
| GA | General Anaesthetic |
| GD | General Duties - RAAF (normally air-crew) |
| GDD | General Details Depot (base area) |
| GIT | Gastrointestinal |
| GOA | General Orders Accounts |
| GOE | General Orders Entitlement |
| GOGA | General Orders General Assistance |
| Gon | Gonorrhoea (VD 20) |
| GOP | General Orders Pensions |
| GOR | General Orders Registry |
| GOT | General Orders Treatment |
| GRES | General Reserves |
| GSW | Gun Shot Wound |

**H**

| | |
|---|---|
| HKK | Hong Kong 1939 War |

**I**

| | |
|---|---|
| ICT | Infected Subcutaneous Tissue (Army) |
| IFBA | Interim Forces Benefits Act |
| IMI | Instructions for Medical Institutions |
| IP | In-patient |
| I&R | Investigation and Report |
| IR | Intermediate Rate |
| IVP | Intravenous Pyelogram |

**K**

| | |
|---|---|
| KIA | Killed in Action |
| KJs +/- | Knee Jerks present or absent |

| | |
|---|---|
| KJs ++ | Knee Jerks increased |
| KJs +++ | Knee Jerks markedly increased |
| KLB | Klebs Loeffler bacilli (Diphtheria) |

**L**

| | |
|---|---|
| LA | Living apart |
| LA | Living Allowance |
| L&A | Light and Accommodation |
| LC | Life Certificate |
| LDH | Lady Davidson Hospital, Turramurra, New South Wales |
| LDO | Local Dental Officer |
| LF | Letter Form |
| LO | Liaison Officer |
| LOE | Loss of Earnings Allowance |
| L of C | Lines of Communication (base area) |
| LTD | Leave and Transit Depot |
| Lues | Syphilis, leutic syphilitic |
| LWOP | Leave Without Pay |
| LWP | Leave With Pay |

**M**

| | |
|---|---|
| MAETU | Medical Air Evacuation Transport Unit |
| MACV | Military Assistance Command Vietnam |
| MAL | Malaya |
| MASH | Mobile Army Surgical Hospital |
| MCS | Medical Clearing Station |
| MEDCAP | Medical Civic Action Program |
| MD | Military District |
| 1 MD | Queensland |
| 2 MD | New South Wales |
| 3 MD | Victoria |
| 4 MD | South Australia |
| 5 MD | Western Australia |
| 6 MD | Tasmania |
| 7 MD | Northern Territory |
| 8 MD | New Guinea |
| MDS | Main Dressing Station |

| | |
|---|---|
| ME | Middle East |
| MEDEVAC | Medical Evacuation |
| MF | Medical Form |
| MI | March In (to a unit, GDD, LTD, etc) |
| MIA | Missing in Action |
| MID | Mentioned in Dispatches (award) |
| MLO | Medical Liaison Officer |
| MO | Marched Out (from a unit, GDD, LTD, etc) |
| MO | Medical Officer |
| MOSU | Medical Operational Support Unit (RAAF) |
| MRU | Medical Rehabilitation Unit |
| MS | Medical Superintendent |
| MTM | Malignant Tertian Malaria |
| MU | Medically Unfit |

**N**

| | |
|---|---|
| NA | Not Applicable |
| NAD | Nothing Abnormality Detected or No Appreciable Disease |
| NB | New Britain |
| N/C | New Claim |
| N/D | New Disability |
| NDF | No Disability Found |
| NEI | Netherlands East Indies |
| NFD | Newfoundland |
| NG | New Guinea |
| NGAWWC | New Guinea Air Warning Wireless Company |
| NH | Naval Hospital |
| NHL | Non-Hodgkin's Lymphoma |
| NICA | Netherland Indies Civil Administration |
| NIE | No Incapacity Established |
| NIF | No Incapacity Found |
| NL | Nipple Line |
| NME | Non Military Employment |
| NOLD | No osseous lesion detected |
| NPD | Not of Pensionable Degree |
| NPI | Nil Pensionable Incapacity |
| NSR | Non Service-related |

| | |
|---|---|
| NSU | Non-specific urethritis |
| NVA | North Vietnam Army |
| NWTB | Non War Tuberculosis |
| NYD | Not yet Diagnosed |
| NZ | New Zealand 1914 War |
| NZR | New Zealand Regiment |
| NZX | New Zealand 1939 War |
| NZX | New Zealand 1939 War |

