

# Chapter 3

## Identification and disclosure of mental ill-health

### Introduction

3.1 This chapter considers the mental health strategies for ADF members and veterans; identification and disclosure policies in the ADF in relation to mental ill-health; and recordkeeping for mental ill-health for ADF members.

### ADF Mental Health Strategies

3.2 In 2002 the Department of Defence (Defence) developed its first Mental Health Strategy (MHS), seeking to promote mental health and wellbeing as well as raise awareness of suicide and the misuse of alcohol, tobacco, and other drugs. In 2009, the *Review of Mental Health Care in the ADF and Transition through Discharge* (commonly referred to as the Dunt Review) was published. The Dunt Review praised the ADF finding that its MHS compared favourably to mental health strategies from militaries in other countries:

The establishment of the MHS by the ADF in 2002 was far-sighted. The Strategy compares favourably with mental health strategies in other Australian workplaces. It also compares favourably with what exists in military forces in other countries. Some of these military forces have mental health policies and programs in place, particularly in relation to PTSD. Others have individual mental health programs in place however they do not have the suite of programs at a whole of forces level that exists in the ADF. The enthusiasm and commitment of ADF members in delivering these programs adds to the ongoing achievement of the MHS. This has meant that programs are well received by members.<sup>1</sup>

3.3 The Dunt Review noted that, despite its achievements, the ADF's Mental Health Strategy needed further improvement 'for it to truly be a Strategy, rather than a small number of small programs as at present'.<sup>2</sup> The Dunt Review made 52 recommendations.<sup>3</sup>

### ADF Mental Health Reform Program

3.4 Defence commenced the Mental Health Reform Program in 2010, based substantially on the findings and recommendations of the Dunt Review.<sup>4</sup> Defence invited a number of external mental health experts, clinicians, policy advisors and

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1 Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009, p. 16.

2 Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009, p. 16.

3 Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009, pp 21–27.

4 Department of Defence, *ADF Mental Health & Wellbeing Plan 2012-15*, p. 5.

researchers (including Professor Dunt) to form the Mental Health Advisory Group, together with representatives of Joint Health Command (JHC), single Services, Defence Community Organisation, Defence Families Association, Department of Veterans' Affairs (DVA) and the Veterans and Veterans Families Counselling Service (VVCS). The Group has met seven times.<sup>5</sup>

3.5 In 2011, Defence released its Mental Health and Wellbeing Strategy (MHWS) and in 2012 released the supporting Mental Health and Wellbeing Action Plan (MHWAP).<sup>6</sup> The MHWAP lists six strategic objectives and the priority actions that need to be taken to achieve them (see Table 1.1). The MHWAP also outlines the goals and deliverables and describes 'what success will look like', for each of the objectives.<sup>7</sup> The Chief of the Defence Force (CDF), Air Chief Marshal Mark Binskin AC, outlined Defence's achievements in the area of mental health since 2009:

...we have upskilled and increased our mental health workforce as well as strengthened our resilience training and prevention strategies, which now begin at recruitment. We have improved the screening programs used to identify problems and we have also undertaken world-class mental health research and surveillance. As a result, we know more now than at any point in our history about the impact military service can have on the mental, physical and social health of current and ex-serving personnel. We have a comprehensive body of data about the causes and prevalence of mental health issues in the Australian Defence Force population.<sup>8</sup>

3.6 Defence advised the committee that it has implemented all 52 of the recommendations from the Dunt Review, investing \$146 million in mental health services and support (as at 30 March 2015). Defence has improved policy and training for Defence health professionals; increased mental health research and surveillance; and strengthened resilience training and prevention strategies.<sup>9</sup>

3.7 The Returned and Services League of Australia (RSL) commented on the MHWAP, stating that its priority actions, whilst positive, are far from achieved:

These hoped for outcomes have at best been only partially obtained at this point in time and a great deal more work is yet to be undertaken in order to achieve them. Too many individuals are suffering in poorly managed circumstances at the present time without the necessary care and supervision that's required from a number of appointed agencies.<sup>10</sup>

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5 Department of Defence, *Submission 34*, p. 3.

6 Department of Defence, *Capability through mental fitness: 2011 Australian Defence Force Mental Health and Wellbeing Strategy*, October 2011; and Department of Defence, *ADF Mental Health and Wellbeing Action Plan 2012-2015*, October 2012.

7 Department of Defence, *ADF Mental Health & Wellbeing Plan 2012-15*, pp 12–25.

8 Air Chief Marshal Mark Binskin AC, Chief of the Defence Force, *Committee Hansard*, 29 September 2015, p. 1.

9 Department of Defence, *Submission 34*, pp 3-4.

10 Returned & Services League of Australia, *Submission 19*, p. 7.

3.8 Consultations for the development of the *ADF Mental Health and Wellbeing Strategy 2016-2020* commenced in March 2015. The consultations are being led by Joint Health Command and 'will involve engagement with a broad range of stakeholders, both internal and external to Defence'.<sup>11</sup>

**Table 3.1 – Strategic objectives and priority actions of the ADF Mental Health and Wellbeing Plan 2012-15**

Strategic Objectives	Priority Actions
Promote and support mental fitness within the ADF	Addressing stigma and barriers to care Strengthening the mental health screening continuum
Identification and response to mental health risks of military service	Improving pathways to care Developing e-mental health approaches Developing a comprehensive peer support network
Delivery of comprehensive, coordinated, customised mental health care	Improving pathways to care
Continuously improve the quality of mental health care	Enhancing service delivery Upskilling service providers
Building an evidence base about military mental health and wellbeing	
Strengthening strategic partnerships and strategic development	Strengthening the mental health screening continuum Enhancing service delivery

Department of Defence, *ADF Mental Health & Wellbeing Plan 2012-15*, p. 11.

### **Requirement for ADF members to be 'medically fit'**

3.9 Defence has an obligation to ensure that ADF member's duties do not detrimentally affect their health, that ADF members can undertake their duties without compromising the safety of themselves or others, and that the ADF as a whole maintains its operational capability. As outlined in the 2013 *Review of Health Information Practices in Defence*, Defence must balance the health of the individual ADF members with the effect that an individual's health issue may create within an operational situation:

The requirement that a member be fit for the performance of their duties is of paramount concern to the ADF. A member's employability and

11 Department of Defence, *Submission 34*, p. 3.

deployability goes to the very reason for being of the ADF; its operational capability. Members must be fit to undertake their duties without compromising the safety of themselves or others. Defence has an obligation to ensure that the undertaking of their duties does not have detrimental effects on the member's health. Accordingly the seeking of health treatment by a member, the provision of health treatment to the member by the Commonwealth, and, the requirement by the ADF that a member undergo a health examination or treatment, renders the provision of such a service as being outside the normally understood relationship of health practitioner and patient. The relationship becomes a 'three cornered' relationship with the ADF having a clear interest not only in the effect of a member's current health statement vis-à-vis the individual but also the greater effect that any health issue may create within an operational situation.<sup>12</sup>

3.10 The *Defence Act 1903* provides for regulations to be made in relation to medical treatment of ADF members and cadets. It is a condition of an ADF member's service that they be physically and mentally capable of performing the duties required of them and, if determined to be medically unfit (including unfitness because of incapacity due to mental ill-health), a member's service may be terminated under the provisions of the *Defence (Personnel) Regulations 2002*.<sup>13</sup>

3.11 ADF members may be ordered to submit to medical examination. Part 6 of the *Australian Military Regulations 1927* provides for compulsory medical examination of an Army member where directed by a superior officer to so attend, including the requirement that the member provide the person conducting the examination with all information and do anything required by the examiner for the purpose of such an examination.<sup>14</sup> Part 4 of the *Air Force Regulations 1927* also provides that an Air Force member may be examined in a way approved by the Chief of Air Force to determine a member's level of medical fitness.<sup>15</sup> The Navy operates similarly, however without such a legislative provision.<sup>16</sup>

### **Screening and early identification of mental ill-health**

3.12 The Chief of the Defence Force stated that 'we are looking for early recognition of a mental health injury and then looking to get early rehabilitation to be able to get people back to work'.<sup>17</sup> Defence advised the committee that it has implemented a comprehensive Mental Health Screening Program to identify and provide assistance to individuals who have been exposed to potentially traumatic

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12 Department of Defence, *Review of Health Information Practices in Defence*, December 2013, pp 19–20.

