

Catherine Lawler

**Submission to:  
Foreign Affairs Defence and Trade References Committee**

**Suicide by Veterans and Ex-Service Personnel**

I am John Lawler's wife. John's experience of living with service related PTSD, his struggle to have that condition acknowledged by ADF and his battle to have his condition accepted as service related by DVA is detailed in the submission he has made to the committee.

What follows is my experience of the horrendous process which veterans with PTSD or mental illness must negotiate in order to access support from DVA, and the effect John's engagement with this process has had on my life and health.

This process has, at times, left John contemplating suicide. It has also left me contemplating suicide.

This submission is made with the knowledge that basic and corps training, which is designed to turn young people into trained killers, does so by disrupting their natural survival instinct of "fight or flight" to such an extent the only reaction they have is "fight" and their brain is permanently and irrevocably damaged. This means that *all* military personnel are at risk of acquiring mental ill-health and PTSD injuries, *regardless* of whether or not they have been deployed.

Any attempt to draw a distinction between ADF personnel who have had operational service and those who have not is discriminatory and it denigrates the undertaking to serve, when and where required, made by those who are not called upon for deployment.

DVA provides support for veterans with mental illness or PTSD in several ways. There is income support for veterans whose mental illness or PTSD is accepted as being a service related disability. In addition to this income support there is full medical support (via Gold Card) for veterans whose accepted disability meets certain criteria. DVA also provides some financial support by covering the cost of psychiatric treatment (via White Card) for those veterans diagnosed with mental illness or PTSD that DVA has not accepted as service related.

There is a wealth of information about these services available on the DVA website and in countless brochures, fact sheets and other publications available on-line or at DVA offices. But the ability of veterans with PTSD or mental illness to access this information is affected by the cognitive impairment that is a key symptom of their condition. These veterans are afflicted with the inability to concentrate, process information, take positive action, and engage with even simple processes. Offering on-line resources as the primary source of information about DVA services for PTSD and mental illness might meet departmental communications guidelines and it might be all that is legally required but it is a serious abrogation of DVA's moral and ethical responsibility to these veterans.

Further, all of the support provided by DVA requires the veteran to recognise they have a mental health condition, understand it is not something they can deal with themselves and admit that they need help. In short, the veteran needs to self-report, something which psychiatric research demonstrates occurs in only 50% of cases.

More importantly, and most damningly, the governing legislation establishes no positive obligation on DVA to identify veterans who have a PTSD or mental health injury, nor to be pro-active in offering treatment and support.

Having admitted they need help the veteran needs to obtain an accurate diagnosis. To obtain this they need a psychiatric assessment and the dilemma presents as to where to go to get a diagnosis. If you make your own arrangements there are costs involved. If you lodge a claim DVA will arrange for an assessment but this will be by *their* consulting medico-legal psychiatrist: a questionably impartial opinion.

Once the veteran has a diagnosis they can ascertain which element(s) of support from DVA they might be able to access and make a claim for those support service(s).

If the veteran's doctor or psychiatrist is aware of it they may be able to help the veteran apply for a White Card, which will cover the cost of psychiatric treatment for PTSD or Anxiety, without the need to prove the condition is service related. It's potentially a good system, but people need to know about it, how it works and how to apply. It would be a better system if treatment was made available to the veteran's families and if DVA ensured all medical practitioners, counsellors, and all other social support services knew about it.

If DVA does not accept the claim the veteran needs to lodge an appeal for an internal review, and if the internal review upholds DVA's original decision, the claim is referred to the Veterans' Review Board (VRB).

If the VRB accepts the claim the veteran may then need to appeal the level of support assessed by DVA which requires another internal review and, if necessary, referral back to the VRB.

If the VRB finds against the veteran, regarding whether the condition is service related or the assessed level of disability, the veteran can appeal the decision to the Administrative Appeals Tribunal (AAT). This ultimate step in the claims process is time consuming and expensive as the AAT is a court of law and it would be very unusual, and possibly not allowed, for the veteran to appear without adequate legal representation.

