Chapter 5

Barriers to accessing mental health services

Introduction

5.1 This chapter considers the barriers to accessing mental health services for ADF members and veterans, primarily their reluctance to seek help. It also focuses on the difficulties and challenges experienced by ADF members and veterans in seeking assistance through Department of Veterans' Affairs (DVA) delivery models and claims processes, including ADF members and veterans who live in regional and remote areas.

Stigma and perceived barriers to care

ADF members

5.2 As discussed in previous chapters, both Defence and DVA agree that early identification and treatment of mental ill-health is essential for achieving the best outcomes for ADF members and veterans with mental ill-health. However, the 2010 ADF Mental Health Prevalence and Wellbeing Study (MHPW study) found that 'a significant number of personnel with mental disorders had received no care in the previous 12 months'. 1 The MHPWP study found potential stigma to be a 'substantial issue', which limited the probability that ADF members would seek treatment for mental ill-health, 2 explaining that:

Research indicates that two main factors contribute to the low uptake of mental health care: the fear of stigma and perceived barriers to care. Stigma is a negative attitude resulting from the acceptance and internalisation of 'prejudice or negative stereotyping', while barriers to care are the organisational, procedural or administrative aspects of access to mental health care that may preclude or reduce access to mental health treatment and support. Barriers may include issues associated with confidentiality, anonymity and confidence in the mental health service providers. These are influenced to varying degrees by internalised stigmas about access to care and the consequences of asking for help. 3

5.3 The MHPW study found that among its respondents, the highest rated barrier to personnel seeking help for a 'stress-related, emotional, mental health or family problem' in the ADF was the concern that seeking help would reduce their deployability (36.9 per cent). The highest perceived stigma that concerned members

---

1 Department of Defence, Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report, p. 207.
was that people would treat them differently (27.6 per cent) and that seeking care would harm their careers (26.9 per cent). The findings are outlined in Figure 5.1.

**Figure 5.1 – Estimated prevalence of stigma and barriers to care, by rank**

![Graph showing estimated prevalence of stigma and barriers to care by rank](image)


5.4 A significant number of submissions also identified stigma surrounding mental ill-health and perceived barriers to care as key factors limiting the likelihood that ADF members would seek treatment for mental ill-health. A study investigating PTSD and stigma in the Australian Army, conducted by John Bale for the Army in 2014, reported on Australian soldiers' experiences of stigma due to mental ill-health. One soldier commented:

> After my break down and subsequent hospitalisation words cannot express how lost I felt, the confusion and most of all the feeling of despair. My Chain of command had no idea how to engage me and my unit turned its back on me. Life was hard enough, but it was made harder that I had served 18 years and was not farewelled from my unit, mess, or Corps. It was not

---

until then that I realised that the stigma surrounding mental health and especially PTSD within the Army was widespread.5

5.5 Another example told of a soldier being accused of malingering and his concerns being dismissed when asking for mental health support and assistance from members of his chain of command:

When first asking for assistance for mental health support from within my immediate chain of command [sergeant and warrant officer class 2] I was met with an attitude that I was malingering and the immediate questioning of my integrity as a JNCO.

I pursued the matter outside my chain of command, although still within my unit, and a meeting with the unit RSM was arranged. I raised my concerns about my mental health and wellbeing and was told to 'harden the f**k up' and to get on with my job.6

5.6 The committee received similar evidence from ADF members and veterans who told the committee that if ADF members raise concerns regarding mental ill-health they are often dismissed or accused of malingering.7 Mr Matthew McKeever, a veteran, told the committee of his experiences, asserting that ADF members who are struggling with mental ill-health, or even physically injured, are commonly ostracised and called 'lingers':

As soon as they find out that you have a mental illness or any kind of illness, regardless of whether it is a knee, back or whatever, you are treated as a malingerer and you are treated quite badly. They do not want to acknowledge you; they want to kick you out as soon as possible.8

You want to ask for help, but you know what the reaction is going to be. I was a platoon sergeant. I used to sit in on med boards. I know exactly what goes on in them. The words that are thrown around are, 'He's weak. He is a linger. Let's just kick him out.' I have seen it firsthand because, as a platoon sergeant, I am part of that criteria. I would quite often be spoken down to because I would stand up for the soldier and say, 'No, that's not right. He's got a serious injury.'

I had a soldier who, at 21, had a hip replacement. They just booted him out of the army as a linger. That is not acceptable. They go on about mateship, courage and initiative. Yes, courage and initiative is what you have. Where does the mateship come into it? It does not.9

5 Mr John Bale, PTSD and Stigma in the Australian Army, October 2014, p. 17.
6 Mr John Bale, PTSD and Stigma in the Australian Army, October 2014, p. 17.
7 For example: Mr Douglas Steely, Submission 6, p. 16; Mr Mark Keynes, Submission 10, p. 3; Mr Jeremy Davey, Submission 25, p. 4; Dr Niall McLaren, Submission 50, p. 3; Slater & Gordon Lawyers, Submission 51, p. 9; Major Stuart McCarthy, Supplementary Submission 54.1, p. 2; Name withheld, Submission 70, p. 4.
8 Mr Matthew McKeever, Committee Hansard, 1 September 2015, p. 35.
9 Mr Matthew McKeever, Committee Hansard, 1 September 2015, p. 39.
Dr Niall McLaren pointed to ADF cultural views of strength as a significant contributing factor to the stigma surrounding mental ill-health:

Compounded in all of this is the intense stigma directed against people with mental problems in the Defence forces, and this stems from the myth of the 'real man'. The myth of the 'real man' is that there is no such thing as pain, sickness or mental disorder, only weakness of will. Anybody who shows pain, sickness or mental symptoms—and this is continuing with the myth—is weak and must be treated harshly until he gets tough 'like us'. That myth is absolutely rife. It is everywhere. It is in the air that people breathe in the Defence forces. Of course, it is fantasy.10

The Chief of the Defence Force (CDF), Air Chief Mark Binskin, acknowledged that stigma regarding mental ill-health is 'one of the biggest challenges we continue to face in the Australian Defence Force'.11 However, when asked by the committee, the CDF disagreed with the allegations that Defence had a cultural problem regarding members seeking assistance when struggling with mental ill-health being ostracised and accused of malingering, responding that 'No, I think that we have had issues in the past and I am sure that there are pockets there now, still, that we will have to work on from a cultural point of view for people to understand that this is a command issue in looking to rehabilitate our people'.12

Defence assured the committee that it has introduced a range of educational resources and activities to reduce stigma surrounding mental ill-health:

