The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Foreign Affairs, Defence and Trade References Committee

The representation of and advice provided by ex-service organisations, commercial entities, not-for-profits and individuals to veterans and families in relation to accessing compensation and income support from the Department of Veterans' Affairs

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Improving the mental health of communities

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 8700 members, including around 6000 qualified psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Key findings

- Adversarial and opaque claims processes can contribute to psychological harm. Compensation schemes should adopt trauma informed, evidence-based approaches with minimally adversarial practices.
- Advocates may support claimants and provide value, but for-profit models that encourage a focus on compensation over rehabilitation may risk poor mental health outcomes.
- Paying psychiatrists more to assess a new claimant than to provide ongoing care continues to encourage a compensation-focused, rather than recovery-oriented, system.

Introduction

The RANZCP welcomes the opportunity to provide a submission to the Senate Foreign Affairs, Defence and Trade References Committee's inquiry into compensation and income support for veterans.

This submission, informed by the expertise of members (including members of the Military, Veterans' and Emergency Services Personnel Mental Health network within the RANZCP) and the RANZCP's position statement PS 99: The mental health of veterans and defence force service members, responds to the following elements of the inquiry's terms of reference:

> (a) the appropriateness of commercial entities, within and outside Australia, providing advocacy services, including the charging of fees or commissions on statutory entitlement payments;
>
> (b) representation of veterans at the Veterans' Review Board, including by legal practitioners;
>
> (e) any other related matters

The submission discusses the potential for adversarial processes to cause psychological harm and the importance of an emphasis on rehabilitation when considering the role of for-profit advocates.

Other relevant submissions and position statements from the RANZCP include:

- Position Statement 73: Mental health for the community
- Position Statement 94: Public insurance schemes: advocating for mental injury claimants
- Position Statement 100: Trauma-informed practice
- Position Statement 105: Cultural safety

- Submission to Royal Commission into Defence and Veteran Suicide
- Submission on superannuation and pension schemes for current former members of the ADF

Adversarial claims processes and psychological harm

In Position Statement 94: Public insurance schemes: advocating for mental injury claimants, the RANZCP highlights that '[a] growing body of research has documented the ways that compensation systems themselves can promote worse health outcomes, especially for people with mental health problems' in part because 'mental injuries are frequently made worse by the prolonged contest to obtain compensation.' For veterans with PTSD, repeatedly recounting traumatic events in new contexts can be harmful. But across all conditions, claimants who report higher levels of stress in engaging with compensation schemes are likely to have significantly higher levels of disability, anxiety, and depression [1].

Current delays in decision making can cause harm, especially if veterans are not aware of entitlement to non-liability mental health care or cannot access providers accepting White Cards. Research commissioned by the Department of Veterans' Affairs (DVA) has explored the mental health impacts of compensation claim assessment processes at length [2]. Meanwhile, the RANZCP has produced a range of submissions and position statements on related issues in other compensation systems:

- Position Statement 94: Public insurance schemes: advocating for mental injury claimants
- Submission to DEWR re Review of the Safety, Rehabilitation & Compensation Act 1988
- Bringing evidence-informed practice to work injury schemes

Claim processing should be as fast and as non-confrontational as possible, including by minimising the need to undergo multiple examinations or to repeat case histories unnecessarily.

When advocates reduce the stress involved in engaging with compensation schemes, they can reduce psychological harm. The RANZCP accepts that the complexity of the system often requires an advocate, especially when psychological injury makes navigating processes more difficult.

However, in other Australian compensation schemes individuals represented by lawyers are more likely to be in psychological distress and claims procedures take longer to resolve for represented than unrepresented clients [3]. It is difficult to determine the directionality of this effect, but it may imply that representation draws out the process when a client's pecuniary interests are particularly well-defended by a lawyer in a way which neglects to consider the psychological harm associated with a longer and more adversarial process.

The RANZCP supports the current model of proceedings at the Veteran's Review Board because it minimises adversarial practices. The RANZCP notes the incorporation of expertise on therapeutic jurisprudence in the development of the Board's General Practice Direction and Vulnerable Veterans Protocol. Particularly valuable features are the requirements to proceed through alternative dispute resolution processes before a hearing is scheduled and an inquisitorial rather than adversarial model where the relevant commission is traditionally not represented.

