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Performance Audit

Administration of Mental Health Initiatives to Support Younger Veterans

Department of Veterans' Affairs

Australian National Audit Office

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Australian National Audit Office

Canberra ACT
22 June 2012

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Veterans' Affairs with the authority contained in the *Auditor-General Act 1997*. I present the report of this audit and the accompanying brochure to the Parliament. The report is titled *Administration of Mental Health Initiatives to Support Younger Veterans*.

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

The Auditor-General is head of the Australian National Audit Office (ANAO). The ANAO assists the Auditor-General to carry out his duties under the *Auditor-General Act 1997* to undertake performance audits, financial statement audits and assurance reviews of Commonwealth public sector bodies and to provide independent reports and advice for the Parliament, the Australian Government and the community. The aim is to improve Commonwealth public sector administration and accountability.

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Abbreviations

ACPMH	Australian Centre for Posttraumatic Mental Health
ADF	Australian Defence Force
CLU	Client Liaison Unit
COAG	Council of Australian Governments
DMIS	Departmental Management Information System
DoHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
ESO	Ex-service organisation
GP	General Practitioner
MRCA	*Military Rehabilitation and Compensation Act 2004*
PBS	Portfolio Budget Statements
SIIP	Support for Injured or Ill Project
SRCA	*Safety, Rehabilitation and Compensation Act 1988*
SWIIP	Support for Wounded, Injured or Ill Program
VEA	*Veterans' Entitlements Act 1986*
VVCS	Veterans and Veterans Families Counselling Service

Glossary

ADF and ex-service communities	This term is used throughout the report to capture all currently serving and ex-serving members, veterans and their families.
Australian General Practice Network	Peak health body for general practitioners (GPs). More than 90 per cent of GPs and an increasing number of allied health professionals and practice nurses are members of their local GP network.
Co-morbidity	The term refers to the occurrence of more than one illness or condition at the same time.
Divisions of General Practice	Professionally led and regionally based voluntary associations of GPs that seek to provide professional support for GPs and to coordinate and improve local primary care services.
Ex-service organisation	These organisations exist to help veterans, their dependants and descendants, in matters ranging from social activities through to health, welfare, pension and advocacy services.
Integrated (health) client data mart	DVA's combined data holdings of client-accepted disabilities and conflict details, and mental health service usage by DVA veterans, dependant family members and widow/ers.
Mental health issues, disorders and conditions	These are used as generic terms in the report to refer to mental health problems.
Operational tempo	The rate at which the ADF is able to deliver its operations effects, for example, the rate at which forces are deployed and the time in which they are turned around for their next task.

Treatment population	The population of eligible veterans, war widow/ers and dependants who have been determined to be eligible for medical treatment under DVA-administered legislation.
Treatment cards	DVA issues treatment cards to eligible veterans, war widows and widowers and dependants, to provide access to health and other care services that promote and maintain self-sufficiency, well-being and quality of life.
Veteran	Under the *Veterans Entitlements Act 1986* (VEA), a veteran is a person who is taken to have rendered eligible war service/qualifying service; or who is eligible to be paid a VEA pension; or is a member of the armed forces; or a member of an Australian peacekeeping force.
Younger veteran	Generally refers to DVA's definition of veterans aged 45 years or less, but DVA's usage varies and can therefore refer to a veteran of more recent wars, conflicts and peace operations from the Korean war to the present day.
Younger member	An alternative to 'younger veteran': DVA's research has indicated that younger members of the ADF and ex-service communities do not identify with the term 'veteran'. More recently DVA has used the term 'contemporary' veteran to reflect the changed demographic of the ADF—including members with multiple deployments, the deployment of women, couples and reservists—and the newer generation of veterans.

Summary and Recommendations

Summary

Introduction

1. Mental health disorders are a major cause of reduced quality of life for many members of the Australian Defence Force (ADF) and veteran communities. Over half the members of the ADF have experienced a mental health disorder at some stage in their lives (54 per cent), which is higher than in the Australian community, where 49 per cent of individuals are estimated to have experienced a mental health disorder.[1]

2. The delivery of mental health services to eligible members of the ADF and ex-service communities is a priority for the Department of Veterans' Affairs (DVA), as a significant number of disability claims relate to mental health disorders.[2] In June 2011, mental health disorders accounted for up to 40 per cent of the total disabilities accepted by DVA as service-related.

3. In 2007–08 Australian governments collectively spent $5.1 billion on mental health services, of which $142 million was for DVA programs and initiatives addressing mental health issues.[3] By 2009–10, DVA's expenditure on mental health was estimated to have risen to $160 million.[4] While there has been substantial funding of mental health care by all governments in the past 10 years, around 65 per cent of Australians with a mental illness do not access

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1 The most common mental health conditions are anxiety, affective disorders (depression) and alcohol disorders: see Hodson, SE, McFarlane, AC, Van Hooff, M, & Davies, C, *Mental Health in the Australian Defence Force—2010 ADF Mental Health Prevalence and Wellbeing Study*: Executive Report, Department of Defence: Canberra, 2011, p. 5. Some veterans have more than one accepted disorder.

2 DVA is part of the Defence portfolio and is responsible for developing, implementing and administering government policy and programs to fulfil Australia's obligations to the veteran and ADF communities. It provides a range of mental health services to veterans, war widows and widowers, current and former defence force members and their families, and eligible members of the Australian Federal Police with overseas service.