...board developments and achievements since 2009 include...mental health education resources and activities such as the annual ADF Mental Health Day to reduce stigma and barriers to care by increasing awareness of mental health issues and understanding of PTSD, depression, suicide prevention and alcohol misuse and how to seek help as early as possible.13

In the ADF Mental Health & Wellbeing Plan 2012-2015 (MHWP), Strategic Objective 1 is 'to promote and support mental health fitness in the ADF' and aims for:

- a culture that promotes wellbeing and reduces the stigma and barriers to mental health care;
- ADF personnel who are mental health literate and know when, how, and where to seek care for themselves and their peers; and
- selection, training, and command systems that promote good mental health and wellbeing.14

---

10 Dr Niall McLaren, Committee Hansard, 1 September 2015, pp 33–34.
11 Air Chief Mark Binskin, Chief of the Defence Force, Department of Defence, Committee Hansard, 21 September 2015, p. 1.
12 Air Chief Mark Binskin, Chief of the Defence Force, Department of Defence, Committee Hansard, 21 September 2015, pp 6–7.
13 Department of Defence, Submission 34, p. 4.
14 Department of Defence, ADF Mental Health & Wellbeing Plan 2012-2015, p. 12.
Impact of mental ill-health on deployment and career

5.11 The MHWP study found that among its respondents, the highest rated barrier to personnel seeking help for a 'stress-related, emotional, mental health or family problem' in the ADF was the concern that seeking help would reduce their deployability (36.9 per cent) and that seeking care would harm their careers (26.9 per cent). This was also reflected in the evidence received by the committee.\(^\text{15}\)

5.12 Walking Wounded told the committee that the medical classification system, and in particular, the requirement that Army personnel be able and ready to deploy, reinforces and confirms ADF members' concerns that their deployability is inextricably linked to their employability:

Most soldiers are honest but most soldiers are realists too. Some years ago, when they changed the medical classification system in Army so that you could no longer serve if you had an injury that prevented you from serving overseas, that cut out a whole bunch of people who were very useful in Army. Just because they could not deploy did not mean they could not do good work elsewhere. I served many years ago with a major at Kapooka, and it was not until I saw him running in PT gear that I realised he only had one leg. He lost a leg in Vietnam thanks to a mine but he had served—and this was 20 years after the end of Vietnam—quite happily with a wooden leg. I thought: why not? Why would you want to lose that experience if that person can still provide that service? We are not going to send him overseas to fight again but, gee, there are lots of good jobs he could do in Army otherwise.

Probably the greatest problem now is that the medical classification system means that, if you are not ready to deploy, you cannot continue employment in the Army. For a lot of young men and women that means that they are losing the job they have always wanted. That is something that needs to be addressed. When you are in uniform, you need that understanding that the organisation is going to look after you, that it is going to keep you on board and you have got that reassurance. Certainly when I was a digger that was the case—you knew that you would certainly not be losing a job because you had suffered a bad injury that you might not get back from. That is not the case these days, of course.\(^\text{16}\)

---

\(^{15}\) For example: Mr Mark Keynes, Submission 10, p. 1; Returned and Services League of Australia, Submission 19, pp 3, 7, 17; Mr Jeremy Davey, Submission 25, p. 3; Australian Families of the Military Research and Support Foundation, Submission 26, p. 16; Dr Kieran Tranter, Submission 27, pp 18, 38–39; Soldier On, Submission 29, p. 4; Phoenix Australia, Submission 30, p. 2; beyondblue, Submission 41, pp 4–5; Name withheld, Submission 44, p. 3; Slater & Gordon Lawyers, Submission 51, p. 8; Royal Australian Armoured Corps Corporation, Submission 59, p. 7; Mr Bradley Skinner, Executive Officer, Walking Wounded, Committee Hansard, 1 September 2015, p. 6.

\(^{16}\) Mr Bradley Skinner, Executive Officer, Walking Wounded, Committee Hansard, 1 September 2015, p. 6.
The Returned and Services League of Australia (RSL) stated that many ADF members fear the impact that disclosing mental ill-health will have on their ability to support their family:

Given a relative lack of civilian qualifications, many servicemen/women (with mortgages and young families) fear the impact that disclosing psychological injury will have on their ongoing employability, deployability, promotional opportunities and therefore their incomes.\(^{17}\)

Mr Mark Keynes told the committee:

Probably the biggest problem is the stigma associated with seeking help. Many troops believe that anyone who asks for help is unlikely to deploy and will probably be medically discharged. Many believe that asking for help can be a career ending move, hence the stigma.\(^{18}\)

Mr John Bale, in his report regarding PTSD and Stigma in the Australian Army, highlighted ADF members' fears of being discharged as a key factor in their reluctance to seek treatment for mental ill-health, especially for ADF members of lower rank:

Job security is vital to soldiers. Soldiering is key to the perceived self-worth of many who serve, and termination of employment by the Army is a dramatic and often confronting experience and one that soldiers will do almost anything to avoid. The fear of being discharged due to the disclosure of PTSD is currently a significant barrier to care, and a promise made by the senior leadership of the ADF and the Australian Army does little to reassure the lower ranks of the Army who are among those most affected by PTSD.\(^{19}\)

To allay these fears, Mr Bale called for the ADF to highlight positive experiences from currently serving ADF members who have undergone rehabilitation for mental ill-health and have successfully returned to their career. Mr Bale also noted that this will also encourage ADF members to seek treatment early, to improve their chances of successful rehabilitation:

The most effective way to allay fears over job security for those who seek treatment for PTSD is to highlight positive experiences from currently serving soldiers who have been rehabilitated and subsequently enjoyed successful careers. These soldiers' stories, highlighting their successful return to an Army career, present a highly effective means of reassuring those with PTSD that they will only be medically discharged if they cannot be successfully rehabilitated. This message can also be useful in reinforcing the need for early intervention, signalling the fact that the sooner individual sufferers seek help, the greater the chance of their recovery, and the less likely they are to face discharge.\(^{20}\)

19 Mr John Bale, *PTSD and Stigma in the Australian Army*, October 2014, p. 32.
20 Mr John Bale, *PTSD and Stigma in the Australian Army*, October 2014, p. 32.
5.17 Defence emphasised its commitment to rehabilitation, informing the committee that of the 869 individuals with a mental illness who completed a rehabilitation program in the period from July 2013 to June 2014 a total of 420 (or 52 per cent) are recorded as having a successful return to work at the end of their rehabilitation program. Defence provided three recent examples of ADF members of differing ranks that completed a rehabilitation program following referral for mental illness:

The first example involves an officer who was diagnosed with PTSD following an operational deployment in 2011. The officer’s health care and rehabilitation program included a six week PTSD program. The officer was successfully returned to work in his current unit. As at October 2015, it is reported that the officer remains well supported by his unit and colleagues, and his ongoing prognosis and needs are being monitored by his health care team.