13 Regulation 85(1)(b) if the member is an officer and regulation 87(1)(c) for an enlisted member.

14 Australian Military Regulation 433.

15 Air Force Regulation 433.

16 Department of Defence, *Review of Health Information Practices in Defence*, December 2013, pp 19–20.

17 Air Chief Marshal Mark Binskin AC, Chief of the Defence Force, *Committee Transcript*, 21 September 2015, p. 6.

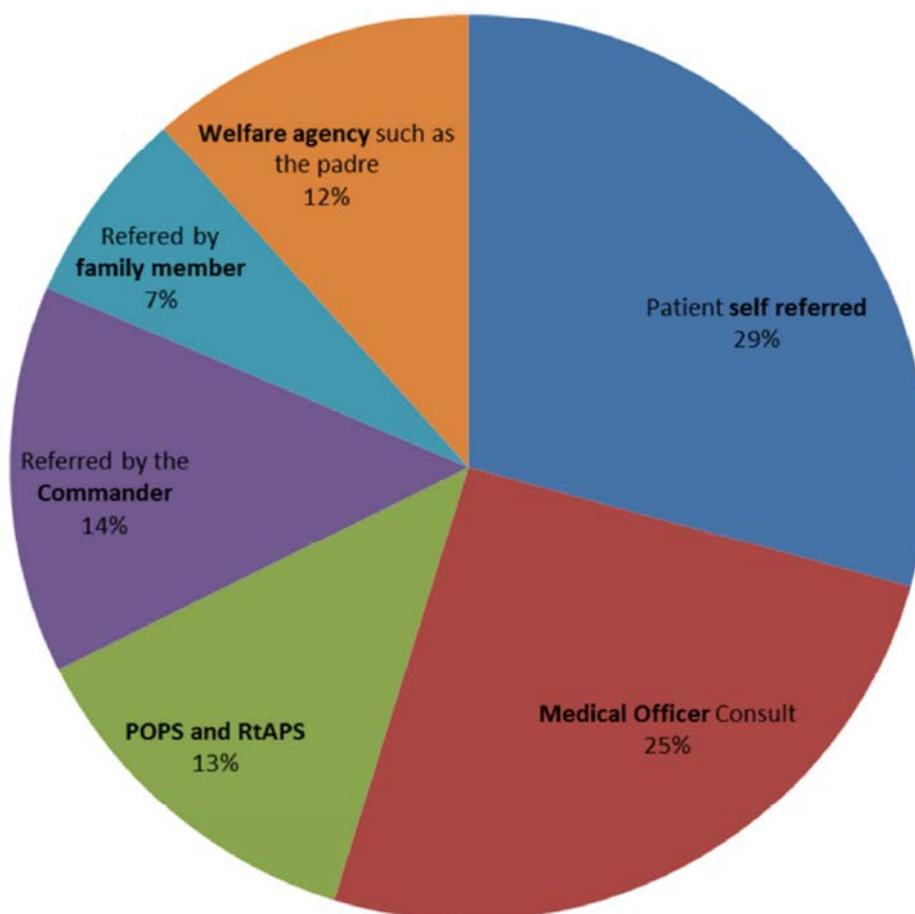
events through activities such as deployments, Border Protection operations, humanitarian and disaster relief missions or training accidents.<sup>18</sup>

### ***Referral pathways***

3.13 Aspen Medical found that the most common referral pathway for ADF members seeing a mental health professional was self-referral (29 per cent), closely followed by referral by a Medical Officer (25 per cent) (See Figure 3.1). Aspen Medical noted that this suggests that ADF mental health policy regarding the shared responsibility between commanders, individuals, and clinicians for the identification and early treatment of mental ill-health is working:

This success is evident in the high self-referral rate. It is possible that another person such as a commander, padre, family member or friend encouraged a patient to self-refer. However, the high rate of self-referral indicates that many individuals are willing to seek treatment. It also suggests that the stigmatism, once attached to [ADF members] mental health, is changing at the individual level.<sup>19</sup>

***Figure 3.1 – Referral Pathway for Mental Health***



Aspen Medical, *Submission 38*, p. 15.

18 Department of Defence, *Submission 34*, p. 4.

19 Aspen Medical, *Submission 38*, p. 15.

3.14 Some submissions questioned the effectiveness of screening in the early identification of mental ill-health.<sup>20</sup> Walking Wounded acknowledged that ADF mental health evaluation screening has 'improved markedly over recent years', but noted that it can be circumvented by ADF members who do not wish to be identified as struggling with mental ill-health:

The concept of post-operational psychological screening (POPS) is good but can often be "gamed" by soldiers who are keen to go on leave, etc, rather than be delayed by admitting to stress disorders. While not widespread, there are many who feel that once they go on leave, they will return to normal. Sadly, we know this isn't always the case.<sup>21</sup>

3.15 However, Dr Kieran Tranter informed the committee of a recent study, using participants from the MHPWS, which considered the diagnostic accuracy of the screening tests used by the ADF—the Kessler Psychological Distress Scale (K10), Alcohol Use Disorders Identification Test (AUDIT) and the Post-traumatic Checklist (PCL)—in a population-based military cohort.<sup>22</sup> The study found that 'all three scales showed that good to excellent levels of overall diagnostic validity' and 'could sensitively detect disorder whilst maintaining good specificity'.<sup>23</sup>

3.16 Aspen Medical noted that it has found that screening activities are 'useful at identifying early some [members] who need help'. Aspen Medical commented that the number of referrals to medical health professionals from Post Operational Psychological Screening and Return to Australia Psychological Screening indicates that screening is effective at early identification of deployed member's mental ill-health and that 'this suggests that the policy and conduct of these mandatory screens are achieving the effect that they were designed to achieve'.<sup>24</sup>

3.17 Currently, there are a number of time points or key events that trigger mental health screening within the ADF, with approximately 8,000 members being screened every year. The majority of mental health screening is connected to deployment and after critical incidents. ADF member's participation in psychological screening, both on deployment and after returning from deployment, is mandated by each operation's Operational Health Support Plan (OHSP). Routine physical health checks, which occur every three to five years, also include an alcohol use screen.<sup>25</sup>

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20 For example: Mr Mark Keynes, *Submission 10*, p. 2; Walking Wounded, *Submission 18*, p. 3; Slater & Gordon, *Submission 51*, p. 7.

21 Walking Wounded, *Submission 18*, p. 3.

22 Dr Kieran Tranter, *Submission 27*, p. 17.

23 Amelia Searle et al, 'The Validity of Military Screening for Mental Health Problems: diagnostic accuracy of the PCL, K10 and AUDIT scales in an entire military population' *International Journal of Methods in Psychiatric Research*, Vol. 24, No. 1, p. 41.

24 Aspen Medical, *Submission 38*, p. 16.

25 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p. 30.

3.18 Defence advised that mental health support and screening may also be tailored to meet the requirements of a particular operation, giving the example of the program for Operation RESOLUTE, which aims to provide psychoeducation, surveillance and early identification and referral of members who require follow-up mental health support.<sup>26</sup>

### *Types of screens*

#### *Return to Australia Psychological Screening (RtAPS)*

3.19 Return to Australia Psychological Screening (RtAPS) is provided to all deployed ADF members nearing the end of their deployment. The aims of the RtAPS are to document traumatic exposure; document and manage current psychological status; provide advice and education to facilitate a smooth post-deployment transition; and provide information to Command on the psychological health of the deployed force. Further, in addition to identifying individuals at risk and arranging referral for more detailed assessment, the data gained from the RtAPS is used by the senior psychologist to brief the deployed element commander and to enable trend analysis.<sup>27</sup>

The RtAPS comprises:

- group psycho-education brief on:
  - the RtAPS and its aims and process (including confidentiality issues and data use);
  - readjustment to family life (including reactions of partner, children, and friends);
  - readjustment to work (including relationships with peers and career decisions); and
  - health issues (including post-deployment fitness, and tobacco and alcohol use).
- a questionnaire, comprising the:
  - Deployment Experiences Questionnaire (including data on operational temp and unit climate);
  - Kessler Psychological Distress Scale (K10);
  - Traumatic Stress Exposure Scale – Revised (TSES–R);
  - Major Stressors Inventory – Revised (MSI–R); and the
  - Posttraumatic Checklist (PCL).
- one-on-one semi-structured screening interview, which covers the following (as a minimum):
  - introduction;

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26 Department of Defence, *Submission 34*, p. 14.

