ADVOCACY, ENTITLEMENTS AND SUPPORT (AES) SPOT[1]

INTRODUCTION

I am feeling a bit of a charlatan as I sit to write for this quarter's Wings AES Spot. Not only did I miss the Summer issue (getting into training for the Festive Season), but I have to admit to going on extended leave when the Winter and Spring issues are due. As he did for the Summer 2013 issue, the Editor intends to include a range of current issues to keep information flowing. That said, this quarter I'd like to address some mental health matters that have arisen in recent experience.

This tack is sparked by the article written by the playwright, Daniel Keene, about his play *The Long Way Home* (Sydney Morning Herald, 6 February 2014, Arts and Society section). Keene says the play *was written in response to and in collaboration with soldiers who have been deployed from Afghanistan to Iraq, from Timor to the Solomon Islands to Somalia.* In other words, it is about experience at the "coalface".

CURRENT EXPERIENCES

Keene continues:

> *No one returns from war unscathed. Homecomings are never easy or as simple as we might imagine. War changes those who fight it. Soldiers come home from war with memories they cannot shake, with wounds that cannot always be healed. Their wounds are not always visible and their memories remain unspoken.*

Some will dismiss this as "poetic licence" – a playwright's flight of fancy, an exaggeration grounded in an emotional response. Indeed, there is still robust discussion over a beer amongst Vietnam veterans about whether claims of, and treatment for PTSD and Depressive or Anxiety Disorder are "real". Some still hold the view that such claims are a blatant abuse of the Veterans' Affairs system.

Clearly, not all who fight are afflicted by a mental illness. Those diagnosed, and under medication and cognitive behavioural therapy certainly know how real their distress is. And so is the damage that their illness has done to their families. "Secondary PTSD" – an illness that afflicts the families of some of those with PTSD – is accepted by psychologists as a real condition. Hence the Veterans and Veterans Families Services (VVCS) preparedness to treat for life children whose veteran father had PTSD. The real challenge for the veteran and the children is recognition, followed by acceptance, followed by therapy for the illness.

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[1] This article was prepared by R.N. (Dick) Kelloway, National and NSW VP AES, NSW-ACT Chair of TIP, practicing advocate and pension officer for RAAFA, the RSL and APPVA.

My experience as an Advocate and Pensions Officer supports Keene's observation. From my lay perspective, over 80% of the veterans I have helped with claims or appeals have shown clear signs of mental illness. In all but a few case, this was subsequently confirmed clinically. The remainder showed hints – flashes of temper, chronic substance abuse, chronic sleeplessness, chronic low esteem, aged by chronic depression or anxiety beyond their years. Unfortunately, some veterans have suppressed their illness for almost a lifetime. Two examples:

- RAAFA Pension Officers helped two WWII fighter pilots and a bomber pilot gain the courage in their early 90s to consult a psychiatrist and have diagnosed clinically significant PTSD from wartime experiences. Each had survived crashes on combat sorties in which they had barely escaped with their lives.

- Another veteran, wounded in Korea and then again during the Malayan Emergency, had hidden himself and his family away in the hills since the late 1950s. He could not bear other people. He broke down on his deathbed when I encouraged him to consent to a psychiatrist talking to him. He was diagnosed with severe PTSD and died three days later of cancer.

In two cases, the veterans' widow is now receiving a War Widows Pension. A rather belated relief after a lifetime of personal and family trauma. In the other, the widow died before the Department was able to process her claim for a War Widows Pension.

RAAF veterans from Vietnam that have sought my support all too frequently have ignored or suppressed or dismissed their symptoms - and the consequences for their family. The trauma arising from their combat experiences has come in many forms. Again, two examples:

- Iroquois aircrew who have climbed back up to altitude after an SAS insertion, knowing that if they were called back to down to recover the patrol they would extract under intense hostile fire. The camaraderie between SAS and 9SQN forged then persists to this day. For many of both groups, so do the symptoms.

- The 35SQN aircrew who flew resupply sorties into the A Shau Valley at somewhere around 150 knots and who, now - despite flashbacks, night sweats, palpitations, smoking and alcohol they cannot give up – think that a hole or two in the aircraft or a round that was so close to their open cockpit window that the percussion was loud above the engine and slipstream noise.

Unsurprisingly, the prevalence of PTSD and the propensity for veterans to shrug off trauma persists into the contemporary era. In a paper presented recently to ESO executives, DVA advised that:

- … two broad categories of claims … together represent approximately 50% of all claims received from members returning from Afghanistan to date. These are mental health (23%) and auditory conditions (24%).

- The 2010 ADF Mental Health Prevalence and Wellbeing Study indicates that the greatest barrier to seeking care for mental health issues is it would stop the member from being deployed (36.9%). It therefore may be reasonable to assume that the rate of mental health claims may increase once deployment opportunities cease.