The second example involves a Senior Non Commissioned Officer (SNCO) who was medically downgraded because of both physical and mental health conditions related to multiple deployments. During 2014, the SNCO was provided with clinical treatment and health care, and referred to the ADF Rehabilitation Program. With the support of the rehabilitation consultant, commanding officer and health care team, the SNCO remained in the unit and was given the time to recover and achieve a full return to work outcome. The SNCO was medically upgraded in mid 2015, is undertaking a military course and will potentially be posted and deployed again in 2016.

The third example involves a junior ranked soldier with specialist skills who witnessed deaths during multiple deployments, resulting in a mental health condition. This member was provided with health care and referred for rehabilitation during 2013. The rehabilitation was successful, with the member being medically upgraded, promoted to a Non Commissioned Officer (NCO), and deployed on operation again in 2014.21

5.18 The RSL also commended the ADF, noting the 'great step forward' of providing a mandatory two-year period of treatment, rehabilitation and/or vocational training for ADF members allowing members to adapt their career plans:

The ADF's recent initiative of giving their employees a mandatory 2 year period of treatment/rehabilitation/vocational training (either back into ADF employment or in the civilian world) once a significant injury is identified is a great step forward.22

5.19 Defence developed a 30-minute documentary, Dents in the Soul—helping to cope with PTSD, which is available from the Defence Health portal website. The documentary aims to 'de-stigmatise PTSD and to show that it can potentially happen to anyone'. It acknowledges ADF members' fears of stigma and condemns attitudes that mental ill-health is 'weakness'. The documentary calls for 'psychological sentry

---

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

22 Returned and Services League of Australia, Submission 19, p. 18.
duty' asserting that commanders and fellow ADF members have a duty to look out for and to help anyone struggling with mental ill-health and declaring that those who do not have failed their subordinates or their mates. The documentary features interviews with current ADF members who have undergone successful rehabilitation for PTSD and returned to work, emphasising that 'recovery rates from PTSD are high but early diagnosis and treatment are particularly important'. It strongly and repeatedly emphasises that Defence has invested in and values ADF members and states its desire to rehabilitate and retain its members.

5.20 Aspen Medical reported that 42 per cent of its clinicians agreed or strongly agreed with the statement that there is increasing awareness and acceptance of mental health issues and PTSD amongst Defence personnel which is reducing the stigma formerly attached to mental health issues, with 21 per cent disagreeing or strongly disagreeing. Aspen Medical commented that 'this suggests that attitudes are changing within the ADF and that the efforts of the ADF and JHC have met with some success', as well as noting that 'it is also clear that this cultural shift will take more time to become fully embedded within the ADF'.

Department of Veterans' Affairs claims processes

5.21 DVA is responsible for a range of programs providing 'care, compensation, income support, and commemoration for the veteran and defence force communities and their families'. DVA administers three key pieces of legislation which governs veterans access to care and support entitlements:

- **Veterans Entitlements Act 1986** (VEA), which provides compensation, income support, and health services for those current and former members of the ADF who have rendered services in wars, conflicts, peacekeeping operations, and certain other deployments before 30 June 2004. Current and former ADF members with peacetime service between 1972 and 1994 and some veterans with warlike service and non-warlike service after 1 July 2004 may also have access to certain VEA entitlements;

- **Safety, Rehabilitation and Compensation Act 1988** (SRCA), which is workers' compensation legislation that applied to members and former members of the ADF, Reservists, Cadets, and Cadet Instructors and certain other persons who hold an honorary rank in the ADF, as well as members of certain philanthropic organisations that provide services to the ADF; and

- **Military Rehabilitation and Compensation Act 2004** (MRCA), which provides compensation and rehabilitation for current and former members of the ADF.

---


25 Aspen Medical, Submission 38, p. 69.
as well as Cadets, Cadet Officers, and Instructors whose injury or disease is caused by service on or after 1 July 2004. The MRCA superseded the SRCA at this date for DVA, as well as most of the provisions contained within the VEA.\(^{26}\)

5.22 There are two ways that veterans can apply to DVA for assistance with mental health conditions:

- the non-liability pathway: for certain mental health conditions whatever the cause, to receive treatment only; and
- the liability pathway: for mental health conditions related to service in the ADF, to receive compensation and treatment.\(^ {27}\)

**Non-liability pathway**

5.23 In 2013, DVA approved 1,244 non-liability applications for mental health and in 2014, approved 3,826.\(^ {28}\) DVA advised the committee that the eligibility requirements for non-liability mental health service provision were expanded in 2014 and again in 2015. Non-liability mental health services are now available to anyone who has deployed on operations overseas or has completed three or more years of continuous service in peacetime since 1972.\(^ {29}\)

5.24 Under the new arrangements, DVA can pay for treatment for diagnosed PTSD, anxiety, depression, alcohol use disorder, or substance use disorder whatever the cause. Furthermore, DVA can now accept diagnosis from vocationally registered GPs, clinical psychologists, or psychiatrists. If a person has been diagnosed with one or more of these conditions, they are issued with a White Treatment Card (White Card), which provides access to treatment such as GP care; specialist care in the community, such as from a psychologist or psychiatrist; and hospital care.\(^ {30}\)

5.25 A number of submissions supported non-liability mental health service provision and called for eligibility to be broadened further.\(^ {31}\) The RSL described the provision of non-liability support as 'invaluable' but called for eligibility to be extended to everyone who has served in the ADF:

DVA's non-liability mental health support for eligible veterans has proved to be invaluable for the veterans who often present to an RSL Pension Officer at breaking point. This allows them to immediately access specialist

\(^{26}\) Department of Veterans' Affairs, *Submission 35*, p. 52.

\(^{27}\) Department of Veterans' Affairs, *Submission 35*, p. 12.

\(^{28}\) Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 2.

\(^{29}\) Department of Veterans' Affairs, *Submission 35*, p. 25.

\(^{30}\) Department of Veterans' Affairs, *Submission 35*, p. 25.