So, lodging a claim with DVA may seem to be a reasonably straight forward process, but the legal aspects under consideration are complex, potentially involving multiple pieces of legislation, the administrative requirements exacting, and the time frames very lengthy. And the veteran is expected to deal with all of this while living with the debilitating effects of PTSD or mental illness.

It is a tortuous and arduous process that serves only to increase the stress levels of the veteran and it impacts negatively on them and their family. The distress generated frequently becomes too much for the veteran, and they give up on their claim, walk away from their family, or take their own lives.

There is *no support* within this process for the partners or families of veterans with PTSD or mental illness.

My husband John Lawler is a veteran of the Australian Army. He served for six years, and acquired PTSD after he was bashed by five Australian soldiers, when he went to the defence of a fellow soldier who was at risk of serious sexual assault.

He has struggled for nearly 40 years to come to terms with what happened to him, and it has only been since his PTSD was diagnosed in 2011, that he has begun to understand the full extent of his injury and the impact it has had on his life.

Undiagnosed, and untreated, his PTSD has had wide reaching effects – it has damaged his life and the lives of those around him. He and his family are not alone in this. It is the lived experience of every veteran who has PTSD or another mental illness. The stories of substance abuse, anger, constant irritability, control issues, depression, emotional distancing, strained and estranged relationships, marriage breakdowns, self-harm, and suicide are numerous. Our lives have been no different.

The effects of dealing with DVA have stalled my husband's recovery and placed enormous stresses on our relationship. It saddens me greatly to see the man I love lose all pleasure in life, and to be sustained only by anger.

When I first met John I knew he had been in the army, but he did not talk about this part of his life very often and when he did it was with anger and bitterness, and frequent references to being merely "cannon fodder".

I also knew that he was a recovering alcoholic, a condition he had suffered with since his time in the army. He was clearly living sober but over the years there were sporadic episodes of significant binge drinking, triggered by times of major stress. This was incredibly distressing and confronting, I had grown up with an alcoholic parent and such episodes terrified me. Fortunately, the binges stopped when John started taking anti-depressant medication.

John had a son from his first marriage who was 10 when I met him. Over the years I watched him grow up confused and conflicted, caught up in a bitter marriage breakdown which he did not understand, and living with a mother who frequently told him his father was an irresponsible alcoholic, who didn't really care for him.

His son's life has been shaped by John's inexplicable outbursts of rage, his constant irritability, impatience and his perfectionism. He struggled to understand John's anxiety and catastrophising, and seemed to interpret it as his father being negative for the sake of it. But moderating all of this was John's inherent goodness, his sense of justice and his absolute love for his son. John incurred massive legal costs to maintain contact with his son and he took personal risks, and made career sacrifices to ensure he was around to be a father to him.

John's relationship with his son endures but over the past four years it has become increasingly strained and fraught. Most distressing for John has been that, in telling his son about his PTSD, the assault he suffered, and the steps he is taking to put things right, a gulf has opened up between them and his son is, more often than not, angry with John, wants very little to do with him and, as though in fear of PTSD being contagious, restricts John's access to his grandchildren.

John first lodged a claim with DVA in 2001, which was later denied by VRB in 2003. It was not until this time that John told me briefly about the assault, and the circumstances surrounding the incident. He spoke of it in the VRB hearing also, but, after that, did not mention it again. Frustrated, angry, and unwell, John chose not to pursue that claim any further.

Appallingly, at this time, although DVA's consulting psychiatrist had diagnosed John with Anxiety Disorder and recommended a treatment plan, no-one from DVA, nor the RSL, advised him that even though his condition had not been accepted as service related, he would be eligible for psychiatric treatment under the White Card facility. This omission has been incredibly injurious to John's psychological and physical health as we did not have the resources to follow up on treatment ourselves.

