
*Mentally Ill Veterans Navigating the Department of Veteran Affairs
Compensation and Entitlement Schemes: The Case for Immediate and Genuine
Law Reform*

This is a submission for the Productivity Commission's Inquiry into whether the current system of compensation and rehabilitation for veterans is fit for purpose now and into the future. The inquiry is specifically interested in the efficiency and effectiveness of the legislative framework, ways to simplify the claims process, as well as how effective the governance, administrative and service delivery arrangements that support the legislation are.

If the purpose is to compensate and rehabilitate Australian veterans, the simple answer is no. The legislative and policy framework designed to regulate and administer veteran entitlements in this country intersects in a way that at best, alienates and discourages, and at worse, deliberately obfuscates the process to deter, genuine claimants. The current system is failing Australian veterans.

This submission deals specifically with the current system's deficiencies compensating for psychological diseases, and how these deficiencies are made starkly apparent by a lack of support or rehabilitation when ex-servicemen and women transition into civilian life. I begin by explaining why the current set-up of veteran entitlements is unnecessarily adversarial and baffling to potential claimants and why this is particularly distressing for veterans suffering from and claiming against mental ill-health. I then make recommendations for simplifying the claims process in a way that is sympathetic to the unique nature of seeking compensation for psychological injuries, before turning to 3 suggestions for concrete law reform in the way we assess claims for Posttraumatic Stress Disorder disability compensation.

PTSD is the third most common disability for which veterans receive compensation¹. If history is anything to go by, the pattern of mental illness disability pensions arising from the Vietnam war shows us the prevalence of these conditions in the population of returned veterans will only rise². For these reasons, and as ill mental health diagnoses becomes increasingly recognised as valid, legitimate illnesses in the wider Australian community, it is vital that our system adequately and efficiently compensates for the psychological scars inflicted by war.

Complexity of the Legislative Framework and Its Administration

That the intersecting pieces of legislation and policy that govern military entitlements in Australia are complex and difficult to navigate is accepted as status quo by those who are familiar with this area of law³.

Military compensation law consists of the *Veterans Entitlement Act 1986*⁴, the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988 (DRCA)*⁵ and the *Military Rehabilitation and Compensation Act 2004*⁶. These are three dense, technical and long acts. They intersect and overlap

¹ (Clarke, 2016)

² (Clarke, 2016)

³ (Creyke & Sutherland, 2008)

⁴ *Veterans Entitlement Act 1986* (Cth).

⁵ *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (Cth).

⁶ *Military Rehabilitation and Compensation Act 2004* (Cth).

to create circumstances of dual-eligibility, which is then offset by a complicated system of entitlement reduction. The three acts vary quite substantially in how they consider initial eligibility, determine causation and calculate to whom, how much and when, compensation is paid. Even within one act, there are varying expectations and processes depending on the type of injury sustained, the conflict the veteran served in and the nature of service. Very little of this is set out clearly and accessibly, so determining which Act to claim under and the exact expectations of how the veteran should go about applying for compensation can be a daunting, even insurmountable, first challenge to the majority of veterans who are attempting to claim entitlements without legal advice, especially in circumstances where there they suffer more than one injury, served in different conflicts and were deployed at home and overseas (these cases are not rare).

There are then sub-legislative instruments called Statements of Principle that govern the causative element of injury and admission of liability by the Commonwealth as well as Guides to the Assessment of Rates of Veteran's Pensions (GARP M) which calculate amounts of compensation available to veterans assessed against the impairment's effect on lifestyle. These are quite crude transpositions of medicine to law which are often too confusing to give veterans any kind of primary indication about the likelihood of success for their claim and the value of entitlements they can anticipate.