\(^{31}\) For example: Returned and Services League of Australia, *Submission 19*, p. 11; Mr Robert Shearman, *Submission 21*, p. 4; Slater & Gordon Lawyers, *Submission 51*, p. 13; and Dr Kevin Kraushaar, *Submission 64*, p.2.
health while their DVA claim is processed. The RSL would support the extension of non-liability mental health support to all who have served in the ADF.32

**Liability pathway**

5.26 A serving or ex-serving ADF member who has a medical condition, including mental health conditions, for reasons related to their service, can make a liability claim. Once the liability claim has been accepted, DVA can provide services such as rehabilitation (including vocational assistance), medical treatment, (such as White or Gold Treatment Cards), attendant care, household services, and a range of other benefits. Compensation may also be provided for an inability or reduced ability to work or to recognise the effects of a permanent impairment resulting from a service-related incident.33

5.27 DVA assesses claims to determine whether the injury, illness, or disease is related to the claimant's service, with most claims being assessed under the VEA, SRCA or MRCA, depending on which piece of legislation applies to the claimant. Claims processed under the VEA or MRCA are assessed using Statements of Principles, which list factors that 'must' or 'must as a minimum' exist to cause a particular kind of disease, injury or death and which could be related to military service. The Statements of Principles are determined by the Repatriation Medical Authority, which consists of a panel of practitioners eminent in fields of medical science. Claims processed under the SRCA are assessed 'using available medical evidence to support consideration of a disease, injury, or illness'.34

**Impact of claims processes on mental health of claimants and their families**

5.28 The committee received considerable evidence regarding the difficulties that many veterans, especially those struggling with mental ill-health, have when seeking assistance from DVA, and the detrimental impact that the claims process can have on their mental health.35 The RSL told the committee that 'the DVA Compensation process complicates, aggravates and perpetuates the pre-existing psychological distress suffered by veterans and their families'.36

---

32 Returned and Services League of Australia, *Submission 19*, p. 11.
5.29 Slater & Gordon Lawyers described the DVA claims process as 'combative' noting that its clients' experiences with the DVA claims process are detrimental to their already compromised mental health:

We are witnessing Veterans being drawn into a system of combative legislation with a bureaucracy of Departments shifting responsibility. My team can attest to the voices of other Veterans advocates and ex-service organisations that lodging claims with the DVA for compensation and treatment of physical and mental issues is "like going through a meat grinder, it grinds you up".

5.30 Soldier On highlighted the confusing and overwhelming nature of the DVA claims processes, noting that it 'routinely aggravates existing mental health conditions':

The process of navigating a claims process routinely aggravates existing mental health concerns in many people attempting to access support from DVA. One partner of a veteran said they weren't in a position to sit down and manage their way through the confusing mix of support available. She described it as looking at the night sky. "There are many bright, shiny places to go, but out of the hundreds of options, where are we meant to go? What we need is a map, we don't need more stars."

5.31 Mrs Catherine Lawler, the wife of a veteran struggling with mental ill-health, told the committee that the claims process can be overwhelming for both veterans and their families. Mrs Lawler noted that the 'torturous and arduous' claims process results in many veterans giving up on their claim:

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

It is a torturous and arduous process that serves only to increase the stress levels of the veteran and it impacts negatively on them and their family. The distress generated frequently becomes too much for the veteran, and they give up on their claim, walk away from their family, or take their own lives. There is no support within this process for the partners or families of veterans with PTSD or mental illness.

Criticisms of DVA's delivery models and claims processes

5.32 In 2013, the Australian Public Service Commission conducted a capability review of DVA. The review found that 'DVA staff are committed to supporting the Australian veteran community' but that 'a major transformational leap forward is

---

37 Slater & Gordon Lawyers, Submission 51, p. 22.
38 Soldier On, Submission 29, p. 9.
39 Mrs Catherine Lawler, Submission 66, p. 2.
required'. The capability review expressed serious concerns regarding DVA's delivery models and compensation claims processing:

DVA’s current operating structure is a complex matrix—an unsustainable hybrid of fragmented national and dispersed business lines, comprising multiple service models, much of which is delivered and processed in-house (with the exception of health services which is outsourced).

This complexity has partially been shaped by the combination of multi-act eligibility and an increase in claims made under the MRCA which is more challenging to administer, but primarily through the division of responsibility for staff, policy and service delivery, all of which can be split across two or three divisions and two or more locations. This complex structure lacks scale and has contributed to the development of fiefdoms in state locations and functional silos to the detriment of consistency and efficiency of performance across key business outcomes, particularly compensation claims processing.

5.33 Mr Brian Briggs, Practice Group Leader, Military Compensation, at Slater & Gordon Lawyers described the DVA claims processes as 'chaotic' identifying 'fundamental problems' with its culture, leadership and equipment:

My first suggestion is this simple proposition: tackle the chaotic claims handling by DVA. An Australian Public Service Commission review found that the Department of Veterans’ Affairs has fundamental problems with its culture, leadership and equipment. The department has itself admitted that it cannot deal with the complicated needs of many physically and mentally injured veterans. The APSC review further found that the decision-making process at Veterans’ Affairs was a confusing mess of committees with duplicated membership and overlapping agendas. For example, 200 individual ICT systems operating within a single department cannot be efficient or productive. The structure of small cells of public servants working in isolation and not considering the whole picture has failed. Files are shipped all over the country—one section may deal with liability before another considers incapacity and then another rehabilitation or treatment. Permanent impairment and compensation will be looked at by an entirely separate team. This entire bureaucratic file shuffling and passing on of an injured member's claim causes significant delays. The frustration of my clients at this inefficiency and ineptitude often overwhelms.

5.34 DVA emphasised its desire to improve its engagement with clients, advising the committee that in late 2014, it commissioned and independent survey to help improve client services which collected approximately 3,000 responses. The results


42 Mr Brian Briggs, Practice Group Leader, Military Compensation, Slater & Gordon Lawyers, *Committee Hansard*, 1 September 2016, p. 15.
showed that 89 per cent of clients were satisfied with DVA's client service and 90 per cent of clients believed that the Department is honest and ethical in its dealings and is committed to providing high quality client service.  

5.35 Mr Shane Carmody, the Chief Operating Officer of DVA, acknowledged both the findings of the Capability Review and the comments made by Mr Briggs, assuring the committee that DVA has strategies in place to address DVA's operating structure; governance arrangements; information and communications technology; approach to clients; culture and staffing; and its efforts to formulate effective strategy, establish priorities, and use feedback:

The review team identified three key areas of focus, and we have discussed those I think more than once during the estimates process. They saw that we needed urgent attention to transforming our operating structure; our governance arrangements and information and communications technology; our approach to clients, culture and staffing; and our efforts to formulate effective strategy, establish priorities and use feedback. All of these issues have been identified, and strategies are in place to deal with them through DVA's strategic plan towards 2020.

In terms of operating structure, as we mentioned during a number of hearings, part of the creation of my position as chief operating officer was to streamline the governance process and take control of a number of key aspects of business. We have programs underway in terms of our clients, culture and staffing, including a strong program such as 'It's why we're here', a very clear program to ensure that our staff have a very good understanding of the client base we are dealing with and the injuries and illnesses they face.