John's mental health deteriorated further over the next four years. He eventually sought help from our GP who prescribed anti-depressant medication and provided a referral to the DVA psychiatrist who had assessed him previously. When John tried to act on that referral and make an appointment, he was told the psychiatrist only saw DVA clients. Angry once more, he chose not to seek another referral and we tried to manage his symptoms ourselves with help from the medication and by minimising stressful situations.

This involved increasing social isolation for both of us. John found it difficult to mix socially, and I did not feel comfortable socialising without him, even when improvement in my own mental illness means I feel like doing so. Most hurtful for me has been that several long term friends have drawn away from us, misunderstanding John's condition and perceiving that I was unfairly being called upon to shoulder the majority of our shared responsibilities.

John has withdrawn from involvement in the day to day tasks of our domestic lives, and I undertake all household chores, inside and outside the house, and financial dealings. I generally liaise with doctors, government departments, his RSL advocate etc. on John's behalf. We will often go for long periods of time when I also do all of the driving. All of this has an impact on my physical health, and I am continuously fatigued. I have gradually withdrawn from the workforce to become John's fulltime carer.

John's levels of distress escalated greatly four and a half years ago, triggered by media reports of the ADFA SKYPE affair. I could not understand what was going on, but he eventually told me, in detail, about the assault he had suffered, the circumstances that had led to the assault, and how angry and betrayed and disgusted he felt about what had happened.

The anger and rage that engulfed John increased the tension between us to unbearable levels. I tried to be supportive, I tried to understand, but I was struggling. I was worn out and worn down. There were many times when I was angry too. I knew I could not be his wife and his psychiatrist too.

I found myself in a position where the best thing to do was to disengage from John, go about my daily business and pretend I did not care. But I did care, and his pain was my pain. I eventually found myself thinking that if I killed myself I could stop myself from sharing his pain. But I couldn't kill myself because I knew my family would never forgive him. Then I realised that if I was to drive my car into a tree no-one would know it was deliberate...

Realising this was a bad place to be I sought help from my GP who diagnosed me with depression, prescribed medication and referred me for additional counselling.

The only support that was available to me was via the public health system. My GP referred me to a mental health nurse and a psychologist whose costs were covered by Medicare under a GP mental health plan. However, there were limits as to how long this treatment could continue. Also, John had started seeing a counsellor through VVCS who invited me to join their sessions.

The mental health nurse I was seeing invited John along to a consultation, and she arranged a tele-med consultation for him with a psychiatrist. This psychiatrist diagnosed John with PTSD and is now his treating psychiatrist.

We had turned an important corner, but the hard work had only just begun.

And I say *hard work* because there is NO SUPPORT for the families of veterans with PTSD provided by DVA and I had to take care of my own mental health, keep our daily lives on track, whilst looking out for John, and trying to keep him from exploding too much and too often while he started treatment and commenced the DVA claims process.

Assistance for veterans lodging claims with DVA is provided primarily by DVA trained advocates attached to ex-service organisations such as the RSL. This in itself can be a huge deterrent to veterans who may be eligible to make a claim, but who, like John, may want nothing to do with ex-service organisations or other veterans, because of their experiences. The close relationship between these advocates and DVA can also engender distrust between the veteran and the advocate because they can be easily perceived as merely working for DVA.

John had had an RSL advocate acting for him when he lodged his previous claim and felt that advocate had not done anything to help his case. Of particular concern to John was that the RSL advocate had sat in the VRB hearing and said nothing. So, after an initial and unsatisfactory consultation with the same advocate, John lodged a new claim with DVA for a disability pension due to his PTSD without nominating an advocate.

It seems that, for the most part, veterans do not obtain legal advice until they are at the stage of appealing their matter to the AAT. I can only guess at the reasons for this, but I suspect it is because the advocate system is promoted as the best way for veterans to obtain advice and assistance, because it is free of charge and provided by veterans who have been trained by DVA, and therefore, apparently, know the processes in detail.