Introducing a right to legal representation or expanding the role of for-profit advocates could threaten this approach by increasing the likelihood of hearings becoming more adversarial and technical, and by discouraging alternative dispute resolution. However, the assistance of a lawyer or for-profit advocate could diminish the stress of engagement.

Rehabilitation and compensation

For-profit advocates generally operate on a no-win no-fee basis (a conditional fee), claiming a percentage of financial compensation from a veteran if it is awarded (a contingency fee). This incentivises them to advise clients to claim for the largest financial compensation possible and to take compensation for permanent impairment as a lump sum rather than over time. The RANZCP notes that this is an anomalous situation; for example, the Uniform Law prohibits lawyers entering into a costs agreement where the amount payable to them is calculated by reference to the amount of any reward or settlement (e.g. *Legal Profession Uniform Law 2014* (NSW) s 183).

In many cases, for-profit advocates arrange assessment for veterans through affiliated medical practitioners, such as by arranging for them to be seen by a recommended clinician or even by employing clinicians directly. For-profit advocates are incentivised to prefer psychiatrists who are more likely to diagnose more conditions with greater severity. This places implicit financial pressure on psychiatrists to provide assessments which best support the advocates' business model. Although professional ethics mitigate this risk, it remains present.

Using contingency fees may not be the most appropriate approach to ensure wellbeing for other reasons. For example, mental illness is often co-morbid with physical injury. Treatment needs to target both, but a for-profit advocate may have little incentive to advocate for a White Card to make treatment for the injury free as well as for compensation, since doing so does not increase their earnings.

Similarly, there is also a risk involved in maximising the potential claims. At the extreme,

> Due to the nature of veterans' compensation systems, some people may perceive a vested interest in maintaining symptomatology until all proceedings associated with their claim have been completed. Therapists are advised to address this issue with the person before initiating treatment. An open discussion of the pros and cons of maintaining symptomatology can often be useful. [4]

Maximal claims can also have negative effects if they discourage rehabilitation and employment. Longitudinal studies show that some veterans can and do recover from probable mental health disorders over time, while treatment and rehabilitation increases wellbeing in others [5]. Meta-analyses consistently show that unemployment impairs mental health, rather than poor mental health merely being associated with unemployment [6]. The RANZCP has previously argued that 'there is clear evidence of the role employment plays in social and economic inclusion, and the health and wellbeing benefits associated with getting and keeping a suitable job. It is therefore critical that there is a focus on vocational rehabilitation services.' The Productivity Commission has, on similar grounds, also recommended that attending rehabilitation be a requirement for receiving invalidity pensions where appropriate [7]. But the incentives, in the case of for-profit advocates, are to emphasise dysfunction and discourage rehabilitation before claims are settled.

Finally, difficulty in accessing care is increased by discrepancies in DVA payment rates. When a claim involving psychological injury is made, DVA will fund a psychiatrist of the claimant's choice to assess them. This is paid at a fixed rate; for example, a report after a consultation of up to one hour can be invoiced for $805. In contrast, ongoing psychiatric care is paid at 145% of the Medical Benefits Schedule (MBS) schedule, so a 30-45 minute consultation providing ongoing psychiatric care to a veteran (MBS item number 304) pays $223.155.

This significant difference in renumeration incentivises psychiatrists, in the context of an ongoing workforce shortage, to prioritise assessment for compensation over treatment, and to have an interest in continuing to receive new claimants for assessment, including through relationships with for-profit advocates. This is particularly problematic when an informed assessment is more likely to result from sustained engagement with a patient over a number of episodes of care by a psychiatrist aware of the cultural specificity of veterans who is informed by ongoing treatment by other providers (for example, from a referring GP).

Meanwhile, veterans can find it very difficult to find clinicians accepting DVA rates for ongoing treatment, since these are below both what would be chargeable in private practice and for assessments in response to a claim for compensation. The RANZCP recommends increasing payment rates for ongoing treatment to avoid incentivising assessment without treatment and to ensure that psychiatrists can remain independent of undue influence when assessing claimants. This could be part of a broader effort to encourage engagement with treatment in a wellbeing-focused approach rather than emphasising compensation alone, in order to avoid a situation in which increased wellbeing threatens compensation.

Further information

The RANZCP thanks the Senate Foreign Affairs, Defence and Trade References Committee for the opportunity to provide this submission. If you have any questions or wish to discuss any details further, please contact Callie Kalimniou, Director, Policy & General Counsel at callie.kalimniou@ranzcp.org or (03) 9601 4984.

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