**O**

| | |
|---|---|
| OBU | Operational Base Unit (RAAF) |
| OCTU | Officer Cadet Training Unit |
| OE | On Examination |
| OE P/R | On Examination Per Rectum |
| OiC | Officer-in-Charge |
| OP | Out-patient |
| OPC | Out-patient Clinic |
| OPD | Out-patient Department |
| OTC | Officers Training Course |
| OTU | Operational Training Unit |

**P**

| | |
|---|---|
| PC | Pension Certificate |
| PCB | Procurement and Contracts Board |
| PD | Personnel Depot—RAAF (Similar to Army GDD) |
| PF | Pension Form |
| PM | Post Mortem |
| PMRAFNS | Princess Mary's Royal Air Force Nursing Service |
| PMRB | Permanent Medical Referee Board |
| PN | Percussion Note |
| PO | Petty Officer |
| POP | Plaster of Paris |
| POP | Paired Organs Policy |
| POW (E) | Prisoner-of-War (Europe) |
| POW (J) | Prisoner-of-War (Japan) |
| PR | Per rectum |
| PT + | Pulse Tension High |

| | |
|---|---|
| PTD | Part-Time Duty |
| PTE | Prior to Enlistment |
| PTE | Prior to Eligibility |
| Pte | Private |
| PU | Permanently Unemployable |
| PUGS | Permanently Unfit—General Service |
| PUHS | Permanently Unfit—Home Service |
| PUO | Pyrexia of Unknown Origin |
| Pupils = | Pupils equal |
| PV | Per Vagina |
| PWO | Pre-war Occupation |

**Q**

| | |
|---|---|
| QAINS | Queen Alexandra's Imperial Nursing Service (British) |
| QARANC | Queen Alexandra's Royal Army Nursing Service |
| QARNNS | Queen Alexandra's Royal Naval Nursing Service |

**R**

| | |
|---|---|
| RAA | Royal Australian Artillery |
| RAAC | Royal Australian Armoured Corps |
| RAAF | Royal Australian Air Force |
| RAAFNS | Royal Australian Air Force Nursing Service |
| RAAMC | Royal Australian Army Medical Corps |
| RAANC | Royal Australian Army Nursing Corps |
| RAASC | Royal Australian Army Service Corps |
| RAE | Royal Australian Engineers |
| RAEME | Royal Australian Electrical and Mechanical Engineers |
| RAF | Royal Air Force |
| RAInf | Royal Australian Infantry |
| RALAC | Repatriation Artificial Limb and Appliance Centre |
| RAN | Royal Australian Navy |
| RANNS | Royal Australian Navy Nursing Service |
| RANS | Royal Australian Nursing Service |
| RANVR | Royal Australian Navy Volunteer Reserve |
| RAP | Regimental Aid Post (Medical, Army) |
| RAPWI | Repatriation of Allied POWs and internees |
| RAR | Royal Australian Regiment |

| | |
|---|---|
| RBS | Right Border Sternum |
| RCAF | Royal Canadian Air Force |
| RCD | Right Cardiac Dullness |
| RD | Receiving Depot (RAAF) |
| R/E | Review of entitlement |
| Regs | Repatriation Regulations |
| RGH | Repatriation General Hospital |
| RMO | Regimental or Resident Medical Officer |
| RN | Royal Navy |
| RNZAF | Royal New Zealand Air Force |
| RNZNC | Royal New Zealand Nursing Corps |
| RRD | Recruit Reception Depot |
| RR & GDD | Recruit Reception and General Details Depot |
| RRT | Repatriation Review Tribunal |
| RTA | Returned to Australia |
| RTA | Recreation Transport Allowance |
| RTO | Rail Transport Officer |
| RTU | Returned to Unit |
| RVN | Republic of Vietnam (South) |