27 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 31–32.

- deployment experiences;
- potentially traumatic events;
- coping strategies;
- current symptoms;
- homecoming and adjustment issues;
- screening questionnaire summary; and
- psychoeducation.<sup>28</sup>

### *Post-Operational Psychological Screening (POPS)*

3.20 Post Operational Psychological Screening (POPS) is mandatory for all ADF members who were eligible to receive RtAPS (regardless of whether they did or not) and is usually conducted within three to six months of a member's return to Australia from an overseas deployment. The POPS process aims to identify individuals who have not reintegrated into occupational, familial, or social functioning and/or are demonstrating signs of adverse post-trauma responses. The POPS questionnaires and write-up are placed on the ADF member's psychology file and Unit Medical Record. The POPS process comprises:

- a questionnaire, comprising the:
  - Kessler Psychological Distress Scale (K10);
  - Posttraumatic Checklist (PCL);
  - Alcohol Use Disorders Identification Test (AUDIT); and
  - additional Command and research questionnaires as approved by the senior psychology asset for the services.
- a one-on-one semi-structured psychological screening interview that includes:
  - introduction;
  - review of the member's deployment experience;
  - homecoming;
  - reintegration;
  - current symptoms; and
  - psychoeducation.<sup>29</sup>

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28 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 31–32.

29 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 32–33.

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### *Special Psychological Screen (SPS)*

3.21 A Special Psychological Screen (SPS) may be provided to individuals and groups 'whose operational role routinely exposes them to intense operational stressors, critical incidents, and/or potentially traumatic events while on deployment'. The aim of the SPS is to aid the monitoring of the mental health status of such individuals and groups. The SPS may be administered regularly (every two to three months) and comprises:

- a psycho-educational briefing;
- a questionnaire comprising the:
  - Kessler Psychological Distress Scale (K10); and the
  - Acute Stress Disorder Scale (ASDS); and
- a one-on-one psychological screening interview.<sup>30</sup>

3.22 The need for SPS is negotiated between commanders and mental health professionals, and the completion of SPS does not negate the necessity for RtAPS or POPS. Furthermore, the SPS can only be conducted by a mental health professional.<sup>31</sup>

### *Critical Incident Mental Health Support (CIMHS)*

3.23 Critical Incident Mental Health Support (CIMHS) is initiated when a 'critical incident' has occurred, such as deployed members being exposed to potentially traumatic events.<sup>32</sup> The activation and timing of the CIMHS is determined by the Commanding Officer in consultation with the CIMHS coordinator (the most senior CIMHS-trained mental health professional available). The CIMHS process comprises a number of activities across three stages:

- provision of social support, and psychological first aid (PFA) if necessary;
- provision of psychoeducation and administration of psychological screens (Acute Distress Disorder Scale and Mental Status Examination) to facilitate the identification of individuals at risk of psychological injury and initiation of referral for further assessment and treatment;
- follow-up (Kessler Psychological Distress Scale (K10), Posttraumatic Checklist (PCL) and Alcohol Use Disorders Identification Test (AUDIT)).<sup>33</sup>

3.24 The timing of the follow-ups generally take place between three and six months after the initial screen. According to the CIMHS database, a total of 354

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30 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 33–34.

31 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p.34.

32 Department of Defence *Submission 34*, p. 14.

33 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p. 34.

individuals received a CIMHS initial screen between March 2012 and March 2014, with the majority of those 354 individuals also having completed a follow-up screen.<sup>34</sup>

### ***Informal screening***

3.25 The Australian Defence Force Mental Health Screening Continuum Framework Report (MHSCF Report), conducted by the Australian Centre for Posttraumatic Mental Health in 2014, highlighted the importance of informal screening for mental ill-health and noted that formal screening is not intended to replace informal processes, but rather, to complement them:

These informal processes may include families, friends, and peers helping the member identify that he or she has a problem. This type of informal screening is of great relevance in organisations such as the ADF that place a high emphasis on "looking after your mates". A commander, manager, or representative can also order a member to undergo psychological assessment or gain psychological support through administrative referral. Additionally, a Medical Officer (MO) can refer a member for psychological support or assessment through medical referral. Of course, members may also self-identify that they are experiencing mental health difficulties and request assistance. These informational processes of identifying members who are struggling with psychological adjustment issues are of primary importance in early detection and access to care.<sup>35</sup>

3.26 Aspen Medical emphasised the importance of maintaining multiple ways to identify and bring ADF members to treatment, noting that 'the multi-faceted strategy taken by the ADF appears to be working'. It noted that in the ADF 'if one method does not identify a case an alternative method is highly likely to'.<sup>36</sup>

### ***Family involvement in identification and screening***

3.27 The importance of involving the ADF member's family in the identification and treatment of mental ill-health was raised by a number of submissions.<sup>37</sup> Australian Families of the Military Research and Support Foundation (AFOM) asserted that families of ADF members are often the first to become aware of signs of mental ill-health and called for family to be involved in post-deployment screening processes.<sup>38</sup>

3.28 Aspen Medical noted that its practitioners strongly supported greater involvement of a supportive family member in the treatment of mental health

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34 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 33–34.

35 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 16–17.

36 Aspen Medical, *Submission 38*, p. 16.

37 For example: Returned & Services League of Australia, *Submission 19*, p. 8; Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 7; Aspen Medical, *Submission 38*, p. 85; Slater & Gordon, *Submission 51*, p. 21; Name withheld, *Submission 70*, pp 9–10. Australian Association of Social Workers, *Submission 77*, p. 3.

38 Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 7.

conditions for ADF members.<sup>39</sup> Furthermore, it found that seven per cent of referrals for ADF members to mental health professionals were from a member's family, commenting that 'the involvement of family also suggests that the ADF and JHC messaging to members' partners, spouses and the broader community are having an effect'.<sup>40</sup>

3.29 The Australian Association of Social Workers highlighted the importance of family involvement and assessment of family dynamics in the identification and assessment of mental ill-health, noting that 'without a clear understanding of family dynamics, including stresses and strengths, mental health assessments will miss important information relevant for treatment and counselling outcomes':

An early family assessment is not only crucial in understanding the impact of a psychological diagnosis on the service personnel and their family, but also means that important supports can be mobilised early. It also alerts the clinician of areas in which clinical treatment might be undermined by family dynamics. Often treatment is disrupted by events in the external environment. Social work assessments that include a family assessment and an assessment of other psychosocial factors are highly valued in mental health teams.<sup>41</sup>

3.30 In 2011, the Family Sensitive Post Operational Psychology Screens (FSPOPS) were trialled with Mentoring Taskforce-2 (MTF-2) in Darwin and with MTF-3 in Townsville in 2012. The FSPOPS project involved training Defence psychology staff in family sensitive practices that can be applied to the POPS process. ADF members undertaking their POPS in Darwin and Townsville were invited to bring an adult family member to their POPS to 'provide an opportunity to discuss issues and challenges that may arise post-deployment'. This opportunity was promoted by Regional Mental Health Teams and Command elements.<sup>42</sup>

3.31 Defence informed the committee that only a very small number of the hundreds of ADF members deployed with MTF-2 and MTF-3 brought family members to their POPS during the trial period. The majority of ADF members who did not bring a family member to their POPS indicated that they 'felt no issues existed that warranted discussion with a family member' or 'simply did not want to bring a family member'. However, those family members who did participate indicated that the experience was 'very good' and that they would participate again if offered.<sup>43</sup>

3.32 Defence advised that the outcome of the trial 'suggests that this initiative was not one that appealed to the wider ADF audience' and that, as such, the trial was not

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39 Aspen Medical, *Submission 38*, p. 85.

40 Aspen Medical, *Submission 38*, p. 16.

41 Australian Association of Social Workers, *Submission 77*, p. 3.

42 Department of Defence, answer to question on notice, 2 February 2016, (received 12 February 2016).

43 Department of Defence, answer to question on notice, 2 February 2016, (received 12 February 2016).

extended or developed into business as usual. However, Defence assured the committee that it remains committed to a family sensitive approach to screening and mental health and rehabilitation service delivery:

The trial has not been extended or developed into business as usual, but the concept of ensuring that family related matters and family sensitive questions are raised during Post Operational Psychology Screens by psychology staff has been adopted. This has resulted in a more family focussed approach to operational mental health screening of ADF members.

