Submission to the Victorian Law Reform Commission: Review of the *Victims of Crime Assistance Act 1996* (Vic)

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The Victorian State Trauma Registry and RESTORE Project

All four authors have worked closely with data from the Victorian State Trauma Registry (VSTR). The VSTR is maintained by the Victorian State Trauma Outcomes Registry and Monitoring group (VSTORM) based at the Department of Epidemiology and Preventive Medicine, Monash University. The registry collects information about every patient admitted with major trauma[1] to 138 hospitals throughout Victoria, representing an estimated total of over 90% of all such cases that occur within the state (Cameron et al., 2005). This data set is of unusually large scope and detail when compared other initiatives globally, and is a world-leading example of registry science. The registry includes quantitative data from hospital records and structured interviews conducted 6, 12, and 24 months following the date of injury. These interviews assess each individual's mental and physical health, their functional independence, and ability to return to key activities such as work and social engagement.

The RESTORE (REcovery after Serious Trauma: Outcomes, Resource use and patient Experiences) study, a longer-term project currently underway has conducted further follow-up interviews at 3, 4, and 5 years following the date of their injury, for a cohort injured between 1 July 2011 and 30 June 2012 (Gabbe et al., 2015; Gabbe et al., 2017). The RESTORE project includes a sub-sample in which patients or their primary carer complete annual semi-structured qualitative interviews where they discuss, in detail, their recovery experience, and involvement with various injury compensation programs and healthcare services.

Our submission

It is important to highlight that the Victorian State Trauma Registry only collects information on recovery from those injuries meeting our inclusion criteria. Thus, our submission does not pertain to those who have experienced a crime yet sustained minor, or no physical injury. This would exclude the vast majority of victims of crime in Victoria. Our expertise positions us to provide key advice and recommendations on the recovery experiences and needs of an important portion of the population under the Victorian Law Reform Commission's (VLRC) terms of reference**.** Namely, Victorians admitted to hospital for very serious injuries obtained in a violent or criminal incident. The seriousness of physical injury as a result of a crime is not the only measure by which an individual may be harmed by crime. However, given that our inclusion criteria represent the most seriously injured people in the population, our insights do reflect the experiences of those who are likely to have some of the greatest need of financial assistance from VOCAT, or any future assistance scheme.

[1] All major trauma patients with an injury as their principal diagnosis (irrespective of age) who meet any of the following criteria: Death after injury; a score greater than 12 on Injury Severity Score, a widely used injury classification system; significant injury (Abbreviated Injury Scale score of greater than 2) to two or more ISS body regions; admission to an intensive care or high dependency unit for more than 24 hours requiring mechanical ventilation; urgent surgery for intracranial, intrathoracic, or intraabdominal injury; fixation of spinal or pelvic fractures; patients with injury as their principal diagnosis whose length of stay is three days or more. Further information and exclusion criteria can be found here: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/state-trauma-system/major-trauma-classification. Inclusion and exclusion criteria have change slightly from year to year. Patients with simple orthopaedic injuries are may still be followed up by the Victorian Orthopaedic Trauma Outcomes Registry, which is managed alongside the VSTR.

Victims' Needs

The consultation paper prepared by the VLRC includes a list of key questions to guide submissions. Question 59 concerns identifying the needs of victims, and how those needs should be met through a state-funded financial assistance scheme. We have identified a number of common experiences of victims of crime who are admitted to hospital with a serious injury, we hope that this will help to address a number of the key needs of seriously injured victims.

Question 60 asks whether the act is achieving its objectives as outlined in section 1(2). One of these objectives is described as follows: "to assist victims to recover from the crime by paying them financial assistance for expenses incurred, or reasonably likely to be incurred as a direct result of the crime." Recovery from serious injury can involve expensive care needs not fully funded under Medicare or other programs. We aim to assist the VLRC to better account for the costs associated with these needs, which in serious circumstances will outstrip current provisions.