**S**

| | |
|---|---|
| SA | South Africa (1914 War) |
| SA | Supplementary Assistance |
| SAI | Standard Allowed Income |
| SAP | Standard Allotment Pension |
| SAS | Special Air Service |
| SAX | South Africa—1939 War |
| SCES | Soldiers' Children Education Scheme |
| SEAC | South East Asia Command |
| SFTS | Special Flying Training School |
| SMR 6/12 | Blood Test |
| SOS | Struck Off Strength |
| SOS | Special Overseas Service |
| SPOA | Service Pension - Old Age |
| SPPU | Service Pension - Permanently Unemployable |
| SPTB | Service Pension - Pulmonary Tuberculosis |
| SR | Service related |

| | |
|---|---|
| SSQ | Station Sick Quarters (RAAF) |
| STS | Soft tissue sarcoma |
| SVN | South Vietnam |
| SWP | Seamen's War Pension |
| SWPA | South West Pacific Area |
| SWP&AA | Seamen's War Pension and Allowance Act |

**T**

| | |
|---|---|
| T&A | Tonsils and Adenoids |
| TB | Tuberculosis |
| TCDD | Tetra-chloro-dibenzo-paradoxin (Dioxin or Agent Orange) |
| TMB | Travelling Medical Board |
| TOS | Taken on Strength |
| TOW | Theatre of War |
| TPE | Termination of Period of Enlistment |

**U**

| | |
|---|---|
| URTI | Upper Respiratory Tract Infection |
| UTI | Urinary Tract Infection |

**V**

| | |
|---|---|
| VAD | Volunteer Aid Detachment |
| VC | Victoria Cross |
| VDC | Volunteer Defence Corps |
| VDH | Valvular Disease of the Heart |
| VDU | Visual Display Unit |
| VHC | Veterans' Home Care |
| VMO | Visiting Medical Officer |
| VR | Vocal Resonance |

**W**

| | |
|---|---|
| WAAAF | Women's Auxiliary Australian Air Force |
| WAG | Wireless Air Gunner |
| WAGS | Wireless Air Gunnery School |
| WO | Warrant Officer |
| WOAS | While on Active Service |
| WPAAT | War Pensions Assessment Appeal Tribunal (Defunct) |
| WPEAT | War Pensions Entitlement Appeal Tribunal (Defunct) |

| | |
|---|---|
| WRAAC | Women's Royal Australian Army Corps |
| WRAAF | Women's Royal Australian Air Force |
| WRANS | Women's Royal Australian Naval Service |
| WS | War Service |

**X**

| | |
|---|---|
| 'X' List | (Transfer to or from) non-effective service (eg. hospital, detention, leave, etc.) |

# PART B - DEPARTMENT OF VETERANS' AFFAIRS ABBREVIATIONS

| | |
|---|---|
| **A** | |
| AAT | Administrative Appeals Tribunal |
| ACAT | Aged Care Assessment Team |
| A&CC | Aged and Community Care |
| AD | Accepted Disability |
| ADL | Activities of Daily Living; Aids to Daily Living |
| AE | Actual Earnings (MRCA) |
| AE | Ability to Earn (DRCA) |
| AFI | Application for Increase |
| AGR | Above General Rate |
| ATDP | Advocacy Training and Development Program |
| ATW | Ability to Work (VEA) |
| AWOTEFA | Average Weekly Ordinary Time Earnings for Full-time Adults<br>(DRCA) |
| **B** | |
| BEST | Building Excellence in Support and Training |
| BCWD | Booked Car with Driver |
| BP | British Pension |
| BOP | Balance of Probabilities |
| **C** | |
| CA | Claims Assessor |
| CCPS | Compensation Claims Processing System (VEA) |
| CIA | Combined Impairment Assessment |
| CLIK | Consolidated Library of Information and Knowledge |
| CSHC | Commonwealth Seniors Health Card |
| **D** | |