Defence recognises the importance of engagement with and support to families of members who are ill or injured. Defence is focusing on developing services and processes that support a family sensitive approach to mental health and rehabilitation service delivery, to promote positive outcomes for members and families. These processes include inviting family attendance at health assessments (where appropriate and with member consent), inviting attendance at psychosocial workshops and information sessions, and referral to available programs and services as appropriate. Resources available to family members are also reinforced through unit family days and direct communications from support services such a Defence Community Organisation or Veterans and Veterans Families Counselling Service.<sup>44</sup>

## Privacy

3.33 Some submissions noted that, linked to the stigma associated with mental ill-health, many ADF members were not comfortable disclosing mental health issues due to concerns that their privacy would not be respected and they would be subject to ridicule.<sup>45</sup> The Australia Psychological Society noted that:

Members report that stigmatisation may occur during service within the immediate base community and the larger organisation. This stigma and issues with confidentiality reportedly create difficulties particularly at the lower level of command where information about confidential disclosures [of mental ill-health] reportedly is disclosed to others in the base community.<sup>46</sup>

3.34 Defence assured the committee that it is required to comply with the provisions of the *Privacy Act 1988* (Privacy Act) and the Australian Privacy Principles. Health Directive 610 *Privacy of health information of Defence members and Defence candidates* outlines the policy regarding the collection, use, and disclosure of health information in Defence by health professionals, commanders, managers, and members. A Health Information Privacy Notice, which details how

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44 Department of Defence, answer to question on notice, 2 February 2016, (received 12 February 2016).

45 For example: Australian Psychological Society, *Submission 22*, p. 9; Mr Jeremy Davey, *Submission 25*, p. 4; Young and Well Cooperative Research Centre, *Submission 62*, p. 3; Dr Kevin Kraushaar, *Submission 64*, p. 10.

46 Australian Psychological Society, *Submission 22*, p. 9.

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health information is collected, used, and disclosed, is available to all ADF members on the Defence Intranet.<sup>47</sup>

3.35 ADF members must give consent for their personal health information to be used or disclosed in all but exceptional circumstances (as defined by the Australian Privacy Principles).<sup>48</sup> Exceptional circumstances include when use or disclosure is necessary to lessen or prevent a serious threat to an ADF member's life, health, or safety; or a serious threat to public health or public safety, including in military workplaces and safety critical areas such as deployment.<sup>49</sup>

3.36 Defence informed the committee that health information is primarily collected by Defence health practitioners 'in order to clinically manage and treat a Defence member's health on an ongoing basis'. This health information is shared between all treating health professionals in order to provide coordinated health care services, particularly when ADF personnel are receiving mental health care. Health information can also be shared with external health care providers with the consent of the ADF member.<sup>50</sup>

3.37 Defence stated that Defence health professionals are obliged to keep commanders and managers informed of the health status of ADF personnel to enable them to manage the workplace and operational impact of an ADF member's health condition. The health information provided is limited to information 'that enables a member's administrative management to be coordinated with their health support and rehabilitation management plans', unless the ADF member consents to more information being provided.<sup>51</sup>

### ***Commanders' need to know and members' right to privacy***

3.38 Some submissions highlighted the conflict between commanders' need to know about the mental health of their personnel and ADF members' right to privacy.<sup>52</sup> The Inspector General of the Australia Defence Force (IGADF) noted that compliance with Privacy Act requirements and the confidentiality obligations of members of the medical profession can 'sometimes impede the reasonable sharing of medical and psychological information concerning a member that may be important for their better management by their chain of command or other Defence agencies with responsibilities for members' welfare and safety'.<sup>53</sup>

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47 Department of Defence, *Submission 34*, pp 7–8.

48 *Privacy Act 1988*, Sch. 1.

49 Department of Defence, *Submission 34*, p. 8.

50 Department of Defence, *Submission 34*, p. 8.

51 Department of Defence, *Submission 34*, p. 8.

52 For example: Inspector General of the Australian Defence Force, *Submission 15*, p. 1; Alliance of Defence Service Organisations, *Submission 40*, pp 11–12; Australian Peacekeeper & Peacemaker Veterans' Association, *Submission 78*, p. 3.

53 Inspector General of the Australian Defence Force, *Submission 15*, p. 1.

3.39 The Alliance of Defence Service Organisations (ADSO) asserted that commanders 'should surely have the right to know, and medical professionals the right to inform [them]', regarding any medical (mental or physical) problems that could compromise a mission or the safety of other ADF members. Further, the ADSO called for the application of the Privacy Act, as it applies to ADF members, to be reviewed:

The bargain struck between the ADF and the individual should be that the ADF provides comprehensive health care free of charge because it has to have a solid base of confidence that the individual meets the fitness standards demanded by the mission. This should mean that the individual surrenders that part of the right to privacy that is relevant to the mission, as he does in other areas, such as military security. Indeed it could be argued that physical and mental fitness is, at least in part, a security matter. ADSO urges that this aspect of the application of the Privacy Act to members of the ADF to be reviewed as a matter of urgency.<sup>54</sup>

3.40 The IGADF advised the committee that some ADF members will choose to seek assistance from sources outside of the ADF for mental ill-health to prevent the chain of command from accessing information about the member's mental health. Such members fear putting their career, job categorisation, or deployment opportunities at risk. The IGADF described this as a 'catch-22 situation for Defence', for any attempts to relax patient confidentiality requirements to better identify and address mental ill-health might further discourage members from seeking assistance/treatment for mental ill-health within the ADF:

...the reluctance of some members who are aware they may have a medical or mental health problem to advise their chain of command or seek help from Service health authorities for fear of putting their career, job categorisation, or deployment opportunities in jeopardy. This can sometimes create a catch-22 situation for Defence where members may be minded to seek assistance from private sources in order to preserve confidentiality of their condition. The catch-22 arises where any relaxing of patient confidentiality requirements within Defence might potentially have the unintended effect of encouraging members to seek help outside the Service system.<sup>55</sup>

3.41 The RSL also commented on ADF members' reluctance to disclosing mental health concerns, noting that some members choose not to disclose symptoms to avoid medical downgrading, which may interfere with their deployment or result in discharge. The RSL stated that 'members are well aware of the financial incentives associated with deployment and the need to be physically fit and mentally fit to deploy'.<sup>56</sup> The RSL, pointing to an opinion expressed in an interview with Dr Andrew Khoo, asserted that:

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54 Alliance of Defence Service Organisations, *Submission 40*, pp 11–12.

55 Inspector General of the Australian Defence Force, *Submission 15*, pp 1–2.

56 Returned & Services League of Australia, *Submission 19*, p. 7.

...encouraging Defence members to seek early treatment for mental ill-health will not be successful until Defence allows members to be treated and continue in their career with Defence. Until then, serving members will continue to believe disclosure of mental ill-health will threaten their Defence career.<sup>57</sup>

3.42 Defence acknowledged that there are times when 'despite all the best efforts on rehabilitation...people will end up inevitably being discharged',<sup>58</sup> but that 'of the 869 individuals with a mental illness who completed a rehabilitation program, a total of 420 or 52 per cent are recorded as having a successful return to work at the end of their rehabilitation program'.<sup>59</sup>

3.43 The adequacy of mental health services is discussed in greater detail in Chapter 4 of this report. Stigma surrounding mental health and other barriers to disclosure is discussed in greater detail in Chapter 5.

#### ***Family access to members and veterans mental health records***

3.44 Slater & Gordon Lawyers called for a review of the Privacy Act, asserting that details of mental health records should be released to families if the ADF member or veteran presents symptoms of mental illness that pose an immediate risk to personal safety, such as self-harm and suicide attempts.

In such situations, the ADF must have the authority to release certain details of a serviceman or woman's mental health record to their families in order for them to assist in providing support...the Committee must do everything in its power to ensure that families do not have to endure the heartbreak of losing a loved one from a potentially treatable mental illness.<sup>60</sup>

3.45 Slater & Gordon pointed to the family of 27 year-old Navy Sailor Stuart Addison, who took his own life in 2002. His family have been campaigning for the next of kin to be contacted immediately by a member's commanding officer in circumstances where suicide attempts or self-harm is evident.<sup>61</sup>

3.46 One submitter called for families to be notified of suicide attempts. The submitter told the committee of their experiences strugglingly with mental ill-health and suicide, stating that their first attempted suicide took place while still a serving

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57 Returned & Services League of Australia, *Submission 19*, p. 7.

