Prime Ministerial Advisory Council on Veterans' Mental Health

Veterans Compensation and Rehabilitation Inquiry

Productivity Commission

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Thank you for the opportunity to contribute to this important inquiry into the Veterans' Affairs' legislative framework and the supporting architecture for compensation and rehabilitation. Timing between the release of the Inquiry Terms of Reference, the Issues Paper and the closing date for submissions has prevented formal consideration of this submission at a scheduled Prime Ministerial Advisory Council on Veterans' Mental Health (the Council) meeting. However, this submission captures the broader view of Council members stemming from previous discussions around legislative issues as they relate to veterans' mental health.

National mental health reform has been a longstanding priority for Government over many years, largely through investment in clinical and community support services. Notwithstanding this increased attention and support, much still remains to be done to build a modern, responsive mental health service system.

A number of recent studies and reviews around veterans' mental health including, the *Transition and Wellbeing Research Programme* – both the *Mental Health Prevalence* and *Pathways to Care* reports, *the National Mental Health Commission Review into the Suicide and Self Harm Prevention Services available to Current and Former serving ADF members and their Families 2017* and the *Senate Inquiry - The Constant Battle - Suicide by Veterans 2017*, to name a few, have identified there are particular risks for many of our current and former serving men and women of the Australian Defence Force (ADF). The identified risk is manifestly related to their mental health and wellbeing which can be adversely affected throughout the course of their military service to our nation. Symptoms of a mental health condition can develop immediately or, in many cases, many years after transition from military service.

In 2014, the Australian Government established the Council with a specific focus on addressing the mental health issues affecting veterans and their families. The Council advises the Prime Minister, the Minister for Veterans' Affairs and the Government on high level strategic and complex matters relating to the mental health of veterans and their families. This advice includes consideration of the means by which any identified gaps in the veteran mental health service system might be addressed in order to move towards a modern, responsive and timely support system.

The Council, which normally meets for one day, three times per year in Canberra, consists of current and former members of the ADF, family members of current and former members of the ADF and others with a demonstrable interest in the mental health and wellbeing of our veterans. The Council has considered and discussed legislation pertaining to veterans, in

particular relating to their mental health, a number of times and has formed a view that much of the legislation is outdated, overly complicated and does not appropriately represent the nature of modern warfare. This can be particularly troublesome for a member with a mental health condition when attempting to gain recognition or assistance for that condition. Recent initiatives by Government to provide immediate access to treatment for, interalia, mental health conditions through the non-liability health care arrangements are commendable but more needs to be done through legislation to recognise and assist those affected by mental health conditions.

The issues paper released by the Productivity Commission in May 2018 raises many important issues, some of which this submission attempts to address. The Council is of the view that many of the issues have overlapping interdependencies and considerations. As such, this paper attempts to address these issues more collectively rather than individually.

Legislative complexity and the changing nature of warfare

The first legislation introduced in Australia providing compensation for war service was the *War Pensions Act 1914*. This was later supplemented by the *Repatriation Act* in 1917. Currently, three Acts administered by the Department of Veteran's Affairs (DVA) determine veteran compensation and rehabilitation entitlements. Veteran's may be covered under the *Military Rehabilitation and Compensation Act 2004* (MRCA), the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) and/or the *Veterans' Entitlements Act 1986* (VEA).

Current legislation provides that the type and level of compensation is largely dependent upon the period of service when an injury (or, in the case of dependents, the serving member's death) occurred and the physical location of that service. Importantly, the location of the service (i.e. whether the member was within a recognised Area of Operations (AO) in which the Nature of Service is clearly defined or not) can result in different outcomes under the range of legislation which currently provide for veterans' rehabilitation and compensation. This approach represents a period in Australian history where physical injury inside an AO with a Nature of Service defined as warlike, was more widely accepted and regarded as more credible than mental health conditions. As a result, the focus of the legislation is largely towards compensation based on injuries sustained rather than on a proactive or preventative approach to the ***needs*** or treatment requirements of the individual. This results in a system that is based on the length and area of service rather than on the veteran's ***needs***. The Council believes this is a key deficiency in the current legislation.

The nature and methods of warfare have changed dramatically since the first *Acts* were developed over 100 years ago. Technology, the main driver for most of this change, has resulted in rapid and powerful innovation in every part of warfare including sensors, weaponry, modes of transport, as well as communication. Application and exploitation of these rapid and potent technological advances and their use in ADF operations, sometimes in the absence a defined Nature of Service, means that ADF members may no longer need to be within a defined and predetermined AO to be exposed to potentially traumatic events. In coalition operations today and subject to Rules of Engagement, it is entirely possible for an ADF member to engage and kill single or multiple defined threats using armed unmanned vehicles from the relative safety of a headquarters thousands of miles away from the threat. The potential for mental health conditions to develop as a result of these actions is clear and should be represented in legislation.

Exposure to traumatic events is no longer dependent on length of service, nor service in a predetermined warlike AO defined by geographic boundaries. As the ADF is increasingly called upon to augment and assist in civil security matters, such as civil maritime security and enforcement, the potential for exposure to harm, be it physical or mental, is likely to continue to increase.