Overall Needs

Major trauma patients who are subject to interpersonal violence often experience poorer long-term recovery when compared with patients injured in unintentional events. Outcomes at 24 months following the date of injury due to interpersonal violence were a focus of our annual report from 2012-2013. We found that these patients had reported poorer mental and physical health and were less likely to be pain-free, have experienced a full functional recovery, or returned to work when compared to other patient groups.

These findings control for socioeconomic status and pre-existing health issues, in order to measure the effect of the cause of injury alone. Socioeconomic disadvantage and pre-existing mental health problems are associated with experiencing interpersonal violence. In all of our annual reports, these demographic factors are consistently associated with poorer outcomes. For victims of crime, this may mean there is a cumulative effect of the event itself on top of pre-existing difficulties.

Disability due to physical injury, cognitive deficit, or mental health problems can be far reaching. In many circumstances a full recovery is never completely realised and the individual is left with some level of disability for the rest of their lives. The current act aims to position victims' compensation provided by VOCAT as complimentary to other services. However, current public systems may be ill-equipped to satisfactorily accommodate more serious disability. It is impossible to provide a full account of all needs of all individuals who suffer a serious injury as a result of a violent crime. However we would note that the provision of services in the case of serious injury can far outstrip the maximum of $60,000 currently awarded by VOCAT. This amount may be insufficient in cases where an injury has resulted in serious disability and complex care needs, and especially where such needs are long-term or lifelong. From the individuals we have had experience with, many report that the compensation they received through VOCAT, whilst welcome, was negligible in the scale of the cost of daily life.

Victims' needs extend beyond access to medical care and safe housing. Practical needs often include, inter alia, in home personal care, case management, cleaning and maintenance services, carer assisted shopping and outings, accessibility aides such as wheelchairs, disability accessible vehicles, home modifications, servicing costs for equipment, and transport costs associated with injury related appointments.

Do Other Funding Sources Meet the Needs of Seriously Injured Victims of Crime?

The changing landscape of disability assistance with the introduction of the NDIS in Australia may meet some of these needs, whilst other needs may be met by Medicare or Centrelink. But there are likely to be some difficulties. Fragmented services may result in unnecessary hurdles in the application for such services, and access to assistance is often patient driven. This may present difficulties for patients who have trouble advocating for themselves and navigating bureaucracies. Common difficulties associated with experiencing interpersonal violence, such as financial instability, head injury, or a psychological condition may contribute to, or further compound such difficulties as will be discussed later in this submission.

The NDIS provides housing for those most at need of supported accommodation, but those with more moderate disability, or more temporary housing needs may not be eligible. Access to public housing may involve significant wait times, and may limit the individual to a geographical area. In some cases individuals will have to move in order to be closer to specialised health care services, accessible transport, or social network members who are able to offer support. Others may have to move due to concerns for their safety, or because loss of income has made it too difficult to meet mortgage repayments. These circumstances may be legitimate, but not provided for by the NDIS, public housing, or income support.

Finally the needs of individuals recovering from injury may only be temporary, and thus they may not qualify for services such as those provided by the NDIS. Although such needs may fall within current quantums, improving the speed and ease with which individuals can gain access to such services may facilitate their recovery and return to usual activities.

Loss of Earnings

Following a severe injury some individuals will be left unable to work, or will be only able to work in a reduced capacity. Loss of income, even temporarily, can result in increased hardship for and injured individual and their family. For some seriously injured individuals, the current maximum of $20,000 provided by VOCAT for loss of earnings is unlikely to appropriately reimburse an inability to work for longer periods, or for individuals who have high living costs, such sole income earners with dependant children. This may still be the case even when considered in addition to payments provided by Centrelink, or any leave entitlements provided by an employer.

Return to Work Programs

Returning to work may be a difficult process that takes many months of reintegration, slowly increasing working hours. Individuals may have to retrain for a different role or entirely new career, as their new disability prevents them from performing their previous duties. This may require access to new education and flexible working hours alongside demanding communication and goal setting with their employer. Expectations on all sides must be carefully managed and communicated. This may not be feasible unless employers and employees are supported through this process. Smaller businesses are likely to be particularly vulnerable to hardship, and individuals who are self-employed often feel increased pressure to return to work early out of a fear they will lose their business. Well managed programs may improve outcomes for both employers and employees (Schandelmaier et al., 2012).