Complex application processes

5.36 A number of submissions highlighted the complex and confusing applications processes required to lodge a claim. The RSL acknowledged that DVA's 'strict processes are required to efficiently and fairly investigate large number of claims' and that DVA has 'a defined budget' within which it must operate but noted that this has

---

43 Department of Veterans' Affairs, Submission 35, pp 6–7.

44 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, Committee Hansard, 21 September 2015, p. 4.

45 For example: Returned and Services League of Australia (Wide Bay Burnett District), Submission 3, pp 1–5; Dr Jerome Gelb, Submission 5, pp 2–3; Mr Douglas Steley, Submission 6, pp 2–6; Mr Robert Shortridge, Submission 16, pp 5–6; Returned and Services League of Australia, Submission 19, p. 18; Soldier On, Submission 29, p. 9; Partners of Veterans Association of Australia, Submission 42, pp 9–10; Name withheld, Submission 44, pp 3–6; Miss Alanna Power, Submission 48, pp 1–4; Slater & Gordon Lawyers, Submission 51, pp 8, 19–20; Mr John Skewes, Submission 52, pp 1–8; Mr John Lawler, Submission 58, pp 1–23; Mrs Catherine Lawler, Submission 66, pp 1–8; Name withheld, Submission 67, pp 1–3; Mr Dennis Bass, Submission 69; KCI Lawyers, Submission 71, pp 1–16; Name withheld, Submission 79, pp 1–2.
led to an adversarial system where DVA’s focus appears to have shifted from supporting veterans to 'looking for reasons not to provide compensation':

…many veterans feel that they are viewed by DVA as trying to cheat the system until proven otherwise. The majority of veterans and advocates (with whom the RSL and other advocates have contact) relate that a steadily increasing proportion of claims seem to be proceeding to the Veterans Review Board and the Administrative Appeals Tribunal, which indicates that the DVA is looking for reasons not to provide compensation rather than ways to support their clients.46

5.37 Mr William Kearney, from the Wide Bay Burnett District of the RSL, told the committee that most veterans, and even many volunteer advocates, do not understand the complex legalities of the claims process and highlighted the significant consequences for veterans and dependants if they, or the volunteer advocates assisting them, are unable to correctly navigate the system:

The danger here is that well meant but incorrect advice, once put on a form, signed by the applicant, then submitted to the Department is evidence that cannot be undone. Further clarification may have a slim chance of repairing damage but this is extremely rare. The outcome of this is that a Veteran, at best, is locked into a lengthy appeals process, or alternately denied benefits for life that they could have been receiving if the case was done correctly.47

5.38 DVA advised the committee that it has 'invested significantly' in its online capacity and improving clients' experiences with the claims processes. Clients can access online claiming for a range of DVA claims and applications, including claims for 'liability compensation following the death of a veteran, determining qualifying service, and service pension and income support supplement'. Furthermore, DVA advised that it has introduced an online 'single claim process' which negates the need for clients to make separate claims under different pieces of legislation:

The online claiming process is a single claim process rather than the client needing to make separate claims under different pieces of legislation. Claims will be considered under all relevant legislation to ensure clients have access to the full range of benefits for which they are eligible. The feedback received from ex-service representatives and departmental staff following a trial clearly showed that a single claim form is far less complex for clients.48

5.39 The DVA website now also offers a range of services including 'Entitlement Self-Assessment', which comprises a series of questions to help existing and prospective DVA clients to assess their potential entitlements. This may be completed by a member or former member of the ADF, (including reservists and cadets) or dependants (partner/spouse or children). Clients can also access 'my Account', which

46 Returned and Services League of Australia, Submission 19, p. 18.
47 Mr William Kearney, Wide Bay Burnett District of the Returned and Services League of Australia, Submission 3, p. 3.
48 Department of Veterans’ Affairs, Submission 35, p. 27.
allows clients to access a range of DVA services online. Clients can update contact
details, access information about accepted medical conditions, make transport
bookings, claim travel expenses, and access forms and fact sheets.49

Recordkeeping, communications technology, and procedural errors

5.40 The committee received evidence regarding lost documents, long delays
whilst waiting for documents to be physically transferred between offices, and
procedural errors.50 Soldier On told the committee that veterans have told them of
documents being lost by DVA:

When we have spoken to a number of veterans it seems that sometimes
their records are either lost or they are not handed over correctly. When you
have a mental health injury, actually talking through the same thing again
and again can be quite confronting, especially when you have to relive your
wound. So, for whatever reason it seems that records are not passed on
correctly. That may mean they are kept correctly but not passed on
correctly.51

5.41 One submitter told the committee that confidential medical documents were
lost by DVA on multiple occasions and outlined a number of procedural and clerical
errors that were made by DVA over the two years it took for their husband's claim to
be finalised:

Documents including confidential medical documents were lost on more
than one occasion, and requests for responses to emails, phone calls and
letters were consistently ignored. Months would pass without any updates
to the claim, despite repeated requests for information.

A number of procedural mistakes and errors of judgement occurred during
the course of the claim including:

- the date of onset of the illness being determined incorrectly (there was a
  7 year difference)
- not receiving the White Card for treatment costs until after liability was
  established
- not being assessed for rehabilitation services despite requests for these
  services

49 Department of Veterans' Affairs, Submission 35, p. 27.
50 For example: Mr Douglas Steley, Submission 6, p. 39; Mr Robert Shortridge, Submission 16,
pp 2, 6–7; Australia Psychological Society, Submission 22, p. 13; Australian Families of the
Military Research and Support Foundation, Submission 26, pp 15, 35; Soldier On, Submission
29, p. 6; Partners of Veterans Association of Australia, Submission 42, pp 9–10; Name
withheld, Submission 44, pp 4–5; Slater & Gordon Lawyers, Submission 51, p. 8; Mr John
Skewes, Submission 52, pp 5–6; Mr John Bale, Chief Executive Officer and Co-Founder,
Soldier On, Committee Hansard, 31 August 2015, p. 20.
51 Mr John Bale, Chief Executive Officer and Co-Founder, Soldier On, Committee Hansard,
31 August 2015, p. 20.
- the level of permanent impairment points determined by DVA was overturned on appeal by the Veterans Review Board (VRB)
- the procedures for determining the payment period for Incapacity Payments were found to be incorrect and also overturned on appeal by the VRB.\textsuperscript{52}

\textit{ICT systems}

5.42 The capability review identified the state of DVA's ICT systems as a significant issue to be addressed, describing the systems as 'antiquated':