| | |
|---|---|
| DC | Deputy Commissioner |
| DDP | Dependants' Disability Compensation Payment |
| DSS | Department of Social Services |
| DFISA | Defence Force Income Support Allowance |
| DHA | Department of Health and Aged Care |
| DMO | Departmental Medical Officer |
| DCP | Disability Compensation Payment |
| DRCA | Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988 |
| DSH | Defence Service Homes |
| DSHIS | Defence Service Homes Insurance Scheme |
| DSM IV | Diagnostic and Statistical Manual of Mental Disorders—4th edition |
| DVA | Department of Veterans' Affairs |
| **E** | |
| EDA | Extreme Disablement Adjustment |
| ESO | Ex-service Organisation |
| **F** | |
| FOI | Freedom of Information |
| FMW | Federal Minimum Wage |
| **G** | |
| GARP | Guide to the Assessment of Rates of Veterans' Pensions - used for<br>VEA claims |
| GARP M | GARP Military: Guide to Determining Impairment and<br>Compensation - used for MRCA PI claims |
| GPH | Greenslopes Private Hospital |
| **H** | |
| HACC | Home and Community Care |

| | |
|---|---|
| **I** | |
| ICD | International Classification of Diseases |
| IR | Intermediate Rate |
| IS | Income Support |
| ISP | Invalidity Service Pension |
| ISS | Income Support Supplement |
| **L** | |
| LDO | Local Dental Officer |
| LMO | Local Medical Officer |
| LOE | Loss of Earnings |
| LPR | Legal Personal Representative |
| LSRF | Lifestyle Rating Form |
| LSQ | Lifestyle Questionnaire |
| **M** | |
| MCE | Military Compensation Expert (MRCA system for investigating<br>Initial Liability claims) |
| MCS | Military Compensation Scheme |
| MEPI | Medical Expenses Privately Incurred |
| MIA | Medical Impairment Assessment |
| MRCA | Military Rehabilitation and Compensation Act 2004 |
| MRC(CTP)A | Military Rehabilitation and Compensation (Consequential and Transitional Provisions) Act 2004 |
| MRCAETS | Military Rehabilitation and Compensation Act Education and Training Scheme |
| MRCC | Military Rehabilitation and Compensation Commission |
| MRCS | Military Rehabilitation and Compensation Scheme |
| MTAWE | Male Total Average Weekly Earnings (DRCA) |

| | |
|---|---|
| **N** | |
| NHRC | Nursing Home Resident Contribution |
| NE | Normal Earnings (MRCA) |
| NWE | Normal Weekly Earnings (DRCA) |
| NIF | No Incapacity Found |
| **O** | |
| OAWG | Officer of Australian War Graves |
| OH&S | Occupational Health and Safety |
| OT | Occupational Therapy |
| **P** | |
| PBS | Pharmaceutical Benefits Scheme |
| PCC | Pensioner Concession Card |
| PI | Permanent Impairment |
| PIR | Pensioner Initiated Review |
| PLS | Pensioner Loan Scheme |
| POI | Proof of Identity |
| PTEC | Personal Treatment Entitlement Card |
| PTSD | Post Traumatic Stress Disorder |
| **R** | |
| RA | Rental Assistance |
| RAP | Rehabilitation Appliances Program |
| RC | Repatriation Commission |
| R&C ISH<br>RD | Rehabilitation and Compensation Integrated Support Hub<br>Rejected Disability |
| RGH | Repatriation General Hospital |
| RH | Reasonable Hypothesis |
| RMA | Repatriation Medical Authority |
| RPBS | Repatriation Pharmaceutical Benefits Scheme |

| | |
|---|---|
| RPPS | Repatriation Private Patient Scheme |
| RTA | Recreation Transport Allowance |
| **S** | |
| SC | Superannuation Contribution (DRCA ) |
| SDA | Specific Disability Allowance |
| SEA | Service Eligibility Assistant |
| SHOAMP | Study of Health Outcomes in Aircraft Maintenance Personnel |
| SMRC | Specialist Medical Review Council |
| SOP | Statement of Principles |
| SR | Special Rate |
| SRCA | Safety, Rehabilitation and Compensation Act 1988 |
| STEC | Specific Treatment Entitlement Card |
| **T** | |
| TA | Travel Allowance |
| TFN | Tax File Number |
| TIA | Temporary Incapacity Allowance |
| TIP | Training and Information Program |
| TMS | Transition Management Service |
| TSR | Temporary Special Rate |
| TTI | Temporarily Totally Incapacitated |
| TPI | Totally and Permanently Incapacitated |
| **V** | |
| VAFIS | Veterans' Affairs Financial Information Service |
| VAN | Veterans Access Network |
| VAS | Vehicle Assistance Scheme |
| VCES | Veterans' Children Education Scheme |
| VEA | Veterans' Entitlements Act 1986 |