Victims of crime may have needs that are very specific to the trauma of interpersonal violence, and it may be appropriate that a system designed to cater for the needs of victims of crime address them rather than a one-size fits all disability insurance scheme. Improved access to counselling and mental health services, and administrative staff familiar with in trauma specific care are two clear examples of such needs.

Support Needs of Victims' Social Network

The injury, and need for care may also widely affect the social network of the injured individual. Loved ones may have to take on extra working hours or caring responsibilities for children, learn to provide physical care, and may also suffer significant stress. These changed circumstances, the loss of their loved one's functional capacity, and any resulting change in their relationship dynamic may also be a source of significant grief.

Victims of Crime and Mental Health

Self-reported mental health scores are the most prominent difference between victims of crime and other injured groups, after controlling for socioeconomic status and pre-existing health issues. A recently published study conducted by our group reported that poor mental health outcomes continue 3 years from the date of injury (Gabbe et al., 2017). In total, 60% of patients injured in a violent event reported experiencing anxiety or depression. A number of studies have reported prevalence in the general Australian population to be below 25% (Clemens, Begum, Harper, Whitty, & Scuffham, 2014; Szende, Janssen, Cabases, & Goni, 2013; Viney et al., 2011). Perhaps particularly illustrative of these difficulties is that mental health outcomes are persistently poorer amongst those injured due to interpersonal violence than any other group of seriously injured individuals, and are comparable or worse than those reported by people injured by intentional self-harm or suicide attempt. Whilst patients injured through intentional self-harm reported anxiety or depression at rates 8 – 10% higher than patients injured in unintentional events, patients injured due to interpersonal violence reported rates 15% – 20% higher than those injured in unintentional events.

<u>Mental Health Services</u>

Victims of crime are commonly reliant on Medicare and in the absence of personal means or private cover this may limit access to essential care, especially mental health services. Medicare patients are currently limited to ten annual appointments with a mental health provider. Ten sessions may be insufficient for individuals who have experienced significant traumatic event such as a violent assault. As highlighted above, mental health outcomes are typically poorer in major trauma cases that have occurred due to interpersonal violence.

Additionally this group are more likely to have a pre-existing mental health condition, and to be experiencing additional stress due to injury, traumatic experience, loss of income, or social isolation. Improving access to mental health services, including peer support programs and individual counselling for victims and their families in the years following an injury should be a priority in any reform considered by the commission.

Recovery from post-traumatic stress, depression, or anxiety can take many years, and may involve frequent and consistent therapy. Some individuals may never recover from psychological condition, particularly where the primary cause has been a significant head injury. Such care is likely to be more demanding than what current quantums allow for, and the needs of patients may not be met.

Additionally the presence of a psychological condition can make the management of daily living more difficult. These individuals may require assistance with social needs such as income, employment, and safe housing in addition to access to healthcare.

Social Services

It is likely that the poorer mental health outcomes reported by victims of interpersonal violence may represent, in part, a response to difficult circumstances, rather than the development of a psychological condition. Anxiety about safety following interpersonal violence may well be proportionate to difficult circumstances. This may be especially true for those victims who experience family violence, and may still be living with or in close proximity to the perpetrator. Likewise the breakdown of relationships, or the inability to return to employment due to injury may result in loss of income that may be a significant cause of stress. The priority then may be to address these circumstances through social services and access to safe housing, rather than a health service.

Victims of Crime and Head Injury

Head injury is common consequence of assault. In our major trauma cohort, 68% of patients injured due to interpersonal violence, between July 1st 2006 and June 30th 2016, sustained a head injury. A comparative estimate of the prevalence of acquired brain injury2 in the wider community is only 2.2% (O'Rance & Fortune, 2007). The consultation paper asked for submissions regarding patient needs (question 59 and chapter 13), this section attempts to address some of the specific needs associated with head injury after interpersonal violence.