Although proportionally, the DVA observations relate more to Army personnel than RAAF, theatre experiences confronting some of today's RAAF personnel still involve exposure to enemy fire. The threat of wounding or death has, however, widened, potentially affecting personnel whose employment would not have put them in imminent danger in earlier conflicts. IEDs, car and suicide bombings, and the immersion of enemy combatants into the civilian population have broadened the risk envelop.

Discussion with senior RAAF officers has, however, highlighted another area of significant concern for personnel and commanders in the highly networked, contemporary, combat theatre. No longer is trauma limited to those who are deployed. Combatants may now be seated in an operational headquarters in a country that is otherwise at peace, yet are viewing video and responding to video feeds that, for all intents and purposes, place them at the scene of action. Having done their day's duty, they then go home to their family and peacetime activities.

This reality brings me to the nub of this article.

Appeals heard by the Federal Court of Australia have on occasions found in the past that there are two dimensions to trauma in combat situations. Clearly, first is the unambiguous and unarguable situation where coming under hostile fire, killing an enemy, or seeing or handling casualties and human remains causes trauma and precipitates in time a psychiatric condition. The case law has, however, not been blind to another dimension – that of perceived danger.

Importantly, the second dimension is now covered by a recent amendment of the Statement of Principles for PTSD. Released by the Repatriation Medical Authority on 15 January 2014, SOP 19 respects the clinically substantiated reality that some veterans will become traumatised by their duty even though they were not physically engaged in combat.

If you open the new SOP on the RMA website www.rma.gov.au/SOP open the alphabetical page link "P" and scroll down the "Regional Hypothesis" column to "posttraumatic stress disorder", you will find that two new factors have been added to the pre-existing SOP 5/2008.

- The first amendment covers the PTSD sufferer who is in a threatening, hostile, hazardous and/or menacing situation (viz., on warlike duty), as a result he/she perceives him/herself to be threatened with death or

injury **AND** which any reasonable person in the same circumstance would perceive as threatening of “life or limb”.

- The second amendment covers the PTSD sufferer who by the nature of their duty is a “vicarious combatant” (my term). Understandably, this factor is tightly worded. The key provisions are that:

    - the trauma sufferer knows intimately the person threatened, or has been in contact with that person through discharge of duties and/or responsibilities; and

    - both the PTSD sufferer and the person threatened have been in the same or similar circumstances, and

    - the PTSD sufferer **AND** any reasonable person in the same circumstance would perceive as threatening to “life or limb”, **AND**

    - “the viewing or listening was part of the PTSD sufferer’s duties and/or responsibilities (ie., not the result of viewing the mass media).

Given that the SOP is now only a few weeks old, it is too early to know how a DVA claims assessor will determine a claim from a “vicarious combatant”. Without wishing to create unfavourable preconceptions, I can see that there is room in the factors for a rather restrictive interpretation. This may mean that the meaning of the instrument (remember: SOPs have the force of legislation) has to be tested at the Federal Court. Should this occur, learned justices have in past noted the “beneficial intent” of repatriation legislation.

Advocates and Pension Officers who support a claimant who is relying on especially the second factor in SOP 19/2014 should be conscious of the beneficial intent of the legislation. To do so, they should ensure that they clearly identify in the primary claim how the PTSD sufferer’s service relates to each of the following issues:

- How the PTSD sufferer viewed or heard the combatant in a dangerous situation was known.

- How the PTSD sufferer had been in the same or a similar situation.

- How the PTSD sufferer **AND** a reasonable person would have been affected by the exposure to trauma.

- How the exposure was related to duties/responsibilities.

Documentary proof of duties **AND** the trauma-causing occurrence will be essential. Where the greatest room for the claim being successful or rejected will, I believe, lie in how the PTSD sufferer having been in a similar or the same situation. By a tight interpretation, this could mean that the PTSD

sufferer has actually been in combat. By a more liberal interpretation, the PTSD sufferer could have, by their professional military knowledge, been critically aware of the effects on a human being of blast, shrapnel, explosive heat, percussion, or small and large caliber weapons. I feel that it is in this or similar argument that testing of the scope and intent of the second provision of the SOP may occur. I strongly encourage prospective claimants, pension officers and advocates to ensure that the foundations of a future test case before the Federal Court are laid in every claim that relies upon the second factor in SOP 19/2014.

INVITATION

If you are concerned about the claim that they are preparing that relies upon SOP 19/2014, or would like to contribute to, or participate in the care and support of ex-RAAF personnel and their dependents, I'd like to hear from you either through Lance Halvorson, the Wings Editor, or direct to me at: <richard.kelloway@bigpond.com>

If I am a little slow to respond, please forgive me. I may be in a tent somewhere around the Arctic Circle until the Summer issue of Wings.

March 2014