\ldots the department is delivering through some 200 ICT systems which are so antiquated that new staff feel they have been transported back '10 years or more'. Applications are not integrated, making it difficult to obtain a whole-of-client perspective. This is further affected by a lack of a single client identification either within DVA or flowing from Defence through to DVA. Past investment has been a patchwork in the absence of a definitive ICT blueprint, which has generated cynicism and frustration.\textsuperscript{53}

5.43 Mr Carmody agreed that DVA has 'antiquated' ICT systems, assuring the committee that DVA was working to modernise and digitise its systems 'within the funding' available:

\begin{quote}
We do have challenges—I will admit those—without a doubt. I mentioned some during a hearing last week. We have antiquated ICT systems. We are doing our best to modernise those systems within the funding that we have available. We are doing our best to digitise our systems to move files off paper and on to digital systems. It will take time.\textsuperscript{54}
\end{quote}

\textit{Case coordination}

5.44 A number of submissions highlighted the lack of continuity when dealing with DVA and called for veterans making claims regarding mental ill-health to be assigned a case officer or staff member to act as a single point of contact.\textsuperscript{55} One submitter called for DVA to assign a case officer to act as a single point of contact for claims relating to mental ill-health:

\begin{quote}
Each time we contacted DVA we would speak with a different staff member, who inevitably passed us on to someone else, usually in another
\end{quote}

\textsuperscript{52} Name withheld, \textit{Submission 44}, pp 4–5.
\textsuperscript{53} Australian Public Service Commission, \textit{Capability review: Department of Veterans' Affairs}, November 2013, p. 39.
\textsuperscript{54} Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, \textit{Committee Hansard}, 21 September 2015, p. 4.
state. A dedicated case manager, with specialist training in mental health awareness should be allocated to each case that involves mental illness.56

5.45 DVA advised the committee that a small proportion of DVA clients are categorised as 'vulnerable with complex needs'. This might be because the client has serious wounds, illnesses, or injuries as a result of their service; a severe mental health condition; relationship or interpersonal difficulties; complex psychosocial needs; or a mix or some of all of these factors. DVA noted that, in general, case management refers to support provided to clients for:

- access to DVA systems and supports, usually referred to as 'case coordination', which are provided through DVA's case coordination service; and
- access to health care and community service, usually referred to as 'clinical care coordination', which are provided through DVA's health care card arrangements (for instance, through social workers) and also through the Veterans and Veterans Families Counselling Service (VVCS).57

5.46 DVA informed the committee that in the 2015-16 budget, the government funded 'a new measure', worth approximately $10 million over the forward estimates, to improve DVA's case coordination:

The measure will improve DVA's capacity to provide one-on-one tailored packages of support to veterans with complex needs, including mental health conditions. It will also improve the level of support and early intervention assistance provided to an increasing number of veterans with complex needs, particularly those returning from recent conflicts.58

5.47 Furthermore, as of 8 February 2016, DVA has implemented a single, nationally consistent, model for supporting complex and multiple needs clients. DVA advised that the new model focuses on supporting clients with mental health conditions and/or complex needs and aims to provide a single point of contact:

In line with the aim of the Budget initiative, there is a focus on supporting clients with mental health conditions and/or complex needs. Staff working within the new model will provide a single point of contact where appropriate, help clients navigate DVA’s processes to ensure they are accessing all of their entitlements, and connect clients with other community-based services and support where relevant.59

5.48 DVA also provided data regarding client update of the various case management support options (see table 5.1).

56 Name withheld, Submission 44, p. 5.
57 Department of Veterans' Affairs, Supplementary Submission 35.1, p. 1.
58 Department of Veterans' Affairs, Submission 35, p. 8.
59 Department of Veterans' Affairs, Supplementary Submission 35.1, p. 1.
Table 5.1–Client update of case management support

<table>
<thead>
<tr>
<th>Program/Support</th>
<th>Data on client uptake or population*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DVA’s case coordination service</strong></td>
<td>From January 2010 to June 2015, over 1,100 clients were referred to the Case Coordination Program.</td>
</tr>
<tr>
<td></td>
<td>As part of the information exchange strategy between Defence and DVA, in 2014-2015 Defence issued DVA with:</td>
</tr>
<tr>
<td></td>
<td>17 NOTICAS* priority notifications; and 961 medical separation notifications.</td>
</tr>
<tr>
<td></td>
<td>*Where a member is medically classified as seriously or very seriously wounded, injured, or ill (defined as an injury or illness that endangers the person’s life; significantly disables the person; or materially affects the person’s future life).</td>
</tr>
<tr>
<td><strong>Social work services under DVA’s allied health arrangements</strong></td>
<td>In 2014-15, there were 906 clients who received support under DVA’s social work allied health items, for treatment or case coordination.</td>
</tr>
<tr>
<td><strong>Veterans and Veterans Families Counselling Service (VVCS)</strong></td>
<td>In 2014-15, there were 227 clients who had their cases managed by VVCS. This compares with 126 complex care cases managed in 2013-14.</td>
</tr>
</tbody>
</table>

**Social work services under DVA’s allied health arrangements**

Social workers help clients overcome a range of problems in relation to stressful life events such as death or divorce and assist them to deal with family, health, employment, income support or accommodation related issues. The services provided by eligible social workers may include:

- general counselling and case management; and
- health service co-ordination and facilitating access to community services.
disorder (PTSD), anxiety, depression, sleep disturbance and anger.

VVCS supports a number of clients in complex situations with comorbidities and or who find it difficult to engage and manage the range of health and social care services they require.

* Note: the same client may access more than one type of support.

Department of Veterans' Affairs, Supplementary Submission 35.1, pp 2–3.

Timeframes

5.49 A number of submissions raised concerns regarding the time taken to process claims. Slater & Gordon Lawyers and KCI Lawyers called for the introduction of time limits for the processing of claims. Slater & Gordon Lawyers noted that state and territory bodies as well as international bodies have statutory timeframes in which decisions are made regarding the processing of claims for assistance and compensation:

…most important, is that time frames are now put in place to ensure that claims for help and other things are dealt with. Every state and territory system in Australia has time frames for decision making. Defence personnel in the UK and US are protected by time frames for decision making. But in Australia there are none, so injured personnel can literally be left waiting for years…An increase of $10 million announced in the latest budget to increase the numbers of delegates who make decisions is welcome but will not adequately solve the problem unless time frames are mandated. I strongly urge the committee to consider the issue of deeming time periods, which will have a significant benefit in assisting not only the PDSD sufferers but also all of our injured military personnel."