58 Air Chief Marshal Mark Binskin AC, Chief of the Defence Force, Department of Defence, *Committee Hansard*, pp 7–8.

59 Department of Defence, answer to a question on notice, 21 September 2015 (received 23 November 2015).

60 Slater & Gordon, *Submission 51*, p. 21.

61 Mark Addison, 'Malcolm Turnbull: we lost our son to suicide while serving in the ADF – please change service contracts so next-of-kin can be notified of self-harm, suicide attempts', <https://www.change.org/p/malcolm-turnbull-we-lost-our-son-to-suicide-while-serving-in-the-ADF-please-change-service-contracts-so-next-of-kin-can-be-notified-of-self-harm-suicide-attempts>, accessed 22 January 2016.

member. The submitter noted that 'suicide prevention takes inside information' and called for the introduction of a 'Family in Crisis Action Plan' to be triggered in the case of a suicide attempt:

...when a Veteran attempts Suicide, that contact is immediately made with the Veteran Family. Implementation of an Action Plan should include ESO Contact, Family Social Worker Contact to be able to assist any needs of the family during the Crisis. Also emergency Crisis care for children should be initialised and paid for by DVA whilst the Veteran is hospitalised and in treatment so that the partner or designated carer or eldest child can participate in the support and information process with the Veteran. "It must not be a journey taken alone by the Veteran."<sup>62</sup>

3.47 Defence acknowledged these concerns but asserted that its focus is on ensuring ADF members are 'afforded appropriate privacy protections' while encouraging them to involve families and support networks in their mental health safety plan, treatment and recovery:

Defence recognises that there have been concerns expressed by family members about what information can be disclosed to them and how disclosing certain health information could have resulted in better mental health outcomes, or in extreme situations prevented a death by suicide. Defence's focus is on ensuring that ADF personnel are afforded appropriate privacy protections while encouraging the member to involve their families and support networks in their mental health safety plan, treatment and recovery by sharing their health information should they wish to do so.<sup>63</sup>

### **Recordkeeping for ADF members**

3.48 Defence informed the committee that 'health-related record keeping is managed in accordance with the Defence Records Management Policy and the relevant legislation'. Defence also advised that it is currently reviewing its health records management policy to provide a 'single policy for all ADF personnel that receive health services from Defence'.<sup>64</sup> However, the management of ADF mental health records has been criticised for a number of decades and have been the subject of a number of inquiries and audits.<sup>65</sup>

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62 Name withheld, *Submission 70*, pp 9–10.

63 Department of Defence, *Submission 34*, p. 8.

64 Department of Defence, *Submission 34*, p. 9.

65 For example: Department of Defence, *Devolution and integration in the Australian Defence Force: the Defence Regional Support Review*, 1989; Australian National Audit Office, Audit Report No.34 (1996–97), *Australian Defence Force Health Services*; Department of Defence, *Future directions for the management of Australia's defence—Report of the Defence Efficiency Review*, 1997; Australian National Audit Office, Audit Report No.51 (2000–2001), *Australian Defence Force Health Services Follow-up Audit; Review of Defence Health Services*, 2004; Department of Defence, *Healthcare in the Australian Defence Force*, 2008; Senate Foreign Affairs, Defence and Trade References Committee, *Australia's Involvement in Peacekeeping Duties*; and Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009.

3.49 The committee received a number of submissions commenting on the difficulties with accessing health records and the complications that can arise when a veteran is making a claim if health records are incomplete or inaccurate.<sup>66</sup> Furthermore, comprehensive health records of veterans can be even more challenging, as noted by Mr Robert Shortridge: 'maintaining records of those ex-service personnel once they have left the ADF will be very difficult as there is no compulsion for them to identify themselves as ex-service personnel or veterans'.<sup>67</sup>

3.50 Walking Wounded described ADF recordkeeping as a 'weak area', noting that, despite good recordkeeping policies, 'human error, tiredness, inattention and carelessness' lead to incidents being reported 'badly or not at all':

Anecdotally, all soldiers have stories of how a particular incident was recorded badly or not at all, including events where injuries occurred. This often leaves the record incomplete or disjointed, particularly where operational imperatives take precedence. In addition, the retrieval of records pertaining to a specific incident some years in the past is often almost impossible, owing to personnel turnover and the reasons cited above. When an ADF member is no longer an ADF member, the task gains a further degree of difficulty.<sup>68</sup>

3.51 One submitter noted that a complete and accurate record of a member's mental health is dependent on the member disclosing their mental ill-health, something that many may be reluctant to do.<sup>69</sup>

### ***Defence e-Health System***

3.52 In 2009, Defence launched the Defence eHealth System (DeHS) (originally called the Joint eHealth Data and Information System). The key features of the DeHS include:

- Primary Care System (PCS): an eHealth care system used to record all clinical, dental, mental health, and allied health consultations, treatments and findings;
- DeHS Access: an online patient- accessible summary of each patient's eHealth record; and
- DeHS Reporting: a suite of reporting tools available to report on individual or corporate information requirements.<sup>70</sup>

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66 For example: Mr Douglas Steley, *Submission 6*, p. 15; Mr Robert Shortridge, *Submission 16*, p. 5; Walking Wounded, *Submission 18*, pp 2–3; Soldier On, *Submission 29*, p. 6; Aspen Medical, *Submission 38*, p. 20; Slater & Gordon Lawyers, *Submission 51*, pp 7–10; Name withheld, *Submission 56*, pp 2–3; KCI Lawyers, *Submission 71*, pp 4–5.

67 Mr Robert Shortridge, *Submission 16*, p. 7.

68 Walking Wounded, *Submission 18*, pp 2–3.

69 Name withheld, *Submission 56*, p. 2.

70 Australian National Audit Office, Audit Report No. 27 2014-15, *Electronic Health Records for Defence Personnel*, 2015, p. 29.

3.53 These three features are intended to provide a clinical management tool 'that enables safe and quality health care for the ADF member'. The DeHS business case noted that the system would:

- inform ADF Commanders of the readiness for operational deployments of individuals and Force Elements;
- contribute to the generation of health performance and work health and safety metrics to support the management of resources as well as planning and accountability; and
- provide for effective health management after an ADF member's discharge by facilitating the transfer or access of an ADF member's health record by DVA as part of ongoing care and/or to inform compensation determinations.<sup>71</sup>

3.54 Furthermore, the DeHS is intended to complement the civilian National e-Health Strategy and link with the national Personally Controlled Electronic Health Record:

The Joint eHealth Data and Information (JeHDI) Project [now called DeHS] will facilitate the provision of one electronic health record for ADG personnel, from recruitment to discharge, then through to management in other agencies...[DeHS] is building the capability to interact with the National Personal Controlled Electronic Health Record (PCEHR) for the interchange of health information across private and public health systems. Members will be able to consent to participation in the PCEHR system while in Defence or when they discharge.<sup>72</sup>

3.55 Defence advised that the DeHS was implemented within all Joint Health Command Garrison health centres on 11 December 2014 and that the DeHS project to implement the system on-board ships is scheduled for implementation on the "First of Fleet" by June 2016, with subsequent roll out to the remainder of the fleet in accordance with the Fleet schedule.<sup>73</sup>

3.56 Defence informed the committee that it is expected that ADF members will be able to access their e-Health record via the internet portal from the second-half of 2015. ADF members will be able to view a summary of their health record, view recent and scheduled appointments, and complete health questionnaires in preparation for a mental health consultation. ADF members will be able to access routine mental health questionnaires and screening tools online, which, Defence advised, will notify mental health professionals if the results of a questionnaire need to be responded to urgently.<sup>74</sup>

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71 Australian National Audit Office, Audit Report No. 27 2014-15, *Electronic Health Records for Defence Personnel*, 2015, p. 29.