| | |
|---|---|
| VHC | Veterans' Home Care |
| VITA | Veterans' Indemnity and Training Association Inc |
| VPAD | Veteran Practitioners' Activity Database |
| VQL | Veterans' Quality of Life |
| VRB | Veterans' Review Board |
| VSC | Veterans' Service Centre |
| VVCS | Veterans' and Veterans Families' Counselling Service |
| VVRS | Veterans' Vocational Rehabilitation Scheme |
| **W** | |
| WHS | Workplace Health and Safety |
| WWP | War Widows'/ers' Pension |

# PART C - HISTORICAL NAVY, ARMY AND RAAF MEDICAL CLASSIFICATIONS

## C.1 Army Medical Classifications—World War I

The following is a list of the medical classifications of members of the AIF, which appear in the medical history and other service documents, particularly those of AIF Depots in the United Kingdom:

A1 Fit for Active Service

A2 Fit for Active Service when fully trained

A3Fit for overseas training camp, to which transferred for hardening, prior to re-joining unit overseas

A4 Fit for Active Service when of age (military)

B1A1 Fit for light duty only - 4 weeks

B1A2 Fit for overseas training camp in three to four weeks

B1A3 Fit for overseas training camp in two to three weeks

B1A4 Fit for overseas training camp when passed dentally fit

B1B, B2B or B1A1 'Observation'

B2B Unfit for overseas training camp six months, and temporarily unfit for Home Service

C1 Fit for Home Service only

C2 Unfit for Overseas Temporarily unfit for Home Service

C3 Permanently Unfit for service

**Note:** Practically all those coming under the classification of B2B, C2 and C3 were sent back to Australia.

## C.2 Army Medical Classifications—World War II

Up to 7 August 1942, the medical classification of recruits was as follows:

Class 1 Fit for active service with field formations

Class 11A Fit for specified duties in any unit in which the particular disability was no bar

Class 11B Fit for any duty other than with field formations

Class 111 Labour Units, CMF Temporarily Unfit; Unfit

By amendment (A287 of 7842) to the publication 'Instructions for the Medical Examination of Recruits' (3091941), issued by the Military Board, the following medical classifications of recruits were adopted:

A1 Medically fit for all active service duties

A2 Medically fit for active service for which the particular disability is not a bar

B1 Medically fit for active service, except with field formation

B2 Medically fit for sedentary duties only

B3 Fit for service in labour units only

C Temporarily unfit

D Permanently unfit for military service

The above was cancelled by A546, of 13111942, and replaced by:

A1 Medically fit for all duties

A2Medically fit for all duties for which the particular disability is not a bar

Medically fit to carry out certain duties which require only restricted medical fitness. These duties will be shown in war establishments

C Temporarily medically unfit

D Medically unfit for military service

### C.3 Royal Australian Naval Medical Classifications - World War II

(Navy Order 412/1942 {which cancelled No 103/1941})

Naval personnel who have been the subject of medical survey, or who have undergone or are undergoing a period of medical treatment were, for drafting purposes to be placed in one of the following categories:

Medically fit for draft anywhere

(B) Medically fit for draft to a ship of establishment where a medical officer is borne

(C) Under medical treatment, unfit for draft or duty anywhere (Anticipated period to be stated)

(D) Medically unfit for sea service temporarily, but fit for duty in a shore establishment (Anticipated period to be stated)

(E) Medically unfit for sea service permanently but fit for duty in a shore establishment as a result of survey

(X) Permanently unfit for sea service or for service in a shore establishment or depot ship north of Brisbane or Fremantle on the recommendation of a Board of Medical Survey

(Y) Temporarily unfit for sea service or for service in a shore establishment or depot ship north of Brisbane or Fremantle (Anticipated period to be stated)

(M) Temporarily medically unfit for appointment or draft to a potentially malarious area

In all signals and correspondence referring to these cases, the letters indicated above follow the name of the individual concerned.