3 Department of Health and Ageing (2010) *National Mental Health Report 2010: Summary of 15 Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993–2008*. Commonwealth of Australia, Canberra, p. 150. Available from: <htttp://www.health.gov.au> [accessed 29 November 2011].

4 DVA has advised that mental health expenditure is currently underreported, particularly in relation to pharmaceuticals.

support services.[5] A 2010 study of mental health in the ADF suggests this figure is likely to be higher for serving members and veterans, many of whom have indicated a reluctance to report mental health issues due to a concern that it may reduce their prospects of deployment and affect their careers.[6] More recently, a former commander of Australian forces in Afghanistan also drew attention to cultural and attitudinal factors that may inhibit ADF members seeking assistance for mental health conditions:

> What worries me though is that the vast majority of people coming home hide these problems. No one encourages them to hide them; it's built into the psyche of the young warrior. They don't want to admit weakness, and I expect that the inclination to cover this up, pretend you're OK, will be a continuing one as we bring our troops home from the Middle East.[7]

4. The profile of the Australian veteran and ex-service community has changed over the years with the decline in World War II, Korean War and war widow populations and the emergence of a growing younger cohort. The younger veteran[8] cohort includes the estimated 50 000 ADF personnel deployed across the globe since the East Timor deployment in 1999[9], which marked the beginning of a heightened operational tempo by the ADF that continues to the present day.[10]

5. Between 4000 and 6000 ADF personnel discharge each year, most of whom are relatively young—the average age of separation for officers is

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5 Australian Bureau of Statistics, 2007, *National Survey of Mental Health and Wellbeing: Summary of Results* [Internet], ABS, Canberra. Available from: <http://www.health.gov.au> [accessed 6 April 2011].

6 Hodson, SE, McFarlane, AC, Van Hooff, M & Davies, C, [2011] op. cit., pp. 17–19.

7 Retired Major-General John Cantwell, 'Transition is the most dangerous phase', *Lateline*, Australian Broadcasting Corporation, 17 April 2012, p. 5. Transcript available from: <www.abc.net.au/lateline/content/2012/s3479770.htm> [accessed 18 April 2012]. See also: Dodd, M, 'Troops face mental health risks', *The Australian*, 19 April 2012, p. 2.

8 The ANAO uses the term veteran for ease of reference in the report and consistency with DVA's terminology. The ANAO notes, however, that younger members of the ADF and ex-service communities have reported that they do not necessarily identify with this term.

9 The Hon Warren Snowdon MP (Minister for Veterans' Affairs), 'Address to RSL National Congress', 20 September 2011, p. 5. Available from: <http://minister.dva.gov.au/media_releases> [accessed 22 September 2011].

10 Operational tempo is defined as 'the rate at which the ADF is able to deliver its operations effects, for example, the rate at which forces are dispatched and the time in which they are turned around for their next task.' See: Department of Defence, *Annual Report 2008–09,* p. 372. Available from: <http://www.dva.gov.au/aboutDVA/publications/corporate/annualreport> [accessed 13 April 2012].

around 34 years, and 27 for other ranks. Many of these young members will have been deployed several times and more than half are married or in long term relationships, and also have children.[11] Further, the members of this younger cohort have indicated that they have different needs and expectations compared to their older counterparts (who are the majority of DVA clients), requiring DVA to adapt its programs and services accordingly. DVA has acknowledged that communicating and engaging effectively with the younger cohort is a particular challenge.[12]

6. The wider mental health environment in which DVA operates is also complex. At the national level, mental health care and services are informed by the Council of Australian Governments' framework for mental health care in Australia. The framework is working towards a mental health care system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.[13] Within the context of the national framework, DVA provides programs and services to support the mental health and wellbeing of members of the ADF and ex-service communities. DVA also provides the Veterans and Veterans Families Counselling Service (VVCS), which is a specialised and free counselling service for eligible ADF members, veterans and their families for service-related mental health conditions.

7. Since 2001, DVA's mental health planning and delivery of mental health support services to clients have been guided by its mental health policy framework, *Towards Better Mental Health for the Veteran Community*[14], which DVA has advised is under review. DVA's approach to mental health issues has also been informed by the considerable body of research since the Vietnam War, which points to enduring and often severe mental health problems

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[11] The Hon Warren Snowdon MP (Minister for Veterans' Affairs), op. cit., p. 3.

[12] Department of Veterans' Affairs, *Annual Report, 2009–10*, DVA, Canberra, 2010, p. 14. A major communication challenge for DVA is that younger veterans are less likely to join ex-service organisations, which have been a traditional means for the department to connect with the veteran community.

[13] Department of Health and Ageing, *National Mental Health Policy 2008, National Mental Health Strategy*, DOHA, Canberra, 2009, p. i.

[14] Department of Veterans' Affairs, *Towards Better Mental Health for the Veteran Community*, Mental Health Policy and Strategic Directions, DVA, Canberra, January 2001.

experienced by returned and ex-service personnel.[15] These problems include the long term psychological burden of modern combat[16], and the over-use of alcohol by the veteran community, which have implications for family cohesion and the reintegration of ADF members into the community.[17] Access to, and the availability of, lethal weapons and exposure to combat are also acknowledged risk factors for suicide among veterans.[18]

8. In addition to the inherent challenges in supporting and facilitating access to appropriate mental health care for eligible members of the ADF and ex-service communities with accepted mental health conditions, DVA faces the challenges of: improving mental health literacy so that individuals recognise the need to seek appropriate help for themselves and others; adopting appropriate early intervention and prevention strategies, in conjunction with the ADF; and supporting those ex-service personnel whose conditions may manifest years and sometimes decades after they have left the ADF.