72 Department of Defence, answer to question on notice, 12 June 2012, (received 29 September 2012).

73 Department of Defence, answer to question on notice, 2 February 2016, (received 12 February 2016).

74 Department of Defence, *Submission 34*, p. 10.

3.57 Defence explained that the data analysis and reporting functions of DeHS will allow Defence to 'target reporting for specific mental health presentations and disorders and that the DeHS system has minimised the use of paper records, with the majority of ADF members receiving primary health care treatment through a Garrison Health Organisation'. All mental health and psychology records created prior to the implementation of DeHS will continue to be available. In addition, as legacy systems are decommissioned, all pertinent records will be transferred to Objective (the approved restricted Defence electronics records management system).<sup>75</sup>

3.58 Aspen Medical reported that it received a number of positive comments in its initial survey regarding the benefits of the new DeHS, with 39 per cent of respondents agreeing that the DeHS has improved the availability of relevant documents and only 18 per cent disagreeing or strongly disagreeing. Aspen Medical noted that many positive comments also expressed a degree to frustration with DeHS.<sup>76</sup>

#### *Hospital admissions, external referrals, and fatalities*

3.59 Defence explained that the DeHS incorporates ADF members' external mental health provider reports, ensuring that a member's health record reflects a continuous view of their mental health care that can be monitored by Defence:

The Defence e-Health System allows for the timely monitoring of external mental health provider reports by the local Mental Health and Psychology Section, and these reports are reviewed at the regular multidisciplinary Case Review meetings to ensure that treatment is meeting the needs of the member, and that the member remains engaged with the external provider. The external reports are then electronically appended to the member's health record via Defence e-Health System in order to provide a continuous view of the member's mental health care.<sup>77</sup>

3.60 If an ADF member requires admission to an external treatment facility as an inpatient, either as an emergency or planned admission, the referral is noted in the member's e-Health record and a Notification of a Casualty (NOTICAS) and a Medical Casualty (MEDICAS) are raised. The NOTICAS and MEDICAS notifications allow command, health, and welfare agencies to ensure that the member's occupational, health, and domestic needs are met and that the member's family is supported during the admission. Once discharged, a discharge summary report is provided to the treating garrison health facility and uploaded into DeHS. Defence advised that the admission of an ADF member to an external treatment facility for mental health inpatient treatment is regularly followed up by the local Mental Health and Psychology Section.<sup>78</sup>

3.61 Defence advised that, following the death of a serving ADF member, the e-Health record is moved from the DeHS to Objective, the approved restricted Defence

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75 Department of Defence, *Submission 34*, p. 9.

76 Aspen Medical, *Submission 38*, p. 52.

77 Department of Defence, *Submission 34*, p. 10.

78 Department of Defence, *Submission 34*, p. 10.

electronic record management system for archival purposes. The archived record can be accessed by Defence health care professionals and member's families can request access 'using normal Defence record access request processes'.<sup>79</sup>

### *Suspected or confirmed suicide*

3.62 Defence informed the committee that the release of post mortem results and coronial inquiry outcomes remains at the discretion of the coroner and are not routinely provided to Defence unless pursued by the ADF Investigative Service. Defence noted that post mortem updates can be made to an ADF member's DeHS record upon receipt of a death certificate or coronial record but that this is not mandated:

Clinicians do not currently update the record regarding speculative diagnosis or causal finding. The finding of suicide has to be a post mortem update and this is permitted to be added to the record by authorised users. The content of these updates/entries are not mandated in any way. If Defence does receive a death certificate or coronial record it will be added to the record.<sup>80</sup>

3.63 Defence advised that Joint Health Command maintains a database, separate to the DeHS, of suspected or confirmed deaths as a result of suicide since 1 January 2000. Suspected or confirmed deaths as a result of suicide are included in the database on the advice of the ADF Investigative Service and/or the findings of State/Territory Coroner Reports.<sup>81</sup>

### *Medical records during deployment*

3.64 Aspen Medical reported that that it 'is rarely easy to find relevant clinical information collected or recorded in-theatre' regarding mental ill-health or potentially traumatic incidents:

Just over 75 per cent of respondents found that it is usually not easy to find clinical information on incidents that occurred in theatre. In many instances the trigger event for a mental health condition may not have an immediate impact on the [member], so in effect there is no clinical record of the event occurring.<sup>82</sup>

3.65 Aspen Medical noted that some clinicians suggested that Medical Officers (MO) and Mental Health Professionals (MHP), when treating a member, should be given access to the member's commander when the traumatic event occurred which

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79 Department of Defence, *Submission 34*, p. 11.

80 Department of Defence, answer to question on notice, 2 February 2016, (received 12 February 2016).

81 Department of Defence, answer to question on notice, 2 February 2016, (received 12 February 2016).

82 Aspen Medical, *Submission 38*, p. 20.

might have caused mental health problems. This would allow the MO and MHP to understand the events without forcing the member to 'relive' them.<sup>83</sup>

3.66 A number of submissions highlighted the importance of accurate and detailed records when lodging a claim with DVA.<sup>84</sup> This is discussed in greater detail in Chapter 5 of this report.

### **Identification and screening of mental ill-health during transition**

3.67 The ADF does not currently conduct post-transition screening. The Defence Community Organisation emails a post-separation survey to all ADF members who have been discharged for at least three months. The post-separation survey asks questions regarding the separation experiences, the member's chosen post-transition occupation, and their perceptions of support received around transition.<sup>85</sup>

3.68 The MHSCF Report noted that screening at discharge was challenging due to transitioning members' concerns that identification of mental health problems might delay their discharge:

During the discussions about timing, the process at transition was raised. Both senior leaders and health professionals noted that screening at transition was challenging as members may be concerned that identifying mental health problems may delay their discharge. There were some suggestions that, if screening were to be included in the transition process, it should occur around six months prior to transition in order to be able to address any concerns without the risk of delaying the member's leave.<sup>86</sup>

3.69 Discharge and transition from the ADF to civilian life will be discussed in greater detail in Chapter 6 of this report.

### **Veteran Mental Health Strategy**

3.70 The Department of Veterans' Affairs (DVA) is responsible for the development and implementation of programs to assist the veteran and defence force communities. It provides administrative support to the Repatriation Commission and the Military Rehabilitation and Compensation Commission. It is responsible for advising the Commissions regarding policies and programs for beneficiaries as well as for administering these policies and programs. Mr Shane Carmody, the Chief Operating Officer for DVA, advised the committee that mental health is a priority for DVA:

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83 Aspen Medical, *Submission 38*, p. 20.

84 For example: Mr Douglas Steley, *Submission 6*, p. 15; Mr Robert Shortridge, *Submission 16*, p. 5; Walking Wounded, *Submission 18*, pp 2–3; Soldier On, *Submission 29*, p. 6; Aspen Medical, *Submission 38*, p. 20; Slater & Gordon Lawyers, *Submission 51*, pp 7–10; Name withheld, *Submission 56*, pp 2–3; KCI Lawyers, *Submission 71*, pp 4–5.

85 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p. 35.

86 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p. 62.

Mental health is a priority for DVA and any suicide is a tragedy, so we must do all we can to prevent it. As the committee knows, funding for mental health treatment is demand-driven and is not capped. We spend around \$182 million annually on veteran mental health services, but our focus remains on early intervention. If people are worried about how they are feeling or how they are coping we encourage them to seek help early. There are services and there is support ready and waiting to help.<sup>87</sup>

3.71 The *Veteran Mental Health Strategy 2013-2023* outlines the strategic framework to support the mental health and wellbeing of veterans. The strategy lists six strategic objectives to guide mental health policy and programs:

- ensure quality mental health care, which puts the client at the centre, is evidence-based, efficient, equitable, and timely;
- promote mental health and wellbeing, addressing the diverse needs of clients and barriers to help-seeking such as stigma;
- strengthen DVA workforce capacity, ensuring a strong understanding of military and ex-military experience, and knowledge of best practice mental health interventions;
- enable a recovery culture, reducing the stigma surrounding mental health in the veteran and ex-service community and encouraging help-seeking and support recovery;
- strengthen partnerships, leading to improved service systems, enhanced communication and coordination, efficient use of resources, and opportunities for continuous feedback and improvement; and
- build the evidence base, building capacity within the mental health provider community and informing policy and program development.<sup>88</sup>

3.72 DVA described the focus of its mental health policy as 'firmly on early intervention':

The benefits of early intervention are clear, both for the veteran and their family. Recent Government budget initiatives further highlight the commitment to treating mental health conditions. Over recent years, significant funding has been invested in new initiatives aimed at improving the mental health of veterans, from improved access to treatment and counselling, through to improvements in the Department's management of clients with complex needs, including those with mental health conditions. Further, the Government is very focussed on improvements to reduce the time taken to process compensation claims, a key early initiative.<sup>89</sup>

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87 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 29 September 2015, p. 3.