Complex Care Needs

Head injury can cause traumatic brain injury (TBI), which may result in cognitive deficits that undermine an individual's ability to behave in a manner that is socially appropriate, organise their affairs, or maintain gainful employment. Patients who sustain these injuries are also more likely to develop a psychological condition(Kim et al., 2007). These symptoms can result in complex and long-term care needs (see: Fleminger & Ponsford, 2005; O'Rance & Fortune, 2007; Prang, Ruseckaite, & Collie, 2012). Considering the high prevalence of this type of injury following blunt force assault, the specific needs of this population must be considered in any change to existing policy.

Brain injury can result in impaired social cognition or behaviour that is aggressive, sexually disinhibited, emotionally labile, or otherwise socially inappropriate. This can be further complicated in patients who lack insight into their impaired cognition or behaviour of concern. Individuals with any of these difficulties may be poor advocates for themselves, and have difficulties engaging with authorities or essential service providers. Difficult behaviour, or problems communicating may also lead to relationship breakdown, and can result in social difficulties in the workplace and in public. These issues frequently threaten social network cohesion, which in turn may limit the amount of informal support received.

More generally, cognitive disability resulting from brain injury needs to be considered when evaluating compensation and service needs of an injured individual, which in serious cases may be profound. Neuropsychologists, occupational therapists, and disability support workers can be

[2] Acquired brain injury (or ABI) includes all damage to brain tissue due to stroke, hypoxia and degenerative neurological disease, as well as traumatic injury (i.e. traumatic brain injury).

invaluable in supporting ongoing independence and in some cases lifelong appointments will be necessary to maintain wellbeing, and to adjust to life's dynamic changes. Some of these needs will be provided for under Medicare and the NDIS, however these schemes may require the patient to advocate on their own behalf, which may present a significant barrier in accessing essential care.

Need For Flexible Assistance

Cognitive impairment following a TBI typically improves in the 18 – 24 months following an injury, with most improvement occurring within the first 6 months. Although some neuroplastic recovery may continue to occur, any improvement following these initial improvements will most likely be due to the individual and their support team adapting new strategies to manage an impaired cognitive profile. Serious cases are unlikely to return to a level of pre-injury functioning, and an individual can live with significant disability for the rest of their lives.

Long term needs may not become clear until recovery has plateaued which may take more than a year, during this time the patient's care needs could be at their highest. It may necessary to award for short term care immediately, and then reassess long-term needs some 18-24 months later, with an option to further assessment if circumstances change.

Moreover victims with TBI may have changing needs in the long term. For example, traumatic brain injury is a risk factor in the development of dementia later in life (Plassman & Grafman, 2015; Ramalho & Castillo, 2015; Shively, Scher, Perl, & Diaz-Arrastia, 2012), a consequence that may not be realised for many years. This ought to be taken into account when looking at whether the variation of an award be limited to six years[3]

Improving Access to Neuropsychological Assessments

Cognitive deficit can be overlooked in initial health assessments that may focus on the physical health and survival of the patient. In addition a lack of insight is not uncommon, and so the victim may not be fully aware of their impaired cognition. As a result, cases may go undiagnosed which will make it difficult for the individual and their social network to understand their unique needs. An undiagnosed TBI may also contribute to the need to reassess victim's needs after an initial claim has been made to VOCAT.

Neuropsychological assessments, a valuable component in diagnosis of cognitive deficit following TBI, are generally not funded under Medicare outside of public hospitals. Providing funding for assessments outside of a hospital setting would allow patients to circumvent hospital waiting lists, improve access for regional consumers, and may help to address under-diagnosis.

Considerations of Character and Behaviour

Questions 34 of the consultation paper refers to considering the character and behaviour of the applicant under section 54 of the Act. As previously mentioned, head injury is common amongst major trauma patients injured by violence. Criminal behaviour and engagement in high-risk or impulsive behaviour is more common following brain injury, particularly frontal brain injury (Brower & Price, 2001; Jackson, 2011; Kim, 2002; Ponsford, Whelan-Goodinson, & Bahar-Fuchs, 2007).