Audit objective and scope

9. The objective of the audit was to examine the effectiveness of DVA's administration of mental health programs and services to support younger veterans.

10. The audit focused on the extent to which DVA has: established an effective management framework to provide mental health services; informed younger members of the ADF and ex-service communities about available mental health services and engaged them in the support system; facilitated

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[15] O'Toole, BI, Outram, S, Catts, SV, and Pierse, KR, 'The Mental Health of Partners of Australian Vietnam Veterans Three Decades After the War and Its Relations to Veteran Military Service, Combat, and PTSD', *The Journal of Nervous and Mental Disease*, Vol. 198(11), 2010, p. 841.

[16] High combat exposure has been found to correlate with higher levels of anxiety, depression and post-traumatic stress. See: Sammons, MT, and Batten, SV, 'Psychological services for returning veterans and their families: evolving conceptualizations of the sequelae of war-zone experiences', *Journal of Clinical Psychology*, 64: 2008, pp. 921–923. doi: 10.1002/jclp.20519.

[17] Australian Centre for Posttraumatic Mental Health, *Psychosocial Rehabilitation for Veterans*: Final Report, ACPMH, Melbourne, Victoria, 2010, p. 13.

[18] Dunt, D, *Independent Study into Suicide in the Ex-service Community*, January 2009, p. 28. Available from: <http://www.dva.gov.au/health_and_wellbeing/research> [accessed 1 November 2010]. Suicide ideation has been found to be significantly elevated in the ADF compared to the general population, but the number of ADF reported suicides is lower than in the general community. However, the evidence is not conclusive, due to the significant level of underreporting and incomplete reporting Australia-wide. Also see: Hodson, SE, McFarlane, AC, Van Hooff, M, & Davies, C, [2011], op. cit., p. 10.

timely access to well-targeted, integrated mental health care; supported younger veterans with complex needs; and monitored and reported on the performance of mental health programs. The audit did not assess the quality of clinical information and services provided by DVA.

Overall conclusion

11. DVA delivers mental health services to eligible members of the ADF and ex-service communities[19], and develops policy responses to the mental health needs of its clients, in a complex and evolving environment. The profile of mental health disorders and the pattern of usage of mental health services by members of the ADF and ex-service communities differ from that found in the wider community[20], reflecting the unique demands of military service and culture. Further, the profile of the veteran community has been changing, with the emergence of a significant younger cohort of veterans, many of whom have served in the numerous ADF deployments of the past decade. The younger cohort of ADF members is particularly at risk of having a mental health disorder, with many of these individuals leaving the military with an undiagnosed and untreated mental health condition.[21] These young ex-service members are particularly at risk of not receiving the mental health treatment they need, as they do not necessarily maintain links with the ADF or engage with DVA after they leave the military, and they have proven difficult to reach through traditional means such as the ex-service organisations.

12. The Government has commissioned a large body of mental health research and reviews of mental health services, aimed at establishing how best to understand and meet the mental health needs of serving members and the veteran community, particularly the younger veteran cohort.[22] DVA's understanding of the needs and expectations of the younger cohort continues to evolve and the department has begun to draw on this body of work. DVA

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[19] The ADF also has responsibility for, and delivers mental health services to, serving ADF members. DVA has prime responsibility for the delivery of mental health services to the ex-service community.

[20] Department of Veterans' Affairs, *Mental Health Update Report*, 2008, p. 8.

[21] Hodson, SE, McFarlane, AC, Van Hooff, M & Davies, C, [2011] op. cit., p. 25.

[22] Two key reports were those prepared by Professor David Dunt in 2009—Dunt, D, *Independent Study into Suicide in the Ex-Service Community, January 2009,* and the *Review of Mental Health Care in the ADF and Transition through Discharge,* January 2009.

has also come to recognise the benefit of reviewing and reforming its mental health policy, programs, services and administrative arrangements in light of research and experience.

13. The department has recently revised, or advised of plans to revise, major elements of its mental health administration. In March 2012, DVA established a new Mental and Social Health Branch to improve the coordination and integration of its mental and social health policies. While this is a significant step in improving coordination of DVA's internal efforts, the department's mental health policy, programs, services and data systems continue to be managed across many separate business areas and there would be benefit in considering how best to coordinate all of DVA's mental health effort. There would be particular benefit in considering the merits of assigning responsibility for mental health data policy to the new mental health policy branch, as a means of improving the reliability and accuracy of the department's mental health data holdings[23], which currently underestimate the number of younger veterans with an accepted mental health condition and which will need to be drawn on in the review of DVA's mental health policy.[24]

14. The department's current mental health policy, released in 2001, focuses on the needs of Vietnam veterans, who were the 'younger' cohort at that time, and whose accepted mental health claims then accounted for around 55 per cent of new DVA cases. In the past decade, however, the department's approach to mental health care has been strongly influenced by the needs of a new cohort of younger members.[25] The update of the mental health policy framework provides an opportunity for DVA to consider the needs of the emerging younger cohort in a formal way, as well as reviewing the policy's

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[23] A previous ANAO audit recommended that DVA develop an agency-wide strategy, assigning ownership for data management and integrity issues to business areas. See ANAO Audit Report No. 28 2008–09 *Quality and Integrity of the Department of Veterans' Affairs Income Support Records*, p. 31.