88 Department of Veterans' Affairs, *Veteran Mental Health Strategy 2013-2023*, pp 34-44.

89 Department of Veterans' Affairs, *Submission 35*, p. 3.

3.73 Mr Carmody reiterated this, stating that 'DVA's major focus is on early intervention. This is the critical step in identifying and meeting the mental health needs of the veteran community'.<sup>90</sup>

### **Identification of mental ill-health in veterans**

3.74 Unlike ADF members, veterans are not required to be screened for mental ill-health and veterans cannot be 'ordered' to seek treatment or assistance when they display symptoms of mental ill-health. However, veterans can access the *ADF Post-discharge GP Health Assessment*, a 'comprehensive health assessment from their General Practitioner (GP)'. The scheme provides GPs with screening tools for alcohol use, substance use, post-traumatic stress disorder (PTSD) and psychological distress 'to help GPs identify and diagnose the early onset of physical and/or mental health problems'. The scheme is funded under the health assessment items on the Medicare Benefits Schedule.<sup>91</sup>

3.75 Generally, DVA is made aware of a veteran's mental ill-health once a veteran has lodged a claim. A number of submissions noted that this puts the impetus for recognising and seeking treatment for mental ill-health on the veteran.<sup>92</sup> Walking Wounded commented that 'once a Defence member leaves the service, the responsibility for overarching care falls foremost onto the individual and, if he or she is lucky, close family members'.<sup>93</sup> The Australian Psychological Society described this as a critical barrier to identifying the scope of veterans' health needs:

Post discharge, veterans are unable to be identified by DVA where they do not seek entitlements to pensions, compensation or treatment. This creates critical barriers to identifying the scope of service-related health and welfare issues and the demand for associated services. While DVA advocates that there should be service pathways which operate under the 'no wrong door policy' approach and maintains registration information about veterans and current serving personnel who seek entitlements, in the absence of such registration, there is little chance that ex-service personnel will seek or receive the DVA funded treatment to which they are entitled.<sup>94</sup>

3.76 The Royal Australian Regiment Association (RARA) noted that 'many veterans leave the ADF without lodging any claims for disability but they develop problems later in life and who are, or consider themselves to be healthy, may feel a

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90 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 29 September 2015, p. 2.

91 Department of Veterans' Affairs, *Submission 35*, p. 30; Department of Veterans' Affairs, 'At Ease: ADF Post-discharge GP Health Assessment' <http://at-ease.dva.gov.au/professionals/assess-and-treat/adf-post-discharge-gp-health-assessment/>, accessed 22 January 2016.

92 For example: Walking Wounded, *Submission 18*, p. 2; Veterans Care Association, *Submission 4*, pp 1–2; Returned & Services League of Australia, *Submission 19*, p. 3; Australian Psychological Society, *Submission 22*, p. 9; Soldier On, *Submission 29*, p. 5.

93 Walking Wounded, *Submission 18*, p. 2.

94 Australian Psychological Society, *Submission 22*, p. 9.

little embarrassed about seeking help'. The RARA asserted that 'DVA is the appropriate sponsor for embracing these people' and called for a review of the processes for identifying and monitoring veterans mental health:

There needs to be a major conversation and paradigm shift in the mindset of the Government and Parliament, Defence Department that includes DVA, veterans, and the broader community as to how we can best keep track of all our veterans well after their service and not just those who have become DVA clients.<sup>95</sup>

3.77 The RSL also noted that many veterans are reluctant to respond to early symptoms of mental ill-health, stating that 'ignoring symptoms and not seeking help can sometimes go on for eight to 10 years after discharge':

We are told by many veterans and their families that symptoms are ignored for a variety of reasons, including pride, learned responses in Defence to ignore emotions and keep going, the financial incentives associated with deployment, a belief that they are not the problem, and a lack of knowledge of the symptoms of mental ill-health.<sup>96</sup>

3.78 DVA acknowledged these concerns, noting that 'the challenge for DVA is to encourage clients to seek help early if they are worried about how they are coping or feeling, and not wait until the symptoms become overwhelming'.<sup>97</sup> Mr Carmody advised the committee that DVA is working to raise awareness of its services, assisting transitioning members, and encouraging the early lodgement of claims:

To ensure that people know about our services and the support that we can provide, the department secretary now writes to all 6,000 or so ADF personnel who separate each year. This letter outlines what DVA can do for them and that we are here to help them if and when required. Even so, around 25 per cent of separating ADF personnel opt out of receiving information from DVA. DVA's on-base advisory service has developed into a very important service, providing advice and support as well as encouraging the early lodgement of claims. DVA now has an on-base presence at over 44 bases around the country. In 2013-14, our on-base service responded to over 13½ thousand inquiries—an increase of over 4½ thousand on the previous year.<sup>98</sup>

3.79 DVA asserted that it is using 'new and innovative ways' to reach out to contemporary veterans and encourage them to take action early to address any mental health concerns. DVA provides a single mental health online portal, known as 'At Ease', which brings together all of its online products. These include: self-help and

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95 Royal Australian Regiment Association, *Submission 46*, pp 1–2.

96 Returned & Services League of Australia, *Submission 19*, p. 3.

97 Department of Veterans' Affairs, *Submission 35*, p. 6.

98 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 2.

supportive phone apps; videos of veterans talking about their mental health recovery; and information about professional support and treatment options.<sup>99</sup>

3.80 DVA advised that it also works in partnership with the ex-service community to implement health and wellbeing programs, which focus on seeking help when needed and healthy lifestyle behaviours such as healthy eating, social connectedness and physical activities.<sup>100</sup> The RSL stated that it is working together with DVA and other ex-service organisations (ESOs) to reach out to veterans who are struggling with mental ill-health:

The RSL, other Ex-Service Organisations (ESOs) and DVA are working hard to 'pick up the pieces' and intervene as soon as anyone in difficulty is brought to our attention. Informal networks of support, both face-to-face and online are extensive. There is a collective goodwill and concern for mates that characterises this sector (among both current and ex-serving members) and together many veterans have saved the lives of others in trouble.<sup>101</sup>

3.81 However, the RSL warned that 'relying on informal networks alone can be fraught with potential problems'.<sup>102</sup>

### ***Veterans identification system***

3.82 The RARA and the Alliance of Defence Service Organisations called for the introduction of a veteran identification number or identification card to assist in the collection of data regarding the health and wellbeing of veterans who are not DVA clients.<sup>103</sup> The RARA noted that:

In recent times, the media has highlighted the incidence of veterans being incarcerated and sadly self-harm and suicide. These three issues raise the possibility that many of the homeless, veterans in the prison system and self-harm are invariably in this state due to mental health issues. Too many veterans are falling through "the cracks" because we don't know who or where they are.<sup>104</sup>

3.83 The Veterans Care Association noted that the provision of a veteran identification card would 'add dignity and honour the service of all veterans'.<sup>105</sup> The ADSO asserted that the introduction of a veteran identification card would allow support services such as medical, ambulance, police and government agencies to better identify veterans:

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99 Department of Veterans' Affairs, *Submission 35*, p. 7.

100 Department of Veterans' Affairs, *Submission 35*, p. 7.

101 Returned & Services League of Australia, *Submission 19*, p. 3.

102 Returned & Services League of Australia, *Submission 19*, p. 3.

103 Alliance of Defence Service Organisations, *Submission 40*, pp 13–14; Royal Australian Regiment Association, *Submission 46*, pp 1–5.

104 Royal Australian Regiment Association, *Submission 46*, p. 1.

105 Veterans Care Association, *Submission 4*, p. 2.

One of the principle requirements of support is being able to identify veterans. The need for a single identifier to follow and ADF through service and into post ADF life is becoming more evident. It has the support of the AMA [Australian Medical Association]. It should cover all serving and former ADF members.