***Categories (D) and (E):*** Personnel in these categories were temporarily or permanently unfit for service in sea-going ships. They were fit for duty in all shore establishments, whether in the tropics or not, and were also fit for duty in harbour craft unless specifically stated to be unfit for this duty.

***Categories (X) and (Y):*** Personnel in these categories were permanently or temporarily unfit for service in sea-going ships or shore establishments and depot ships north of Brisbane and Fremantle. They were fit for duty in shore establishments south of and including Brisbane and Fremantle, or in harbour craft in the same area unless specifically stated to be unfit for such duty.

The term ‘Harbourcraft’ did not cover local defence vessels that kept at sea for any appreciable time.

Invaliding categories were:

PUNS - Physically unfit for naval service

BNPS - Below naval physical standard

## C.4 Royal Australian Air Force Medical Classification, World War II

The letter ‘A’ represents fitness for air duties, and the letter ‘B’ fitness for ground duties. Numerals qualifying fitness for air duties were added as requisites after the letter ‘A’ as follows:

1 Full duties as pilot

2 Limited flying

3 Combatant passenger (piloting excepted), such as wireless, air gunner or observer

4 Non-combat passenger

Letters were subsequently added after both ‘A’ and ‘B’ for the purpose of indicating limitations of fitness as follows:

H Home service only

T Temporarily unfit

B Permanently unfit

Hence:

A1B Fit full flying duties as pilot and fit ground duties

A2B Fit limited flying duties and fit full duties on ground

Limitations vary for various reasons and the reason is always indicated. Thus a pilot might be classified:

A2B Non-operational flying

A2B Limited flights, one hour daily

A2B Limited to flights of 10,000 feet and so on

A3B Fit air gunner and air observer and fit ground duties

A man over 72 inches tall or over 175 pounds cannot be assessed fit air gunner. Therefore, you will sometimes come across ‘A3B’ (AO only), that is, air observer only:

A1b-A3B Fit both pilot and air gunner and observer

A4B Fit ground duties and fit to fly as non-combatant passenger. An assessment used mostly for A and SD officers

A1hBh Fit fly as pilot in Australia only and fit ground duties in Australia only

A3HBh Fit air gunner or observer in Australia only and fit ground duties in

Australia only

AtBt Temporarily unfit for all duties

AtB Unfit flying duties temporarily but fit ground duties

ApB Unfit flying permanently but fit ground duties

ApBp Permanently unfit all duties

# PART D - ARMY PULHEEMS SYSTEM OF MEDICAL CLASSIFICATION

**Note:** The following is the text of an Army Instruction in relation to the PULHEEMS medical classification system.

These instructions are intended as a guide to non-medical officers on the method used to determine and record a PULHEEMS assessment, and an explanation of the use of PULHEEMS employment standards. The instructions are applicable solely to the AMF and apply to all ranks serving in the PMF (including Army Reservists) and CMF. Although they are worded to apply to males, the provisions are, except where stated to the contrary, equally applicable to female members.

The PULHEEMS system of medical classification is designed to:

a) provide a functional assessment of a member's capacity for work;

b) assist in expressing the physical and mental attributes appropriate to individual trades and employment;

c) assist in the economy of manpower by posting members to the employment for which they are most suited in the light of their physical intellectual and emotional make-up; and

d) provide a system which is administratively simple to apply in both peace and war.