5.50 KCI Lawyers commented that the long processing times unfairly deny veterans and their families access to much needed assistance:

DVA continue to cause Veterans and their families substantial delays as they have no time limits imposed to make timely decisions. This remains a vexed issue when compared to other Workers' compensation…The time has well and truly come for DVA to make a decision within a reasonable and a defined period. The old adage of "justice delayed is justice denied" is also

60 For example: Dr Jerome Gelb, Submission 5, pp 2–3; Mr Douglas Steley, Submission 6, pp 12–13; Mr Robert Shortridge, Submission 16, pp 5–6; Returned and Services League of Australia, Submission 19, p. 38; Mr Robert Shearman, Submission 21, p. 5; Mr Geoff Bolwell, Submission 33, pp 23–24; Partners of Veterans Association of Australia, Submission 42, pp 9–10; Name withheld, Submission 44, pp 3–6; Miss Alanna Power, Submission 48, pp 1–4; Slater & Gordon Lawyers, Submission 51, pp 13–19; Mr John Lawler, Submission 58, pp 1–23; Mrs Catherine Lawler, Submission 66, pp 1–8; KCI Lawyers, Submission 71, pp 1–16.

61 Mr Brian Briggs, Practice Group Leader, Military Compensation, Slater & Gordon Lawyers, Committee Hansard, 1 September 2015, p. 16.
true when considering the delay to provide compensation payments by making timely and accurate decisions is akin to denying the benefit.\textsuperscript{62}

5.51 DVA assured the committee that 'the Government is very focussed on improvements to reduce the time taken to process compensation claims' describing it as a 'key early intervention initiative'.\textsuperscript{63} The average times taken to process compensation claims under the VEA and liability claims under MRCA and SRCA for the financial years 2011-12 to 2013-14 are listed in table 5.2.

\textbf{Table 5.2 – Time taken to process claims}

<table>
<thead>
<tr>
<th></th>
<th>TARGET AVERAGE</th>
<th>2011-12 OUTCOME</th>
<th>2012-13 OUTCOME</th>
<th>2013-14 OUTCOME</th>
<th>2013-14 CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEA</td>
<td>75</td>
<td>74</td>
<td>79</td>
<td>75</td>
<td>-4</td>
</tr>
<tr>
<td>MRCA</td>
<td>120</td>
<td>158</td>
<td>155</td>
<td>144</td>
<td>-11</td>
</tr>
<tr>
<td>SRCA</td>
<td>120</td>
<td>180</td>
<td>171</td>
<td>160</td>
<td>-11</td>
</tr>
</tbody>
</table>

Department of Veterans' Affairs, \textit{Submission 35}, p. 28.

5.52 DVA disagreed with calls to introduce statutory timeframes. Ms Lisa Foreman, First Assistant Secretary, Rehabilitation and Support, advised the committee that statutory timeframes have been considered in the past and were found to be unsuitable for DVA's unique situation:

Last year, we tabled a report in the Senate on the review of statutory time frames which looked at the options that we might be able to adopt in relation to our claims processes, but overall there are two significant issues in relation to compensation claims that we receive compared to compensation claims under states' compensation and private compensation schemes. Firstly, we have no time limit on when a member—a veteran—can lodge a claim. So an injury could have occurred in the forties, the fifties or the sixties, and a veteran is still able to lodge a claim with us; there is no limit. We do not have any directions on the state of the claim that we receive. Essentially, a veteran can put a claim in which just has their name, address and injury, and they sign it. A lot of other compensation schemes actually will not accept a claim until it is fully completed. In our case, that would mean that it has not only the details of the veteran but also reports from their medical specialists or doctors about the nature of the injury and the illness, proof of identity that the veteran has served, and details of where they served and when they served. We do not do that; we allow veterans to come in and immediately give us their claims. We then go away and try and get that additional information. We will contact their specialists and ask them to produce a report. We will contact Defence and ask them to

\textsuperscript{62} KCI Lawyers, \textit{Submission 71}, p. 16.

\textsuperscript{63} Department of Veterans' Affairs, \textit{Submission 35}, p. 3.
produce details of their medical records and the incident that gave rise to the compensation. I think, overall, we are in a very different position to other compensation schemes in Australia.64

5.53 Mr Carmody also expressed concerns regarding the introduction of statutory timeframes, noting that it could damage the integrity of the claims system:

…one of the key points in statutory time frames is what you wish to achieve. For example, do you want to have a deemed acceptance at the end of a particular period? If that were the case, that would encourage everybody to go slow on their claims process, because we have to collect all of the information. If you were to have a deemed acceptance, people would be reluctant to put in their material, because at the end of a particular period of time we are going to accept it anyway. That would be unfair across the whole system. If you decided to have a deemed rejection at the end of a particular period, if somebody gets 95 per cent through their claims process and the time elapses, they have to go back and start again. So there are some real issues in trying to manage this. A great amount of our time that is taken to process is taken up with collecting information which in other jurisdictions would be provided in advance. That is probably the simplest answer.65

Availability of services in regional and remote areas

5.54 Some submissions highlighted a lack of available services, especially in regional or remote areas, as a significant barrier to treatment.66 Ms Maria Brett, Chief Executive Officer of Psychotherapy and Counselling Federation of Australia, told the committee that due to workforce shortages, veterans seeking treatment may have to wait a 'significant amount of time':

…particularly relates to rural and regional areas, because we know there are workforce shortages. If you are trying to access one of the outreach counsellors from VVCS and you live in a place where someone is not available, you will actually be waiting, and that sometimes can be for quite a significant amount of time to get a service. This is why, in our discussions with the health minister we are very interested in potentially using

---

64 Ms Lisa Foreman, First Assistant Secretary, Rehabilitation and Support, Department of Veterans' Affairs, Committee Hansard, 21 September 2015, pp 12–13.

65 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, Committee Hansard, 21 September 2015, p. 13.

66 For example: Walking Wounded, Submission 18, p. 3; Australian Psychological Society, Submission 22, pp 9–10; Psychotherapy and Counselling Federation of Australia, Submission 23, pp 1, 6; Mr Jeremy Davey, Submission 25, p. 4; Soldier On, Submission 29, p. 8; Dr Kieran Tranter, Submission 27, p. 20; Phoenix Australia, Submission 30, p.6; Veterans' Health Advisory Council (South Australia), Submission 55, pp 7–8; Australian Association of Social Workers, Submission 77, p. 4.
counsellors to participate in a rural and regional trial, and that could be something potentially that DVA—

5.55 Ms Catherine O'Toole, Chief Executive Officer at Supported Options in Lifestyle & Access Services (SOLAS), advised the committee that 'specialist mental health services are very light on the ground in regional areas'. Ms O'Toole advised that SOLAS was working to build capacity in northern and western Queensland:

Specialist mental health services are very light on the ground in regional areas. Our organisation made a commitment, when we got federal funding some time ago, that we would work to build the capacity in our regional areas. That is why we subcontract in Charters Towers, Ingham, Ayr, Burdekin, Richmond and Hughenden—because there were no specialist mental health services. We have been able to build that capacity in that community. It is much more financially viable as well. We have also created jobs and built skill bases in those communities.