Australian societal understanding and expectation surrounding military service has also changed significantly over the past 100 years since the first legislation providing compensation for war service was introduced. Today's society, including current and former members of the ADF and their families demand that appropriate protections are in place to rehabilitate and where necessary, compensate those ADF members injured physically or mentally during their service to their nation. This expectation applies whether the injury occurs during war, when conducting peacetime operations (such as protecting our maritime borders and disaster relief) or when training.

In terms of mental health conditions, it is the Council's view that, while there is still a long way to go in educating the Australian population in matters relating to mental health, there have been some advances in educating current and former members of the ADF and disavowing the mystique and stigma surrounding mental health. Increased reporting of mental health conditions during and post service is a positive outcome of this education and should be applauded. It is expected to continue for some time yet and any legislation which assists in motivating our current and former members of the ADF to self-report supports early intervention approaches which are paramount. The Council is of the view that this limited successful education may be one of the issues driving a rise in reported mental health conditions in this cohort and why legislation needs to better align with modern warfare, the increasing use of the ADF in civil matters and its effects on the health of our veterans.

The recent Senate Inquiry, *the Constant battle: Suicide by veterans*; noted that previous reviews have examined the issue of the complexity of the legislation and have recommended that moving to a single piece of legislation to apply to all veterans should not be pursued. It was noted that this assumption has resulted in ad hoc measures intended to simplify the system, and, that while any attempts at simplification was welcomed, the fundamental problem of complexity has not been resolved. Instead, adding further addendums, instruments and alterations to an already complex system has further confused the population in which it was developed to assist. Legislative reform is urgently required to address this problem. The Council agrees with the Committee's views that simplifying the legislative framework would result in efficiencies for all.

A legislative focus of the ***needs*** of the ADF member irrespective of how long they have served or where they have served would seem appropriate and worth investigating further. Prioritising the treatment and rehabilitation of the member ahead of any consideration of compensation is, in the Council's view, a key issue. Compensation must, of course, remain available when the condition prevents the individual from reentering the workforce or there is a need for other fiscal relief however the ***needs*** of the individual in terms of treatment and rehabilitation in order that they can willingly, competently and confidently reenter the workforce should be paramount.

An Approach

The Council is cognizant of the important work DVA is currently undertaking in Veteran Centric Reform. Exploring legislation which is more centric to the modern veteran is a crucial step in ensuring veterans are appropriately supported following transition from full or part time service in the ADF. The development of one legislative instrument focusing on the

needs of the contemporary veteran that supersedes all previous instruments but preserves the existing provisions of the current Veterans Acts for those entitled until no longer required would be an appropriate and useful way forward. This approach could grandfather the existing entitlements until no longer required and at the same time provide a single legislative instrument covering veterans support. While a single legislative instrument, in the short term, would likely increase the complexity of the legislation it has the potential to streamline advocacy and reduce complexity in the longer term.

The Council believes there are some key considerations that will assist in developing a legislative framework that is representative of the cohort which it needs to support. These include;

- Redefining the term veteran. The effective redefining of the term 'veteran' will assist in appropriately representing any person that has served in the ADF, whether this be full time or part time service;.
- Ensuring there are two streams within the legislation that determine support available; firstly, access to services (support, rehabilitation and treatment for any health condition) and then compensation (monetary and support) if required;
- Reducing time taken to process applications; noting that legislation should support any person that has served in the ADF.
- Appropriate alignment between DVA and the Medicare Benefits Schedule (MBS) for the payment of services, to increase incentives for providers to treat veterans rather than turning them away.

Alignment of DVA payments and the MBS fee has been raised previously with the Council. It would appear there is a limited, but perhaps increasing, number of medical specialists turning our veterans away once they become aware they are DVA clients. The Council understands the concern regarding accepting DVA clients stems from the fact that MBS fees have been frozen for many years. DVA payments are linked to MBS fees and as medical specialists are prevented from charging a gap fee on a DVA payment it is this issue which causes some specialists not to accept DVA patients. DVA offers a premium to the standard MBS fee of 115% for GP consultations; 135% for specialist consultations; and 140% for procedures, however the inability to charge a gap fee beyond the DVA premium would appear to be significant.

While this issue might be considered more a micro-level function that is outside the remit of this Inquiry, the Council recommends it be noted when making any changes to legislation. There are flow on effects of this interconnectedness and from a strategic level, if there are issues with indexation of MBS items (to which many DVA items are mirrored), regardless of whether legislation changes, there may be systemic boundaries that have the potential to continue to cause frustration around both eligibility status and payment to veterans and their families.

The Council is of the view that a veteran centric model of support for servicemen and woman needs to incorporate change systemically. Ensuring that any future legislation developed is comprehensive enough to support the veteran cohort of yesterday and today, while being flexible enough to provide for future cohorts, with potentially very different afflictions.

Yours sincerely

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Chair
Prime Ministerial Advisory Council on Veterans' Mental Health
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