The allocation of a PULHEEMS classification is a medical responsibility. The assessment is considered and recorded under the following qualities:

a) ***Physical Capacity (P)***: a member's general physical characteristics and his potential capacity to develop physical stamina with training;

b) ***Upper Limbs (U)***: the functional use of the hands, arms, shoulders, upper spine and, in general, the member's ability to handle weapons Disabilities of the upper limbs which also affect general physical capacity may also affect the assessment under (P);

c) ***Locomotion (L)***: a member's ability to march Disabilities affecting marching ability which also affect general physical capacity, may also affect the assessment under (P);

d) ***Hearing (H)***: the hearing acuity. Diseases of the ears are assessed under the (P) quality;

e) ***Eyesight (EE)***: the visual acuity in the right and left eyes. Diseases of the eyes are assessed under the (P) quality;

f) ***Mental Capacity (M)***: a member's ability to learn army duties Assessment under this quality is based on:

   1) the impression given on personal interview with particular regard to alertness and the ability to apply inherent intelligence;

   2) record of school and occupational progress;

   3) selection tests results, particularly those most closely concerned with the measurement of intelligence itself and of acquired ability.

g) ***Stability (S)***—emotional stability.

## D.1 Degrees of Assessment

a) ***Physical Capacity (P)***—assessed within degrees 0-8 In this quality, degrees 1, 2 and 3 signify fitness for unrestricted service; degrees 4, 5 and 6, which are equivalents of 1, 2 and 3, restrict a member to service in a temperate climate; degree 7 restricts a member to non tropical pars of Australia; degree 8 signifies 'Permanently Unfit for Service', while degree 0 indicates 'Temporarily Unfit'

b) ***Upper Limbs (U) and Locomotion (L)***—assessed within degrees 1,2, 3, 7 and 8

c) ***Hearing (H)***—assessed within degrees 2, 3, 7 and 8

d) ***Eyesight (EE)***—visual acuity (ie ability to see) in both eyes is recorded in certain ratios, i.e. 6/6, 6/9, 6/12, 6/24 etc. They show a member's visual acuity without the aid of glasses Normal vision is expressed as 6/6 which means that the member can read at 6 metres, what is regarded as being normal for him to read at 6 metres 6/24 vision means that the member can read at 6 metres what could normally be read at 24 metres In recording a PULHEEMS assessment, these ratios are expressed in degrees of 1-8 as follows:

6/6 of better = 1

6/9 = 2

6/12 = 3

6/18 = 4

6/24 = 5

6/36 = 6

6/60 = 7

less than 6/60 = 8

Visual acuity for the right eye is recorded under the first E and the left eye under the second E. The degree of unaided vision is recorded immediately below the letter symbol and the degree of aided vision, where applicable, is shown under the degree of unaided vision. Thus, a member whose visual acuity is unaided right eye 6/12, left eye 6/18 and whose aided right eye is 6/6, left eye 6/9, will be recorded as:

E E

<u>34</u> 12

A member whose unaided vision in both eyes is 6/6 will be recorded as:

E E

<u>1</u> <u>1</u>

e) ***Mental Capacity (M)***—assessed within degrees 2, 3, 7 and 8

f) ***Stability (S)***—assessed within degrees 2, 3, 6, 7 and 8. An assessment of degree 6 restricts a member to service in a non-tropical climate.

D.1.1 Use of degrees 8 and 0 under any quality except EE

When it is considered that a candidate for entry into the Army is unfit for any form of Army service or a member is unfit for further service and should be invalided immediately, he is assessed as degree 8 under the appropriate quality.

When a medical board finds that a member is unfit for duty and is to remain under medical care, but should not be transitioned medically unfit immediately, he is assessed as degree 0 under the appropriate quality.

D.1.2 Method used to record remediable defects

If a member has a condition which may be remedied by surgery and/or treatment but he remains on duty because admission to hospital is postponed or not indicated he is to be assessed on his present capacity. The degree recorded under the affected quality is to be not less than 7 and is to be followed by the letter R. In such cases the operation and/or treatment should be judged as giving a reasonable promise of success within three months.

When a member is admitted to hospital, he will appear before a medical board after 8 weeks absence from duty due to illness. When a member appears before a medical board before he is transitioned from hospital he is to be assessed on the lines given in the **PULHEEMS** Medical Pamphlet.

When a member is on transition from hospital is fit to return to duty, but not full duty, and cannot be assessed under the original degree in qualities P, U, L or S, he is to be assessed under his present capacity and provided he is likely to show improvement within a reasonable time the letter R is to be inserted immediately after the degree affected. An appropriate note is to be added in the lower half of the medical box indicating the period for which R is applicable.