[24] As at 28 June 2011, DVA had identified 107 311 clients in its mental health cohort, but could not establish the younger veteran cohort with any confidence. The ANAO subsequently identified 3748 younger veterans with a mental health condition accepted by DVA. DVA has advised that it is considering how it can more accurately report on its mental health cohort and use that information to inform future planning and its new mental health policy.

[25] The importance of DVA better understanding and more effectively responding to the needs of the younger cohort was documented in DVA's corporate documents, including its Strategic Plan, as early as 2002–03. DVA's capacity to effectively engage and meet the needs of each client group, particularly the younger cohort, would be strengthened by clearly identifying and targeting messages tailored to the various client cohorts.

alignment with national policy frameworks and strategies released since 2001.[26] In February 2012, DVA advised that the release of the ADF's new mental health strategy in 2011[27] provides an opportunity to update DVA's mental health policy in 2012.

15. In recent years, DVA has delivered a suite of small, disparate mental health programs and initiatives[28] designed to inform younger members of the ADF and ex-service communities of mental health care and support services and encourage them to access those services. This strategy has been complemented by initiatives intended to raise awareness of this group's mental health needs among health professionals, as a means of improving the quality of veterans' mental health care. A number of these measures were introduced as part of a package of mental health reforms funded through the 2006–07 Budget. Overall, these small programs and initiatives have been of limited effectiveness, with a number of evaluations and reviews highlighting the need for DVA to more effectively target them and related communications activities, as a means of engaging its various client sub-groups, particularly younger veterans.

16. These programs have included: three DVA websites designed to improve the mental health literacy of clients and encourage self-help, which have consistently attracted very few 'hits'[29]; and voluntary support programs such as the Transition Management Service (TMS) and the *Stepping Out* program. The TMS was launched in 2000 to support medically discharging members' transition to civilian life in recognition of the potential stress caused by unplanned separations; and to prioritise and expedite their compensation

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[26] The 1992 national mental health policy was still in place in 2001 but has since evolved, particularly with the introduction of service standards and the routine monitoring of consumer outcomes. In 2008, the national strategy was extended through a new policy that promotes an integrated, whole-of-government response to the improvement of mental health care services through the Council of Australian Governments' National Action Plan (the COAG action plan). In addition, the ADF released its mental health and wellbeing strategy in 2011.

[27] Department of Defence, *Australian Defence Force Mental Health and Wellbeing Strategy* [Internet], October 2011. Available from: <http://www.defence.gov.au/health/DMH/i-MHRP.htm#13> [accessed 28 October 2011].

[28] These programs and initiatives are in addition to mental health treatment services.

[29] These websites are: *The Right Mix* (delivered at a cost of $330 000 per year); *At Ease* ($993 475); and *Touchbase* ($800 000). Delivery costs include the development of supporting paper based resources, and start-up and maintenance costs.

claims to ensure that these members received their benefits without undue delay.[30] DVA's 2010 younger veteran satisfaction survey found that only 41 per cent of those surveyed, who were eligible to use TMS, had accessed the service. The *Stepping Out* program was also designed to facilitate a smooth transition from military to civilian life but only attracted 15 per cent of the participants originally anticipated and delivered 17 per cent of the sessions funded by the government.

17. DVA has also sought to improve its communication with health providers, as a means of raising awareness of veterans' health issues and facilitating access to services by DVA clients—through a shared care model designed to integrate and coordinate service delivery, particularly for clients with multiple health conditions.[31] Again, these initiatives have been of limited effectiveness. An evaluation by the Australian Centre for Posttraumatic Mental Health (ACPMH), which surveyed staff and health professionals from 17 Divisions of General Practice sites where DVA had implemented initiatives to promote the shared care model, found that most GPs and other health providers remained unaware of DVA's initiatives and the range of resources available.[32] The evaluation concluded that the cost-effectiveness of DVA's approach to increasing the knowledge and skills of health professionals through peak health bodies was not established and that little evidence in the literature existed to support such an approach.

18. DVA has recognised, for some years, the challenges of communicating with younger members, who tend to have higher expectations than their older counterparts[33], and they are more comfortable with online communications

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[30] The cost of the TMS for the six years to 30 June 2010 was estimated to exceed $4.2 million. The cost of TMS services could not be confidently determined, however, due to inconsistencies in, and incompleteness of, the data reported by the ADF and DVA.

[31] Funding for shared care initiatives was the major element of a $19.7 million package in the 2006–07 Budget to improve access to preventative and community-oriented mental health care, particularly for younger veterans.

[32] The evaluation observed that 'Many health providers expressed surprise at the range of initiatives DVA has developed…[and] there was a level of frustration expressed about the failure of DVA to provide the resources to them' reflecting a 'lack of effective dissemination'. Australian Centre for Posttraumatic Mental Health, *Evaluation of the Department of Veterans' Affairs Mental Health Initiatives 2007–2010,* Final Report, ACPMH, Melbourne, December 2010, pp. 5 and 79.

[33] Documented feedback indicates that the younger cohort seeks more streamlined services that meet their immediate needs, and are less accepting of the delays which can arise when processing often complex claims.

platforms and less likely to join ex-service organisations—a traditional conduit for communication between DVA and veterans. DVA therefore sought and received funding in the 2006–07 Budget to develop, implement and review its communications and education strategies and commissioned research in 2011 to inform the design of a communications strategy, which was yet to be developed in March 2012. DVA's Veterans and Veterans Families Counselling Service (VVCS) also received funding in the 2006–07 Budget to develop a targeted communications strategy designed to increase younger veterans' awareness and use of VVCS services, which similarly has yet to be developed.[34] While the communications challenges have long been recognised by DVA and funding made available by the Government, over five years have elapsed since the 2006–07 Budget measures were announced and DVA has made only limited progress in fully implementing them.