This conundrum of complexity is then compounded by an equally mystified service delivery arrangement. There are very few valuable resources available to veterans that make sense of this daedalian legislation. The CLIK policy manual for example is the Department of Veteran Affairs' irrefutable point of reference for all compensation inquiries. Instead of a 'self-help' or 'how-to' guide, the 'library' reads more like annotated legislation. It contains an overload of information for every possible different entitlement, combination of service and compensation calculation, none of which is synthesised in a useful or digestible manner. Veterans are instead required to wade through hundreds of pages of information that don't apply to them and carefully siphon through the sections that do apply to their service and injury. The information that is relevant and available can then be framed so obscurely as to lose its value entirely: for example in the 'Evidence' section, instead of indicating to the veteran the sorts of supporting evidence the DVA is looking for, or guidance about what will and won't be given weight in establishing causation, the section is instead a spiel on why the veteran can expect his or her claim to be decided according to the 'laws of natural justice'. Its this kind of obfuscation, bordering on deliberate unhelpfulness that, to me, characterises the entire CLIK policy manual.

Why is this particularly troubling for Veteran's seeking the Disability Pension for mental illness?

When a complex legal system combines with a strong risk of under-reporting mental illness in the military⁷, we see genuine claimants going uncompensated and untreated.

At the most basic level, its easy to appreciate how a confusing process to apply for and receive compensation for service injuries and diseases can be particularly bewildering and alienating to

⁷ Department of Defence, Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report, p. 207 found that a 'significant number of personnel with mental disorders have received no care in the previous 12 months'

someone experience severe psychological injury symptoms. When this deters genuine claimants at the outset, we have a significant access to justice issue.

Obtaining compensation from the Department of Veteran Affairs is designed to be self-directed. Apart from some very well-intentioned, but under-qualified and in-experienced RSL volunteers, limited Legal Aid in NSW and QLD, or private legal advice for those who seek it out and can afford it, there aren't proper support mechanisms scaffolded around the system of compensation. When veterans suffering from mental ill-health feel alone and isolated in their claims process as a result, this is likely to exacerbate their symptoms and can seriously impede recovery⁸. Risk factors induced by serious psychological injury are only increased when veterans are waiting extended periods of time for determinations to be made, when the payment of interim compensation is rare⁹ and when delays and rejections are common.

Because the resources available, namely the CLIK manual, are largely unhelpful, there's a pronounced lack of clarity surrounding the expectations of compensation claims, particularly how strictly veterans need to adhere to the Statement of Principles in terms of the presentation of their symptoms and links to service. It's reasonable to infer that this is resulting in a high number of rejected claims. This can be a devastating vote of no confidence for the veteran, who can feel disbelieved that they suffer a genuine mental illness at all. This is likely to have a negative affect on the mental wellbeing of the ex-servicemen or women, whose claims aren't rejected on merit, but for procedural inaccuracies. Again, when this deters genuine claimants from reapplying where their claim has been rejected, we have a significant access to justice issue.

How could this process be made more user-friendly, efficient and effective?

The Department of Veteran Affairs should introduce case-workers specifically trained in DVA compensation procedures that guide veterans through the process and liaise with the Department. This would reduce the reliance on the good will of untrained volunteers at the RSL and would help improve relations between veterans and the Department instead of the current system which seems confrontational, overly-adversarial and puts the two entities at odds with one another. It could also relieve the stress felt by veterans awaiting a decision if caseworkers could provide regular updates, therefore demystifying the process and making decisions more transparent.

The Department must also radically rethink the CLIK policy manual. In its current form, the 'policy manual' is inadequate at guiding veterans through their claims process, the information needs to be condensed, put in digestible language and made far more useful by streamlining and disaggregating the information.

I also believe it's vital that the Department of Veteran Affairs be more honest about the legal technicalities of claims and recommend that legal advice is sought, or perhaps even offer it. At the moment, on the Application Form for a Disability pension, the veteran is given 11 lines on half an A4 page to describe the symptoms of his or her disability and connect them to their service. This gives a misleading indication of brevity and simplicity when causation is in actual fact determined by very strict criteria and connections set out in legislative instruments¹⁰.

⁸ (William, 1993) (Linz & Sturm, 2013) (Levula, Harre, & Wilson, 2017)

⁹ Leaked report of Jesse Bird Inquiry to the ABC (Atkin, 2017)

¹⁰ *Statement of Principles* (Cth).

A more general consideration is having a better support system that eases the transition to civilian life. Anecdotally, it appears that discharge from the army is the critical juncture where symptoms flare up and the support network is lost. This combines to create a stressful, hopeless period of time for the veteran, which a lengthy and convoluted claims process only exacerbates. If the symptoms themselves can't be altogether reduced by a better managed transition out of the military, at least it can mitigate the feelings of isolation.