5.56 DVA acknowledged that, as it operates and purchases services from within the broader mental health system, workforce shortages can impact on the availability of services for veterans in regional and remote areas:

DVA operates within a broader mental health system and it is important to recognise that while there has been significant expansion of mental health services over the past two decades in Australia, this sector continues to have workforce shortages in the face of growing demand especially in some regional areas.

Committee view

Stigma and perceived barriers to care

5.57 Early identification and treatment of mental ill-health is essential for achieving the best outcomes for ADF members and veterans with mental ill-health. As such, the committee is very concerned that perceived stigma surrounding mental ill-health continues to be identified as a significant barrier to ADF members and veterans seeking treatment for mental ill-health.

5.58 Evidence of ADF members who were brave enough to report mental ill-health and seek treatment being ostracised, ridiculed, and accused of 'malingering' is deeply disturbing and completely unacceptable. The committee acknowledges that Defence has introduced a range of educational resources and activities to reduce stigma surrounding mental health; however, it is clear that more must be done to root out and denounce stigma regarding mental ill-health.

67 Ms Maria Brett, Chief Executive Officer, Psychotherapy and Counselling Federation of Australia, *Committee Hansard*, 31 August 2015, p. 53.

68 Ms Catherine O'Toole, Chief Executive Officer, Supported Options in Lifestyle & Access Services (SOLAS), *Committee Hansard*, 1 September 2015, p. 51.

Impact of mental health on career prospects

5.59 The MHWP study found that the highest rated barrier to ADF personnel seeking help was the concern that seeking help would reduce their deployability (36.9 per cent). The committee acknowledges that is a legitimate fear and a difficult one for Defence to address. 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 it operational capability.

5.60 The committee understands the principle that it would be inappropriate and irresponsible for Defence to deploy ADF members who are not mentally well enough for deployment, in the same way as it would be inappropriate for an ADF member who is not physically well enough to be deployed. However, this does not absolve Defence of its responsibility to address these fears. Defence should continue to emphasise the benefit of early identification and treatment of mental ill-health for an ADF members' long-term career prospects when considering seeking assistance for mental ill-health. Defence should also encourage ADF members to plan beyond their next deployment by showing examples of members who have successfully deployed after rehabilitation for mental ill-health.

5.61 An ADF member who chooses not to disclose or treat mental ill-health, and is subsequently deployed, is exposing themselves to significant risk of further deterioration of their mental health. This may result in a much more serious mental health condition which may ultimately lead to the ADF member being medically downgraded, medically discharged, or even the inability to work at all. Comparatively, an ADF member who disclosed and sought treatment for mental ill-health early may have their deployment delayed, but is significantly more likely to have positive mental health outcomes. This may result in later deployments, after mental health concerns have been addressed, and ultimately result in a longer and more successful career in the ADF.

Recommendation 11

5.62 The committee recommends that Defence mental health awareness programs do more to emphasise the benefit of early identification and treatment of mental ill-health for an ADF members' long-term career and encourage ADF members to plan beyond their next deployment.

Recommendation 12

5.63 The committee recommends that the Department of Defence and the Department of Veterans' Affairs develop a program to engage current and former ADF members, who have successfully deployed after rehabilitation for mental ill-health, to be 'mental health champions' to assist in the de-stigmatisation of mental ill-health.

DVA delivery models, claims processes, and ICT systems

5.64 Veterans and their families who are seeking assistance and treatment for mental ill-health must engage with DVA to receive it. Therefore, the extent to which DVA processes act as a barrier to the early identification and treatment of mental ill-
health is directly proportionate to the ease and speed with which veterans' claims are processed. As such, the committee is deeply concerned by evidence that the DVA claims process can be detrimental to the mental health of veterans seeking assistance and treatment for mental ill-health.

5.65 The Australian Public Service Commission's capability review highlighted considerable failings regarding DVA's operating structure; governance arrangements; information and communications technology; approach to clients; culture and staffing; and its ability to formulate effective strategy, establish priorities and use feedback. The committee acknowledges that DVA has strategies in place to address these shortcomings; however, it is clear that more must be done to ensure that veterans are able to quickly access the assistance and treatment they require.

5.66 The committee commends DVA for its efforts to simplify its complex claims process. The introduction of an online 'single claims process', which negates the need for clients to make separate claims under different pieces of legislation and ensuring that clients have access to the full range of benefits that they are eligible for, is a significant step towards improving client engagement. The committee also notes DVA's introduction of online 'entitlement self-assessment' and 'my Account' services.

5.67 The committee is very concerned by the evidence it received regarding lost documents, long delays whilst waiting for documents to be physically transferred between offices across different states and territories, and procedural errors. DVA's 'antiquated' ICT systems appear to be at the root of many of these concerns. The committee is not satisfied by DVA's comments that 'it will take time' to modernise these systems within the funding that it has available. The digitisation of records and modernisation of ICT systems must be made a priority and should be funded accordingly.

Recommendation 13

5.68 The committee recommends that the Department of Veterans' Affairs be adequately funded to achieve a full digitisation of its records and modernisation of its ICT systems by 2020, including the introduction of a single coherent system to process and manage claims.

5.69 Good case coordination is essential to ensuring that veterans and their families who are seeking assistance for mental ill-health can navigate the claims process with the minimum impact on their mental health. The committee is satisfied that DVA recognises this and is encouraged by the government's recent investment to improve DVA's case coordination. The committee is also pleased to note DVA's recent implementation of a single, nationally consistent, model for supporting complex and multiple needs clients, which will aim to provide a single point of contact during the claims process.

5.70 Early identification and treatment of mental ill-health is essential for achieving the best outcomes for ADF members and veterans with mental ill-health. As such, it is essential that claims are processed in a timely fashion, to ensure that veterans and their families are able to receive assistance and treatment as soon as
possible. The committee commends DVA for its non-liability mental healthcare provision and its recent expansions to the eligibility requirements to receive it.

5.71 The committee acknowledges DVA's assurances that it is aware of the importance of improving the timeliness of claims processing. The committee is satisfied that the strategies DVA is implementing to improve the timeliness of its claims processing, together with the digitisation of records and modernisation of ICT systems, will ensure that claims are processed within acceptable timeframes.

5.72 The committee acknowledges calls to introduce statutory timeframes; however, based on the evidence received, the committee is not convinced that mandating a timeframe will benefit veterans and may have unintended consequences.