19. DVA and the ADF are jointly responsible for providing support to ADF members transitioning from military to civilian life. Effective transition support can be of considerable benefit to veterans. In the case of those with known mental health conditions, it provides information and support relating to available services and benefits. For other personnel exiting the ADF, it can help them understand the possibility that they may develop a mental health condition at some stage in their lives, and inform them of how to access the entitlements[35] potentially available to support them. A key risk is that if discharging members are not adequately informed and equipped by the ADF and DVA during the transition process, they are less likely to have knowledge of, and may not access, available services after they leave the military.

20. A key initiative supporting transition, which has not yet been fully implemented, was the launch in 2007 of a whole-of-life framework[36], intended

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[34] Belsham, S & Associates P/L, *Final Report Review of the Veterans and Veterans Families Counselling Service Delivery Model*, July 2010, pp. 41–42. This subsequent review of the VVCS in 2010 identified the need for DVA to improve VVCS stakeholder engagement and visibility within the ADF and ex-service communities. DVA advised in 2011 that it was in the process of developing a general VVCS communications strategy, which does not focus specifically on younger veterans.

[35] The importance of veterans submitting claims for service-related injuries early is well understood. See: Haigh, B, 'Veterans' Affairs fails many', *The Canberra Times*, 25 April 2012.

[36] The initiative, known then as the Integrated People Support Model, was announced on 23 August 2007 in the CDF/SEC Joint Directive 08/2007, *Secretary and Chief of the Defence Force Directive on Support to Our Australian Defence Force Personnel*.

to provide comprehensive cross-agency support to individuals from the time of their enlistment through to their resettlement in the community. Documenting the roles and responsibilities of the various agencies in the framework is an essential first step in progressing the initiative, which has yet to be done five years after it was launched. In October 2011, the ADF and DVA implemented new reforms within the whole-of-life framework, to better support wounded, injured or ill members. The reforms include an on-base DVA advisory service, which was implemented after TMS ceased operating.[37] While the Support for Wounded, Injured or Ill Program (SWIIP)[38] was launched in October 2011, the agreed milestones, reporting mechanisms and performance measures for the initiative were still to be developed in March 2012.[39]

21. Transition support could be further improved if the ADF were to provide DVA with de-identified data, on an annual basis, of the known mental health conditions and deployment patterns of members discharging from the ADF.[40] Many members of the ADF continue to be discharged with undiagnosed and untreated mental health conditions, and an appropriate exchange of information would contribute to the development of DVA's communications and targeting strategies, particularly for members in the groups most at risk of developing mental health conditions.[41]

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[37] Department of Veterans' Affairs, *Update on Progress of Defence/DVA Links Steering Committee*, Ministerial Brief No. B10/0213, 3 March 2010, p.5.

[38] SWIIP aims to ensure better integration of services and support to prevent injured and ill members from falling 'through the cracks'. Snowdon, W, (Minister for Veterans' Affairs), *Care for wounded, injured and ill ADF personnel, Defence on the record*, Department of Defence, Canberra, 1 August 2011. Available from: <http://news.defence.gov.au/2011/08/01/care-for-wounded-injured-and-ill-adf-personnel/> [accessed 7 October 2011].

[39] DVA advised that relevant performance measures would only be developed on completion of 20 projects launched as part of the SWIIP.

[40] ADF information relating to patterns of deployment and service, including the involvement of ADF members in conflict, can provide insights into the various mental health conditions which may affect discharging members in the future.

[41] The study into the prevalence of mental health in the ADF found: half of ADF members will experience anxiety, affective or alcohol use disorder in their lifetime; one in five members had experienced a mental disorder 12 months prior to interview; the rates of mental disorder were highest in the 18–27 age group; depressive disorders in males and females were significantly higher than the general community (depression is a prevalent outcome following deployment and traumatic exposure); higher rates of Post Traumatic Stress Disorder (PTSD) compared to the general community; the rate of suicidality was more than double that of the general community; and trends showed greater levels of traumatic symptomatology with each deployment.

22. A targeted approach can be highly effective in managing the needs of clients who are vulnerable, at risk and/or have complex needs. DVA established a Client Liaison Unit in 2007 to actively manage its relationship with such clients[42], and a Case Coordination initiative in 2010 to identify and case manage clients at increased risk of self-harm or harm to others. Both programs have been effective in supporting vulnerable clients, and the work of the Client Liaison Unit has been publicly recognised and commended by the Commonwealth Ombudsman and the courts. Nevertheless, there remains scope for the department to improve its administration of vulnerable clients, including through the introduction of quality assurance processes and performance measures, and improved controls to alert staff if a client is being case managed and should not be contacted directly unless authorised.

23. The mental health needs of members of the ADF and ex-service communities continue to attract attention and concern in the ADF and wider community[43], with many thousands of ADF veterans, including younger members, continuing to return from deployments around the globe. In some cases, veterans will have known mental health needs, while in others, these needs will appear later in life. The current and future needs of these Australians will present ongoing challenges for DVA, working in concert with the ADF. Addressing these challenges will necessarily require a more strategic and coordinated approach than has been in place to date, if DVA is to effectively plan and deliver mental health programs and services that meet both the current and emerging needs of serving and former members.