D.1.3 Effect of loss of sight in one eye

Applicants who have lost sight in one eye are not normally accepted for service, except under special circumstances where the persons have special professional, technical or other qualifications that they can perform adequately in the Army. Such cases are referred to AHQ (DMS) for decision as to acceptance and appropriate grading.

The loss of sight in one eye does not preclude members from further service provided their sight in the remaining eye, physical capacity and stability (PES) are up to the minimum level for retention.

Assessment for loss of sight in one eye under the EE qualities is recorded in the following way:

| | | | |
|---|---|---|---|
| a) | where one eye has been removed | E | 8 |
| b) | where vision in one eye is lost | E | 8 |

D.1.4 Effect of loss of a Limb

Applicants who have a limb amputation are not normally accepted for service, except under special circumstances where the persons have special professional, technical or other qualifications which they can perform adequately in the Army. Such cases are referred to AHQ (DMS) for decision as to acceptance, appropriate grading and recommendation for employment.

### D.1.5 Special Appliances

Whenever a member is required to wear a special surgical or medical appliance (excluding spectacles, artificial eyes and artificial dentures), the assessment under the quality affected is marked with an asterisk and an entry made in the AF Med Series of forms. This entry is made by the president of the medical board authorising the use of the special appliance and is the authority for issue of the appliance.

### D.1.6 PULHEEMS - employment standards

Since the standards on which a PULHEEMS assessment are based are constant throughout the Army, except for the women's corps which has a lower standard in P, U and L, and since the functions of the corps vary, it would be uneconomical in manpower to require the same minimum PULHEEMS assessment for combatant and communication zone duties.

To simplify the application of the system, the PULHEEMS assessment acceptable to each corps for each zone of operations have been grouped and are expressed in a letter code known as a ***PULHEEMS EMPLOYMENT STANDARD (PES).*** The interpretation of this code is given below:

a) ***FE (forward everywhere)*** - Employment at full duties (in any area) in any part of the world in any zone of operations.

b) ***FNT (forward non-tropical)*** - Employable at full duties in any area in temperate climates only in any zone of operations.

c) ***CZE (communication zone everywhere)*** - (Normally employed in communication everywhere) zone in any part of the world but may be employed in a combat zone in any role that is not primarily a fighting one.

d) ***CZNT (communication zone non-tropical)***—Normally employed in the communication non-tropical) zone or areas in non-tropical climates only but may be employed in a non-tropical combat zone in any role which is not primarily a fighting one (The tropical regions are defined in Section 11, paragraph 3).

e) ***BE (base everywhere)***—Employable in the base area only in any part of the world.

f) ***BNT (base non-tropical)***—Employable in the base area only in non-tropical climate.

g) ***HO (home only)***—Employable in urban areas of Australian only.

h) ***TMU (temporarily medically unfit)***—To be used when a member is found by any medical board to be temporarily medically unfit for service.

i) ***MU (Tent) (tentatively unfit)***—To be used:

   1) by a re-classification medical board when it considers that a member is medically unfit for further service (Note: a re-classification medical board is not empowered to classify a member as MU);

2) by a final medical board when it is of the opinion that a member requires further treatment.

j) ***MU (medially unfit for further service)***—To be used by a final medical board.

D.1.7 Method of calculating

D.1.7.1 Officers

PULHEEMS employment standards for officers are not linked to specific employment in any area, as an officer must normally be capable of carrying out any duty of his corps in any area in which he is fit to serve.

D.1.7.2 Male and other ranks

The PULHEEMS employment standards for male, other ranks, are linked to specific trades and employments for each arm.

D.1.7.3 Other ranks of the women's corps

In the women's corps the PULHEEMS employment standards are linked, in all areas, to specific trades and employments.

D.1.7.4 Members assessed 0

When a member is assessed 0 and P, U, L or S, the PES is to be expressed as TMU (Temporarily medically unfit). The period and the assessment are to be shown in brackets, i.e. TMU (PO + 3/12