These injuries may contribute to problems both before and after an offence, and may be directly related to the crime itself. The assessment of criminal responsibility in head injured individuals is

[3] Question 37 of the consultation paper.

beyond the scope of this submission. Regardless of such matters, these individuals are no less deserving of medical or social assistance, especially if their TBI is found to genuinely contribute to their offending behaviour or dangerous substance use.

Accessibility

Bureaucratic Burden of Recovery From Serious Injury

A common theme of our in-depth qualitative interviews with individuals recovering from serious injury has been the bureaucratic burden associated with health and compensation services. In many cases the increased bureaucratic labour is reported for many years following an injury. The burden of medical appointments, and the need to organise bureaucratic affairs associated with health care and compensation claims, are laden on top of everyday commitments. This is complicated by the fact that injured individuals' may be limited due to their injury. Organising household affairs, caring for dependent children, or working commitments, become more taxing in the face of injury and disability. Thus, health issues may impede an individual's capacity to manage everyday affairs, whilst simultaneous medical appointments and claims processes place increasing demands on their time, and cause stress. These appointments or claims are especially stressful when important consequences (e.g., access to continuing care, income support etc) rest on their outcomes.

Accessibility of Fragmented Funding Schemes

Question 58 of the consultation paper concerns the accessibility of VOCAT.

Currently, VOCAT provides limited funding for additional access to mental health and social services. However individuals report the application for funding can take time, during which they may either be left without access to care, or must fund the care themselves which may further compound financial issues they are experiencing due to limited financial means, loss of employment, or increased costs such as child care or damage to property.

In addition to navigating an interaction with VOCAT, an individual may be required to access support from a number of government and private sources. This fragmentation is likely to increase bureaucratic burden, and may prevent an individual accessing essential funding through VOCAT, NDIS or Centrelink. The processes involved in applying for funding in each case can be quite involved, placing a considerable bureaucratic burden on the individual who must provide evidence of ill health or financial costs incurred as a result of the crime.

These procedures are bound to be challenging for people who are unfamiliar with a legal context or demanding bureaucracies. They are less accessible to those who have more modest financial means, and who have spent less time in formal education, precisely the same group likely to most need the support, and who are more likely to be affected by violence.

The expectation that an individual organise their access to funding, in the face of difficult personal or financial problems, psychological condition, physical disability, or cognitive impairment due to traumatic brain injury is likely to leave some of those most at need unable to access essential services is likely to leave some of those most at need unable to access essential services. As previously mentioned serious violent crime can result in cognitive impairment due to brain injury and psychological conditions. These conditions may confound an individual's ability to advocate on their own behalf, or organise the procedural demands required in making a claim. Individuals with

significant cognitive or psychiatric disabilities are likely to find any bureaucracy confusing, frustrating and impenetrable, or due to their condition, may lack the motivation or organisational capacity necessary to initiate a claim even if procedures are relatively straightforward.

Improving Access

Procedures should be centralised, clear, fast and straightforward so as to minimise bureaucratic labour. Where possible access to essential health and social services should involve minimal need to lodge a complex claim, go through legal proceedings, or prove the existence of an injury.

In complex cases, it may be necessary to provider a caseworker to provide additional procedural assistance, or advocate on their behalf. Ideally a single caseworker should able to advocate on behalf of the individual *across all services*, including VOCAT, in order to reduce fragmentation. These staff should be familiar with the complexities of trauma, and with any specific need of the client due to injury or disability. Consistency of staff is especially important when dealing with clients with complex cases, as familiarity with their circumstances will limit the need to repeatedly explain their situation.

In our interviews we have come across cases in which individuals are not fully aware of assistance provided by the Victims Support Agency, or VOCAT. Better integrating these services with hospital admissions and healthcare providers may help to improve awareness of available support.

If an administrative system is able to minimise the procedural demands placed on individuals and provide specialised support workers depending on circumstances this may better meet the needs of seriously injured people.

Effect of Compensation Schemes on Recovery

Recent research into adverse interactions with other compensatory schemes may be useful in assessing scheme design for victims of crime compensation.