24. The ANAO has proposed five recommendations to strengthen DVA's administration of mental health programs and services to better support younger veterans.[44] The recommendations focus on: better differentiation

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[42] The Client Liaison Unit is not considered to be formally part of DVA's mental health programs because clients are accepted into the program based on their behaviour, not a mental health condition. However, DVA advised that the Client Liaison Unit is within the department's 'mental health umbrella' because the difficulties reflected in clients' relationship with DVA may overlay acute mental health problems.

[43] See: Haigh, B, 'Veterans' Affairs fails many', *The Canberra Times*, 25 April 2012; Le Grand, C, 'The Black Dog of War', *The Australian*, 26 April 2012, p. 13; *Lateline*, Australian Broadcasting Corporation, 'Transition is the most dangerous phase', 17 April 2012, p. 5; and Dodd, M, 'Troops face mental health risks', *The Australian*, 19 April 2012, p. 2.

[44] The recommendations do not address clinical treatment services, which have not been examined in the audit.

between, and understanding of, the various veteran cohorts, particularly the younger groups; evaluating the performance of mental health programs; developing a targeted communication and dissemination strategy to reach younger veterans and members; and measures to improve the integrity of DVA's mental health data holdings.

Key findings

Chapter 2—Framework for providing mental health services

25. DVA's mental health policy framework was endorsed by the Repatriation Commission in 2000 and released in 2001.[45] The policy focuses on the needs of Vietnam veterans, who were considered at that time to be the 'younger' cohort, and whose accepted mental health claims then accounted for around 55 per cent of new DVA cases.[46] In the past decade, however, the department's approach to mental health care has been strongly influenced by the needs of the emerging cohort of younger members of the ADF and ex-service communities. Updating DVA's mental health policy framework provides an opportunity for the department to review its alignment with national policy frameworks and strategies released since 2001, and to also consider the needs of younger cohorts in a formal way. DVA has advised that the release of the ADF's new mental health strategy in 2011[47] provides the opportunity for the department to update its mental health policy in 2012.[48]

26. The 'younger veteran' concept was first used by DVA in the 1990s to differentiate the 'Vietnam veterans and younger veterans' from their World

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[45] The intention of DVA's mental health policy was to: guide the department's future planning and development of mental health care and services; improve the integration and coordination of mental health services within DVA; and improve mental health care for veterans and their families, through a collaborative approach with DVA's key partners, such as the Departments of Health and Ageing and Defence. Department of Veterans' Affairs, *Towards Better Mental Health for the Veteran Community,* DVA, Canberra, January 2001, p. 1.

[46] ibid., pp. 5–7. In June 2011, Vietnam veterans with accepted mental health disabilities accounted for approximately 30 per cent of DVA's total mental health treatment population.

[47] Department of Defence, *Australian Defence Force Mental Health and Wellbeing Strategy* [Internet], October 2011. Available from: <http://www.defence.gov.au/health/DMH/i-MHRP.htm#13> [accessed 28 October 2011].

[48] DVA originally advised the ANAO in December 2010 that its mental health policy was under review at that time.

War I and II counterparts. However, most Vietnam veterans are now in their 60s and 70s and the 'younger veteran' concept is no longer a meaningful descriptor for this group. DVA has also applied the 'younger veteran' concept to other veteran cohorts in the post-Vietnam war period, to describe veterans aged 45 years and less.[49] DVA has acknowledged the difficulties associated with the 'younger veteran' concept and is considering the use of an alternative concept such as the 'contemporary veteran' group when referring to veterans from recent deployments.[50] There would be benefit in DVA clearly identifying the various client cohorts, to strengthen its capacity to engage with different clients[51], and for the purpose of planning, identifying trends and undertaking comparative analysis with similar age cohorts in the community.

Chapter 3—Supporting younger veterans and members to transition to civilian life

27. The ADF and DVA jointly provide support to ADF members transitioning back to civilian life. Effective transition support can be of considerable benefit to veterans with mental health conditions, by helping them understand the full range of entitlements potentially available to support them and by facilitating their access to appropriate mental health care services. A system of support that is clearly visible to exiting members and their families and which promotes early intervention, prevention and treatment for mental health issues may also assist members who have not sought assistance for mental health conditions while serving to access appropriate care after they have left the ADF.

28. DVA is expected to provide quality and timely services to serving and former members of the ADF, to help the Defence and ex-service communities understand the full range of available entitlements, and to assist members to

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[49] DVA defines younger veterans as those aged 45 years and less for the purpose of surveying their views, but uses a range of different definitions of younger veterans for various purposes. The VVCS has also adopted its own definitions of 'younger veterans' for various purposes—with one definition referring to younger veterans as those below 35 years of age and another referring to younger veterans as those below 50 years.

[50] While the concept of a 'contemporary' veteran or group may temporarily overcome some methodological issues, it too is a relative concept. Further, it does not differentiate between the younger and older members of the 'contemporary' cohort, whose ages may range from late adolescence to the mid-fifties.

[51] Australian Centre for Posttraumatic Mental Health, *Pathways to care in veterans recently compensated*, Creamer, M, Hawthorne, G, Kelly, C, Haynes, L, Melbourne, 2004, p. 114.

experience a seamless transition on discharge from the ADF.[52] Developing better links with the ADF was considered a priority in 2002, as was informing the ADF and ex-service communities of their full entitlements and available services.