However, this system is flawed, and fraught with shortcomings. It relies on lay people to provide advice on and navigate the requirements of lengthy and complex legislation and the success or otherwise of a veteran's claim relies on the accuracy of the advice given, paperwork completed and evidence obtained.

One example of John's case being potentially prejudiced due to poor assistance was when the RSL advocate he first saw completed his claim form. He asked John if he drank alcohol. John said "no" because he does not drink alcohol anymore. The advocate was quite insistent that John should leave the form with him to submit. However, John wanted to take the form home to review it before submitting it. It was then he realised the question on the form

actually read “Have you ever consumed alcohol?” to which the answer was “yes”. John was astounded that he had been misled into providing an incorrect answer on this important document. He subsequently corrected the form and submitted it without any further assistance from any other party. This correction was crucial, because one of his diagnosed conditions is alcohol dependence. Subsequent experience has demonstrated that DVA deems the words on claim forms as final and binding. Once something is committed to writing on the form, there is no chance to clarify or correct.

John’s claim was subsequently denied and he decided he would lodge an appeal. He decided to find another advocate and was put in touch with a welfare officer at the Vietnam Veterans Association. This man said he would liaise between John and the VVA advocate.

When the deadline to apply for an appeal arrived, John contacted the welfare officer who admitted that neither he nor the advocate had forwarded the required form. We completed the form ourselves, and personally delivered it to our local DVA office, who faxed it through to the relevant department. The VVA welfare officer undertook to ensure that the application for appeal was accepted even though the form was late. To our relief the application for appeal was accepted.

John was aghast and furious that he had almost lost the ability to appeal his claim due to the inaction of someone else.

I suggested we could see a lawyer to help prepare his case for presentation to the VRB. We were not able to find any lawyer that advertised as practising in the veterans’ affairs. So we searched the AAT case reports, and contacted the firm that appeared to act for veterans in most of the appeals. On doing so, we were told that this firm would only assist us if the matter was appealed to the AAT, because they “did not want to upset the advocates”.

We contacted another RSL advocate and had a meeting to discuss John’s claim. During that meeting, we were told that John did not have a claim because he had not been on his way home from work. We were also told that because he was not drinking anymore, he was not an alcoholic. Horrified at the inaccuracy of this information, John kept looking for someone to act on his behalf.

In sheer frustration he asked his psychiatrist if he knew of any advocates that his other clients had had good experiences with. We followed up on a number of suggestions and eventually established contacted another RSL advocate, who has been acting for John since.

Nevertheless, this relationship has had its fair share of difficulties. For example, the RSL advocate would often make negative comments about John’s case, such as the absence of evidence of the assault in his personnel or medical records, or that the statutory declaration John had obtained from a former colleague, stating he knew about the assault, was only hearsay and not worth the paper it was written on. When he said these things he would go on to say he was “playing the devil’s advocate”. I was astonished he would do this without then suggesting possible strong points of John’s case because, in my view, such comments would have discouraged someone less determined than John to such an extent that they may have given up on their claim.

The level of assistance provided was also very limited, and it seemed geared toward only completing requisite forms, within proscribed timeframes. For example, John wanted to

contact the soldier he had defended to ask for a witness statement to the incident. The VVA welfare officer had said there would be no problems locating the soldier, the RSL advocate said it might be possible if the soldier was still serving or drawing superannuation, but offered no further assistance in this regard.

Frustrated John turned to Google and eventually located the soldier. The internet reference was an obituary. The soldier had died of a brain tumour seven months prior, which was several months after the VVA welfare officer had said he would be able to locate the soldier.

It was on our initiative that key reports, and items of evidence, were obtained. For example, John took the initiative to get in contact with soldiers he had served with and who he thought might remember the assault. These enquiries provided one statement providing knowledge of the incident. Another example is that, on our way home after our second or third meeting with the RSL advocate to discuss the VRB appeal process, I realised no mention had been made of obtaining a report from John's psychiatrist. I rang the advocate and suggested that this report was needed, and he agreed to send a request. I can only wonder whether he would have made the request without this prompt from us.