A National Veteran Identity Card could fulfil this need and would allow support agencies (medical, ambulance, police, government agencies, etc.) to identify and allocate veterans to the appropriate assistance needed.<sup>106</sup>

3.84 Mr Carmody advised the committee that DVA is working with Defence to implement a single identification number but that there are a number of complications including non-ADF DVA clients (such as war widows) and privacy issues:

We are also trying to work with Defence on this single number but, as I have said, we have 340,000 clients and a large number of our clients do not have ADF service; they are war widows. So 60,000 to 70,000 people do not have a Defence number. We also have the situation where, particularly, our World War II and or Korean veterans had different prefixes on the numbers that they were allocated when they were in service, by state. There were different prefixes by gender. Our history of engagement with the numbering system is a very long one, and there is a range of very different numbers. We are in the process of working with Defence to try and resolve that in looking forward; however, in terms of all of our current client base, we need a very complex system of cross-referencing the various numbers that they might have been given, including DVA numbers. It is not a straightforward matter of just giving everyone a number, because as I said, a large number of our clients will not have one to start with.<sup>107</sup>

3.85 The records required for DVA claims, and the systems under which these records are stored and accessed, is discussed in Chapter 5 of this report.

### **Committee view**

3.86 The committee acknowledges the challenge of ensuring that ADF members' duties do not detrimentally affect their health; that ADF members can undertake their duties without compromising the safety of themselves or others; and that the ADF as a whole maintains its operational capability. The committee commends the ADF for its mental health and wellbeing strategy and acknowledges the significant achievements that it has made since the introduction of its first Mental Health Strategy in 2002. Early identification and treatment of mental ill-health is crucial for ADF members struggling with mental ill-health to achieve the best possible outcomes as well as ensuring that the ADF maintains operational capability.

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106 Alliance of Defence Service Organisations, *Submission 40*, pp 13–14.

107 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 21.

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### ***Identification of mental ill-health in the ADF***

3.87 The committee is satisfied that the RtAPS, POPS, SPS, and CIMHS screening processes, together with informal screening, are useful tools for the early identification of mental ill-health among ADF members who have been deployed. However, the committee is concerned that similar care is not taken to identify mental ill-health among ADF members who have not been deployed. As discussed in chapter 2 of this report, the findings of the MHPW study indicated that there is no significant link between deployment and an increased risk of developing PTSD, anxiety, depression or substance abuse disorders. Yet, despite this, mental health screening appears to focus primarily on identifying mental ill-health in members who have been deployed.

3.88 The committee is encouraged by the referral pathways reported by Aspen Medical and the high percentage of self referrals and referrals from medical officers, which indicate that mental health policy regarding the shared responsibility between commanders, individuals, and clinicians for the identification and early treatment of mental ill-health is working. However, the committee believes that regular formal and informal screening of ADF members, regardless of their deployment status, will improve the early identification and treatment of mental ill-health in the ADF.

3.89 The committee acknowledges that ADF members may be concerned about the potential impact that the discovery of mental ill-health may have on their careers. Nonetheless, the committee believes that the early identification and treatment of mental ill-health is significantly less likely to negatively impact a members' career, both within and beyond the ADF, than mental ill-health that is left untreated. Furthermore, annual screening would provide a regular opportunity for ADF members to pause and consider their mental health as well as providing a forum to express concerns that they might have without the member needing to initiate an appointment with their medical officer or psychologist.

### **Recommendation 1**

**3.90 The committee recommends that Defence conduct annual screening for mental ill-health for all ADF members.**

### ***Privacy and disclosure of mental ill-health***

3.91 The committee acknowledges ADF members' right to privacy and the stigma and concerns regarding career prospects that might cause ADF members to conceal mental ill-health from their commanders and colleagues. However, the committee recognises that the ADF members' right to privacy must be carefully balanced with commanders' responsibilities to ensure that ADF members' duties do not detrimentally affect their health, that ADF members can undertake their duties without compromising the safety of themselves or others, and that the ADF as a whole maintains its operational capability.

3.92 The committee is satisfied that the provisions of the Privacy Act and the Australian Privacy Principles appropriately govern the collection, use, and disclosure of health information in the ADF. The committee notes the concerns raised by the IGADF and the calls from ADSO and Slater & Gordon Lawyers for the Privacy Act,

as it applies to ADF members, to be reconsidered. However, as the root of these concerns appears to be ADF members' reluctance to disclose mental ill-health, the committee does not believe that stricter disclosure laws or a lessening of ADF members' rights regarding privacy will assist in the early identification and treatment of mental ill-health. More effort should be given to addressing the stigma of mental ill-health in the ADF than tampering with privacy laws.

### ***Recordkeeping***

3.93 The committee commends the goals of the DeHS, which, once fully implemented and integrated with the civilian National e-Health Strategy, will provide ADF members and veterans with an accurate, easily accessible, and continuous health record. The committee also notes that Defence is currently undertaking a review of its health records management policies to consolidate a 'single policy for all ADF personnel that receive health services from Defence'.

3.94 Accurate health records are vital in ensuring that ADF members receive informed and targeted treatment for mental ill-health as well as being a crucial element in the DVA claims process. As such, the committee is concerned by evidence from medical officers and mental health professionals that it remains difficult to find relevant clinical information collected or recorded during deployment.

3.95 The committee acknowledges that there are a range of factors that can impact accurate recordkeeping, especially on deployment, and that accurate recordkeeping of ADF members' mental health may also be inhibited by reluctance to report mental ill-health. However, it is essential that mental ill-health and potentially traumatic events are accurately recorded during deployment and that medical officers and mental health professionals can easily access these records when treating ADF members. It is also important to ensure that veterans and DVA can easily and quickly access these records when assessing claims.

### **Recommendation 2**

**3.96 The committee recommends that the Australian National Audit Office conduct an audit into the scope and accuracy of recordkeeping of relevant clinical information collected or recorded during deployment regarding mental ill-health or potentially traumatic incidents.**

### ***Identification of mental ill-health in veterans***

3.97 The committee commends DVA for its 'At Ease' online portal, which provides comprehensive information regarding mental ill-health to ADF members, veterans and their families. The committee recognises that veterans are private individuals who, unlike ADF members, cannot be ordered to undergo mental health screening or ordered to seek treatment or assistance when they display symptoms of mental ill-health. DVA is limited in its ability to identify or monitor mental ill-health in veterans to those veterans who have sought assistance or made a claim with DVA.

3.98 The committee acknowledges these limitations and notes the calls for DVA to monitor the health of veterans who have not made a claim. However, any move to monitor veterans without their consent would constitute a significant breach of privacy. Nonetheless, whilst engagement with DVA must be initiated by the veteran,

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the committee acknowledges that more must be done to encourage veterans to seek assistance early and to make the process for seeking assistance simple and swift.

3.99 The committee is very concerned regarding the piecemeal identification systems for veterans; more must be done to ensure continuity of identification of veterans, regardless of whether they are clients of DVA. The committee acknowledges that DVA is working with Defence to implement a single identification number between the two departments, however the committee believes that all veterans should be provided with a universal identification number and identification card that can be linked to the veteran's service and medical records and utilised by both Defence and DVA, as well as other services such as the those offered by the Department of Health and Department of Human Services. All ADF members should be issued with a veteran identification number and identification card upon discharge. All current and future clients of DVA should be issued with this number and card and veterans who are not currently clients of DVA should be actively encouraged to register for the veteran identification number and identification card.

### **Recommendation 3**

**3.100 The committee recommends that all veterans be issued with a universal identification number and identification card that can be linked to their service and medical record.**

3.101 The *ADF Post-discharge GP Health Assessment* scheme is an important tool for the early identification and treatment of mental ill-health; however it too relies on the veteran to initiate. The DeHS (once fully implemented and integrated with the civilian National e-Health Strategy) should provide veterans with an accurate, easily accessible, and continuous health record. This should ideally allow GPs and other health professionals to identify that their patient is a veteran as well as allowing them to view records regarding any mental ill-health concerns or exposures to potentially traumatic events that may have occurred during the veterans' service.

3.102 Furthermore, annual reminders through the e-health system prompting GPs to suggest the veteran undergo *ADF Post-discharge GP Health Assessment* would encourage veterans to engage with the scheme or even simply provide an opportunity for veterans to discuss any mental health concerns with their GP. In the meantime, GPs should be encouraged to promote the *ADF Post-discharge GP Health Assessment* to all veterans.

### **Recommendation 4**

**3.103 The committee recommends that the Department of Health and the Department of Veterans' Affairs ensure that e-health records identify veterans and that GPs are encouraged to promote annual *ADF Post-discharge GP Health Assessment* for all veterans.**