29. As discussed earlier, the ADF implemented a whole-of-life support framework in 2007, intended to provide comprehensive, cross-agency support to individuals from the time of their enlistment through to their resettlement in the community.[53] Increased support and care for young members during the transition process is a priority of the framework. However, younger veterans interviewed by the ANAO were unanimous in their view that once their mental illness rendered them medically unfit for military service, a lack of compassion for their circumstances and the speed of their discharge left them feeling 'abandoned' and 'rejected' by the ADF.

30. New reforms to better support wounded, injured and ill members, implemented by the ADF and DVA in October 2011 within the whole-of-life support framework, included an on-base DVA advisory service. The focus of the on-base advisory service is on outcomes rather than process, with the potential to reduce the complexity often encountered by individuals in accessing the level of support they need. In the context of developing the reporting and performance framework for these reforms, there would be merit in DVA and the ADF jointly developing an evaluation framework for the whole-of-life approach, including DVA's on-base advisory service.[54]

31. Between 2001 and 30 September 2011, DVA delivered a voluntary Transition Management Service under agreement with, and on behalf of, the ADF, to provide a higher level of service for members separating from the ADF on medical grounds; including prioritising and expediting their

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[52] Department of Veterans' Affairs, *Rehabilitation and Compensation Business Redesign*, Blueprint, Version 0.4, Final Draft, 16 December 2010, p. 3.

[53] Departments of Defence and Veterans' Affairs, Joint Working Group Submission to the Defence/DVA Links Steering Committee, *Future Support to ADF Members,* Version 1.0, 5 February 2010, pp. 2–5.

[54] Further, the provision of de-identified data to DVA, on an annual basis, of the known mental health conditions and deployment patterns of members discharging from the ADF, would enable DVA to better identify, monitor and support high risk groups, and would inform DVA's future planning, particularly its communications and targeting strategies for members in the high risk categories.

compensation claims so they would receive benefits more quickly.[55] As a voluntary program, the Transition Management Service was reliant on the ADF to inform and refer members and therefore required well-targeted marketing by DVA to be visible to members. DVA's 2010 younger veteran survey found that only 41 per cent of those eligible for the Transition Management Service were aware of the service, although 60 per cent of those who did access the service found it useful.[56] The ANAO found that there was an inadequate basis upon which to assess the effectiveness or efficiency of the service, due to: inconsistencies in the data collected and reported by DVA and the ADF; the lack of documented records; and the absence of indicators to measure and assess performance and outcomes.

32. The *Stepping Out* program is a group-based DVA education program designed to facilitate a smooth transition for all ADF members and their partners returning to civilian life. While an evaluation of the program in 2009 found that it was attracting its target audience and stakeholder feedback was generally positive[57], it has only attracted 15 per cent of the participants originally anticipated and delivered only 17 per cent of the sessions funded by government through the 2006–07 Budget—arguably due to the way it has been marketed.[58] DVA has not addressed the program's marketing issues but has acknowledged the need for an evaluation of the program's effectiveness, which is planned for 2012.

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55 Departments of Defence and Veterans' Affairs, Joint Working Group Submission to the Defence/DVA Links Steering Committee, *Future Support to ADF members,* Version 1.0, 5 February 2010, pp. 17–18.

56 However, 40 per cent had reported not finding the service so useful, which was consistent with other evidence acquired during the audit that suggested the quality and service delivery of the Transition Management Service varied depending on location and could have been improved.

57 Australian Centre for Posttraumatic Mental Health, *Stepping Out Program, Evaluation of the pilot program rollout,* ACPMH, Melbourne, September 2009, p. 7.

58 A review conducted in 2009 indicated that *Stepping Out* is not well known by the ADF, could be better promoted and the focus of its marketing as a psycho-social program may be off-putting for some members. See: Dunt, D, *Review of Mental Health Care in the ADF and Transition through Discharge,* 2009, p. 22. Defence has subsequently advised that ADF Transition Centres provide members with information and scheduled dates regarding *Stepping Out* program events.

Chapter 4—Engaging with key stakeholders to provide integrated and accessible mental health services

33. DVA consults with, supports and informs the veteran and ADF communities on health issues through a wide range of avenues, including ex-service organisations (ESOs), health providers and service delivery agencies.[59]

34. ESOs have traditionally provided a useful conduit for DVA into the veteran and ADF communities, by eliciting feedback and commentary on issues affecting serving and ex-serving members and their families, including mental health.[60] In 2009, DVA established a number of cross-organisational consultative forums, with members drawn from key ESOs to continue the work of raising awareness of mental health issues in the veteran community and to improve consultation—in particular, with younger veterans. While ESOs appreciated the opportunities provided by the forums, a number observed that younger members were not represented by the larger, established ESOs who participate in the forums. They indicated that some of the smaller and recently established ESOs are more representative of the views of young members and should be invited to participate in the consultative forums.

35. The Training and Information Program (TIP) is a collaborative program between DVA and ESOs that provides ESO practitioners with training about pensions, welfare and advocacy, to enable them to provide assistance and advice to members of the ADF and ex-service communities on compensation and other benefits administered by DVA. DVA reviewed the advocacy and welfare services it supports through the TIP and related programs in 2010, and found that while TIP had been useful in improving the knowledge of many ESO practitioners, there was scope to further improve their knowledge of the

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[59] Arrangements for engagement include formal inter-agency protocols, service level agreements and other strategic arrangements, transition services, the Veterans' Affairs Network and service centres, quarterly newsletters, targeted information and marketing materials, websites and various cross-agency consultative forums.