Despite the fact that individuals who are eligible for compensation are likely to have improved access to healthcare and financial means, compensable status has been paradoxically associated with poorer outcomes following an injury. This finding has been reported in a number of systematic reviews (Elbers, Hulst, Cuijpers, Akkermans, & Bruinvels, 2013; Giummarra et al., 2016; Murgatroyd, Casey, Cameron, & Harris, 2015) international studies (Cassidy et al., 2000), and consistently within our own data (Gabbe et al., 2007; Gabbe et al., 2017; Ioannou et al., 2016; Victorian State Trauma Outcomes Registry Monitoring Group, 2013).

Such studies report that compensable patients report experiencing worse pain, mental health, or work related disability, than patients who are non-compensable, or do not make a claim. Although some have attributed these findings to pre-existing problems (Elbers et al., 2013), published studies by our group have attempted to control for such factors[4] and have still found an association between compensable status and poorer health and functional outcomes in the years following injury (Gabbe et al., 2017). One study has demonstrated that when patients who had access to

[4] Age, gender, socioeconomic status (SES) as measured by the IRSAD, geographic remoteness, nature of injury, level of education, CCI, preinjury disability, cause and intent of injury, pre-existing mental health, drug and alcohol conditions, highest level of education, preinjury work status, and whether managed at a major trauma service.

private health insurance or other financial aid are removed from the non-compensable group many of the discrepancies vanished (O'Donnell, Creamer, McFarlane, Silove, & Bryant, 2010). It is possible that the removal of patients with access to private healthcare from one group, and not the other, may have inadvertently removed patients who were more health conscious or had greater access to financial means, and thus biased their findings. Regardless even after removing such cases compensable patients still reported significantly greater anxiety, which the authors interpret as being explained by the level of stress experienced in dealing with the compensation agency.

The study published using longer term follow-ups from our RESTORE project seems to suggest that this gap may begin to close after 3 years. A number of studies have also demonstrated that this effect may be mediated by perceptions of fault, perceptions of procedural injustice, or stressful interactions with compensation agencies (Giummarra et al., 2017; Giummarra et al., 2016; Grant, O'Donnell, Spittal, Creamer, & Studdert, 2014; O'Donnell et al., 2015; O'Donnell et al., 2010). The possibility that the stressful claims may contribute to a decline in wellbeing is consistent with many of our patient interviews, which often explore the stress and frustration involved in dealing with a compensation provider or legal processes.

Improving Compensation/Assistance Practices

The authors cited in much of this research make several practical policy suggestions that could potentially improve the experience of compensable patients. These suggestions are directly relevant to the VLRC terms of reference, and provide important insights into how a scheme for victims of crime could be best organised by drawing on years of research into the difficulties associated with other systems.

Individuals who have sustained a head injury, are financially vulnerable, or are experiencing mental health issues, are more likely to have stressful interactions with compensation providers. Several authors (Giummarra et al., 2016; Grant et al., 2014; O'Donnell et al., 2015; O'Donnell et al., 2010) suggest that such cases should be identified so that stepped-care early intervention can be delivered to minimise or prevent stressful interactions before they begin. Early identification of cases that may be problematic due to psychosocial stress would also allow triaged care, where individuals who were unable to meet the procedural demands of compensation had pressing essential needs met in advance of making a claim.

Feelings of injustice and fault are likely to be particularly visceral in a population who have been injured due to an intentional or negligent criminal act. Such feelings may be associated with attributions of fault for the event that caused the injury, or by way of a procedural injustice associated with criminal proceedings, compensation, or healthcare. Psychological interventions for injustice beliefs, or restorative justice programs which aim to foster forgiveness and acceptance, may be in conflict with the retributive and adversarial nature of legal proceedings which aim to attribute responsibility for an offence. Although not perfectly comparable to the current system under the VOCAT, there is some limited evidence that Tort compensation is associated with poorer recovery than no-fault administrative systems (Cassidy et al., 2000; Giummarra et al., 2017). In either case, perceptions of fault for the injury event, even in no-fault administrative systems, are associated with negative outcomes even after controlling for the severity of injury (Giummarra et al., 2017).