How else should the laws be reformed to better accommodate veterans with mental ill-health - the Problem with the PTSD Statement of Principle

In addition to the general recommendations detailed above, it's also very important to note the inadequacies of the current compensation schemes for posttraumatic stress disorder. The regime's causation tests require rigid adherence to a strict Statement of Principles (SOP) which doesn't consider the distinctive character of PTSD induced in military personnel by modern warfare. When this means many genuine sufferers of PTSD induced by military service are going uncompensated because the way in which their mental illness manifests is not fitting within this inflexible understanding of the PTSD disease imposed on the Veteran's Entitlement Scheme, we have a significant access to justice issue. There are three ways in which the current structure and use of the PTSD SOP is failing military veterans.

The avoidance criteria is inappropriate in the context of veteran diagnosis

How PTSD is defined and diagnosed underwent 'substantial change' in 2013 when the Diagnostic and Statistical Manual of Mental Disorders issued DSM-5¹¹. One of the necessary symptoms was changed from avoidance OR numbing to avoidance AND numbing (i.e. a discrete 'avoidance' symptom was now required to substantiate a diagnosis)¹². Reports have studied the differences in diagnosis under the two regimes' symptomatologic criteria.

One study looked at 512 earthquake survivors in Italy and found only an 87.1% consistency rate between diagnoses under the 2 models¹³. 87% of the inconsistent diagnoses that fulfilled DSM-4 criteria but not DSM-5 criteria can be attributed to the subjects not fulfilling the new criterion C (active avoidance). In a review of 1822 US soldiers (served in Iraq or Afghanistan so results comparable to Australian soldiers who had served in these combat zones), the results were very similar¹⁴. The rate of PTSD diagnosis under the DSM-5 scheme and the repealed DSM-4 were very similar (12% vs 13% respectively), however, 30% of soldiers who would be diagnosed with PTSD under the previous scheme, would not receive diagnoses under the new model¹⁵. For soldiers who met DSM-4 criteria but did not meet DSM-5 criteria, the most common reason was 'not reporting one of two DSM-5 C avoidance symptoms'¹⁶.

This new inclusion of a discrete avoidance criteria, where a PTSD diagnosis is contingent on 'persistent avoidance of stimuli associated with the traumatic event(s)'¹⁷ is a stumbling block for

¹¹ (Konecky, Meyer, Kimbrel, & Morissette, 2015)

¹² (Carmassi, et al., 2013)

¹³ (Carmassi, et al., 2013)

¹⁴ (Hoge, Riviere, Wilk, Herrell, & Weathers, 2014)

¹⁵ Ibid.

¹⁶ Ibid. echoed in (Guina, Welton, Broderick, Correll, & Peirson, 2016) (Kilpatrick, et al., 2013) (Forbes & Flecher, 2011) (Konecky, Meyer, Kimbrel, & Morissette, 2015)

¹⁷ *Statement of Principles No. 82 of 2014* (Cth.)

civilian and military PTSD diagnosis. This isn't justified given military personnel are taught to engage with trauma (war) head on, even re-experiencing past trauma with analysis and strategizing. For them, trauma is not a one-off, freak accident, but a day-to-day reality that they are employed to engage with. Reminders of their trauma, the war, are not something they can 'avoid', but are confronted with and asked to participate in, over and over again.

The avoidance criteria is also problematic in instances where avoidance does not fit the 'classic presentation' and is instead a) not prominent b) manifests differently (with amnesia, dissociation, detachment, numbness) c) instead of avoidance, sufferers engage in intense repetition compulsions¹⁸.

Compensation for complex posttraumatic stress disorder

Medical legislative instruments inadequately compensate for PTSD induced by prolonged and repeated trauma, and this leaves a diagnostic gap in DSM-5, and therefore the SOP, for complex PTSD.