When DVA advised John he had been assessed at 80% level of disability the RSL advocate said he "should be pretty happy with that" and seemed taken aback when John said he wasn't and that he wanted to appeal the decision. During this meeting we raised that issue that John had not been requested by DVA to complete a Lifestyle Rating Form and that he should do so, specifically, completing the long form, as discussed during the VRB hearing. In response the RSL advocate said there was no point in completing this form because it would not make "a bit of difference". He said there was no way John would be assessed with a Lifestyle Rating of more than 3. Nevertheless, John and I contacted DVA, pointed out that this form had not been requested, and John was subsequently requested by DVA to complete the form, which he did. John's self assessment using this form put his Lifestyle Rating at 5.

When the VRB referred John's claim back to DVA for assessment of his level of disability he was not assessed at the special or intermediate rate because his previous claim form noted spinal conditions which had been found to be not service related. It was not until then that we were advised about the "alone" test. If the RSL advocate had brought this issue to our attention earlier, we could have addressed it as part of the first VRB hearing and had the issue resolved prior to DVA's assessment of John's level of disability. Now, the matter is going before the VRB again, and yet another 12 months have passed.

To prepare for the upcoming VRB hearing, the RSL advocate said John should obtain a report from an orthopaedic surgeon stating his spinal conditions were not sufficient to prevent him from working. I suggested we also needed report from John's psychiatrist confirming John had believed his subjective distress was due to his back and neck because his mental illness was, at that stage, undiagnosed. The RSL advocate said a psychiatric report wasn't needed because we already had one, and a second one would be overkill. I said I wanted to cover all bases and counter any possible argument before DVA had the chance to make them. We arranged for the orthopaedic and psychiatric reports ourselves.

As an aside, while researching exactly what the "alone" test meant, we were able to point out to a DVA claims officer that the wording of the statement of principles relating to this criteria was ambiguous, and not in accordance with the wording in the VEA.

**Catherine Lawler**

Submission to:

Senate Standing Committees on Foreign Affairs Defence and Trade

I have worked for lawyers for many years and have a good understanding of legal processes. My husband and I are both tertiary qualified with significant reasoning capabilities. Even so, this has been a debilitating and gruelling process for us. I cannot imagine how those who do not have these resources cope with DVA and their administrative nightmare. Perhaps they do not. Considering the average veteran is not likely to have the ability to comprehend and deal with this complicated, convoluted, impenetrable and adversarial process, it is not unreasonable to conclude that the system has been deliberately designed to ensure most claims fail.

The DVA claims process purports to be simple, easily accessible, fair, and timely. The experiences I have described above demonstrate that it is unnecessarily complex, impenetrable, adversarial, and drawn out. It is also marked by a significant power imbalance in that the VRB has at least one member of the panel who is a lawyer. This means the veteran, who is only represented by a lay person, is disadvantaged if the VRB chooses to exploit their position of power.

The DVA claims process ultimately causes further damage to the mental health of the veteran and in doing so further damages the mental health of the veteran's family.

I believe the system of DVA training volunteer advocates works to the detriment of claimants and benefit of DVA by dissuading veterans from, at best, pursuing the full extent of their entitlements and, at worst, not claiming at all.

This system needs to change and veterans should be afforded proper legal representation from the very start of the claims process. This could be achieved by the government adopting a Legal Aid type system, necessarily independent of DVA, where qualified lawyers are paid set fees for performing set functions. The cost of this would surely be offset by savings in not having to train advocates, and more accurate and efficient processing of claims.

The process for John's DVA claim has taken four years so far. I can only hope we are nearly at the end. In the meantime, I keep reminding myself that the angry John is not the real John. The real John is the good John and I hope that, one day, soon, the real John will be the only John in my life.