<u>Minimising Compensation Stress and Procedural Injustice</u>

Perceptions of procedural injustice are likely to be catalysed by stressful claims, or differences between an individual's expectations and the outcome of compensation matters. Grant et al. (2014) identify several common causes of claims related stress. These include difficulty understanding the procedural demands of a claim, claim delays, and the number of medical assessments necessary for the claims process. Where possible, exposure to such factors should be minimised. Reducing the complexity of procedural demands, providing information on how to lodge a claim that is accessible regardless of healthcare or legal literacy, staff familiar with the applicants case, and independent assistance with more complex cases may help to reduce stress associated with understanding the procedures.

Grant et al. (2014) identify several aspects of communication with providers that could feasibly contribute to feelings of procedural injustice. Participants reported that getting the agency to listen to what they had to say, and the feeling that they were being treated with respect contributed to the stress of the claims process. Coaching staff on meeting these needs, which may be quite demanding, may contribute to reduction of compensation related stress, and re-traumatising experiences.

Experiences of procedural injustice are likely to be minimised by managing expectations as to the kind of coverage available, and the timeline of any process need to be established through clear communication with the applicant. Provided that these expectations are then met, feelings of unfair treatment will be minimised.

A compensation case can take years, and the bureaucratic labour involved is often substantial. The demands of such a process may divert time away from more practical aspects of recovery such as managing one's healthcare needs, participating in a healthy lifestyle, and returning to work, study or caring responsibilities. The consultation paper suggests that an administrative system may operate faster than judicial processes, the negative effect of claim duration on stress and recovery should be a mitigating factor in this decision.

Burden of Proof

The need to determine health status and long-term care needs in order to evaluate compensation outcomes arguably creates a motivation to exaggerate symptoms, especially if the patient feels their case is unlikely to be taken seriously in the event that they present a brave face. Malingering[5] may be a concern to compensation providers, which may further intensify their efforts to seek evidence of a condition. As a result independent medical examination is a common, and stressful part of these processes. Giummarra et al. (2016) argue that these examinations may contribute to the experience of secondary victimisation, especially in cases of milder injury, where the patient may feel they are suspected of malingering to maximise financial gains. This can feed into the perception that their health is not being taken seriously. Independent medical examination may increase healthcare fatigue, and draw focus away from medical appointments that directly concern the individual's recovery. The potential psychological effects of having a de facto incentive to present oneself as

[5] There are ways of testing for malingering for certain types of injury. These suggest it is not uncommon, although a relative minority. See Sullivan, Lange, and Dawes (2006).

unwell could undermine engagement in treatment, in so far as maintaining a positive attitude may be favourable to treatment, but not in one's financial interests.

Support Needs Suggested by Service Users

In addition to those suggestions offered by researchers a number of suggestions have been commonly offered by patients during our in-depth interviews. These include:

- Access to a consistent caseworker who is familiar with their case and works for the patient not a provider
- Staff who are specialised in trauma sensitive care
- Administrative assistance even after receiving compensation payouts
- Improved support for family and friends
- More proactive communication where staff contact the patient, more flexibility in return to work programs
- Access to provider approved healthcare services that can be accessed without the need to make a claim
- More collaborative decision making n claim outcomes that includes the individual and essential healthcare staff
- Funding for carer assisted outings
- Identical care regardless of whether the individual has a current legal case against the provider
- Greater funding or access to peer support groups.

Conclusion

We remain resolute that the primary outcome of interest in the settlement of judicial, medical, and financial matters must be the quality of life of the individual and their immediate social network. In some circumstances it may be the case that settlement of legal matters is of secondary concern to the victim and those who have concern for their wellbeing. Particularly in the case of serious injury where a person's health needs may be more pressing than the need to seek retributive justice. As victims and perpetrators are more likely to suffer from prior mental health problems, improved state funding for mental health, and early intervention programs for victims of crime and potential perpetrators may assist in preventing the problem of violence in the first place. Prevention is always more humane that treatment, this may be especially so after injury sustained due to interpersonal violence.

We would like to thank the VLRC for the opportunity to put forward a submission on these issues.

Sincerely,

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All annual reports from the VSTORM group can be accessed here:

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/state-trauma-system/state-trauma-registry

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