Complex posttraumatic stress disorder (CPSTD) describes a syndrome found in sufferers of 'prolonged, repeated trauma' and was first proposed in 1992 by Herman¹⁹. Herman asserted that the traditional definition of PTSD did not adequately address this unique trauma exposure, that fit outside of traditional understandings of 'circumscribed traumatic events'²⁰. Examples of complex trauma experiences was expanded in 2004 by Courtois to include "other types of catastrophic, deleterious, and entrapping traumatization occurring in childhood and/or adulthood, such as ongoing war..."²¹.

Ultimately, CPTSD is typical of exposure over a sustained period to repeated instances or multiple forms of trauma, 'typically of an interpersonal nature, and occurring under circumstances where escape is not possible due to physical, psychological, maturational, environmental, or social constraints'²². This fits a common-sense understanding of modern warfare, particularly the counter-insurgency operations of Iraq and Afghanistan: where conflict is less isolated instances of extreme violence, and more prolonged deployment in dangerous, foreign settings where an ill-defined enemy, the use of technology, the rise non-state actors, creates an insidious, ever-present fear that may not actualise in any one single 'trauma'. Because troops are 'deployed' to this, 'escape' is unlikely: war is their occupation.

There is a case to be made for an individual CPTSD diagnosis based on symptomology (especially in a military context) but more research is required. Despite overlap between PTSD and CPTSD core symptoms, expressions of 1) change from previous personality and 2) loss of previously sustaining beliefs, could set CPTSD apart as a distinct diagnosis. This could be particularly important for veterans of 21st century war who report significant moral dilemmas and change in personal moral convictions after repeated involvement in the 'asymmetries' of counter-insurgency²³.

¹⁸ (Hoge, Riviere, Wilk, Herrell, & Weathers, 2014)

¹⁹ (Resick, et al., 2012)

²⁰ (Herman, 1992)

²¹ (Courtois, 2008), 412.

²² (Cloitre, Petkova, Wang, & Feihan, 2012)

²³ (Gross, 2010)

It is at least possible that a) complex PTSD is a distinct mental illness and should have its separate test for diagnosis and symptoms as well as precisely tailored rehabilitation initiatives and b) that military personnel have a predisposition to contracting this form of PTSD. At the very least this should be investigated and researched further, specifically amongst returned veterans.

Rigid use of the PTSD statement of principles does not leave room for the invariable nuance of stress-related mental illness (and psychological injury generally)

Submissions to the parliamentary committee's review of veteran mental health consistently criticised the regimes lack of flexibility when considering causation claims and recommended that the RMA be given the discretion to accept liability for a claim where there is 'substantial compliance' with the SOP's²⁴ and this submission concurs. Diagnostic Manuals should always be textured by the clinical experience and opinions of medical professionals, and the Statement of Principles should be interpreted with more flexibility by the Repatriation Medical Authority. Without this, it's impossible to acknowledge the nuance of the posttraumatic stress disorder: trauma is subjective and best defined by a person's reaction to an event as opposed to the event itself²⁵.

To conclude, the area of military compensation and veteran's entitlement law requires the following: more academic research, encouraged by fellowships, funding honours theses and further study, particularly into the kinds of mental illness suffered by veterans, and how best to treat and rehabilitate veterans of modern warfare. This is such an emotionally charged area at the moment and we need to inject rationality and apolitical assessment by prioritising an ecosystem of academic literature that studies veteran entitlements and disabilities on an ongoing basis, instead of reactionary and politically charged reviews. Any reform will also require bipartisanship because we cannot have Military Compensation falling victim to the ebbs and flows of electoral cycles: we need long-term national strategy.

At a broader abstraction, we need a genuine system of rehabilitation and compensation based on respect, and a real, measurable attempt to treat veterans for **all** of the injuries both mental and physical incurred during military service. The Australian Government has two options. It must accept liability for all psychological injuries that can reasonably be connected in causation to the military service of the brave service-women and men in their employ, no matter how complex, differently-presenting or obscure their symptoms may be; or it needs to stop sending them altogether. This will be simply impossible without more funding. I can only assume that it's been the Department and successive Government's refusal to adequately fund comprehensive and proper compensation for the soldiers it continues to wilfully send into combat, that explains the current systems dishonesties and shortcomings.

²⁴ *Statement of Principles* (Cth).

²⁵ (Guina, Welton, Broderick, Correll, & Peirson, 2016)

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