[60] ESO representatives are mainly volunteers supporting the veteran and ADF communities regarding pension and compensation-related claims and appeals, as well as welfare support, referral and information. DVA funds the training and administrative costs of ESOs to provide pension and welfare-related advice and support to members.

more recent legislation[61], and the overall consistency of their advice and advocacy services. The review recommended standardising ESO advocacy services and developing a quality assurance system.[62] A new and standardised TIP training package was under development during the review and was planned to be rolled out nationally in 2011–12, but DVA subsequently decided not to roll it out in 2011–12.

36. DVA has also sought to improve its communication with health providers.[63] The shared care approach is designed to coordinate service delivery by health providers, GPs, the VVCS and the ADF, in order to deliver a more integrated system of care for individual members and veterans who often have multiple health conditions.[64] While the shared care approach is consistent with DVA's mental health policy and the mental health reforms in the 2006–07 Budget[65], there was little evidence to suggest that DVA's interventions had realised an integrated system of shared care across the health system for members of the ADF and ex-service communities.

37. In addition to initiatives designed to meet the needs of veterans through third parties—such as ESOs and health professionals—DVA has adopted strategies to support self-help by veterans. The internet is playing an increasingly significant role in mental health literacy and the delivery of self-help treatments for mental health disorders, particularly for younger members who tend to be more comfortable with internet-based services. The development of self-help initiatives gained additional momentum through the

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[61] The 2010 review of the ESO advocacy and welfare services found that ESO practitioners have fairly widespread knowledge and understanding of the *Veterans' Entitlements Act 1986* (VEA) and its compensation focus, but are less comfortable with the more recent *Safety, Rehabilitation and Compensation Act 1988* (SRCA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA), and the emphasis they place on rehabilitation.

[62] Department of Veterans' Affairs, *Review of DVA-funded ESO Advocacy and Welfare Services*, DVA, Canberra, December 2010, p. 85. The review also considered that a holistic approach to supporting practitioners would include TIP training, mentoring and on-the-job training.

[63] In order to raise the profile of DVA with health providers, the department has focused on: shared mental health care coordination strategies; educating health providers about the needs of veterans; and facilitating access by DVA clients to appropriate community-based mental health care through a shared care model.

[64] Multiple health conditions are also known as co-morbidities and may include a combination of physical and/or mental health conditions.

[65] Both emphasise the benefits of coordinated and integrated mental health care.

mental health reforms in the 2006–07 Budget[66], which included additional funding for such measures. The ANAO's examination of three DVA websites[67] strongly supports the findings of a DVA-sponsored evaluation which concluded that awareness and use of DVA mental health sites is generally low because clients 'just don't know about them'.[68] The very low levels of site visits were attributed to communication activities that did not appropriately tailor messages to the different demographic groups within the ex-service community as a means of raising awareness of the sites.[69]

38. A number of evaluations and reviews have found that DVA mental health strategies are not always effective in targeting specific messages to the various sub-groups within the ADF and ex-service communities, particularly the younger cohorts.[70] In 2006–07, DVA received $19.7 million through the Budget process to better meet the needs of younger veterans by improving access to preventative and community-oriented mental health care. One of the priorities of the measure was the development, implementation and review of communication, awareness and education strategies and the development of a VVCS communication strategy targeting younger veterans. DVA has only partly implemented some of these strategies[71], and is yet to undertake the market research to enable the development of an appropriately targeted communication strategy to provide visibility of VVCS and DVA services to

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66 Department of Veterans' Affairs, *New Policy Proposal—Young Veterans Branch and VVCS Branch, Explanatory Notes*, DVA, Canberra, 2007, p. 6.

67 The three websites were *The Right Mix, At Ease* and *Touchbase*.

68 Australian Centre for Posttraumatic Mental Health, op. cit., p. 115.

69 ibid.

70 The Hon Warren Snowdon MP (Minister for Veterans' Affairs), New program to strengthen Defence families, Media Release, Parliament House, Canberra, 23 August 2011. Available from: <http://minister.dva.gov.au/media_releases/2011> [accessed 7 October 2011].

71 The ANAO's analysis found that it was not possible to conclude that any of the VVCS 2006–07 Budget initiatives examined had fully achieved their stated outcomes.

younger members.[72] DVA commissioned research in 2011 to inform the design of a communications strategy[73], which was yet to be developed in March 2012.

39. The importance of effectively marketing DVA services was further emphasised in a 2010 review of the VVCS.[74] DVA funded the review to determine the appropriate service delivery model for the VVCS to meet the changing needs of the ADF and ex-service communities. The review recommended that DVA develop and implement a marketing plan with targeted strategies to reach the different DVA client cohorts, in order to improve stakeholder engagement and help make the VVCS more visible to the different groups within the ADF and ex-service communities.[75] Similarly, a recent report on the prevalence of mental health and wellbeing in the ADF identified a need to set up systems to communicate with, and ensure visibility by DVA of, the younger cohort in particular[76], during transition and post-separation from the military. As a community-based provider of mental health care services for the ADF and ex-service communities, the VVCS needs to be clearly visible and accessible to discharging members and their families.

Chapter 5—Targeted support to vulnerable clients

40. In May 2007, the Minister for Veterans' Affairs committed to developing a more proactive approach to managing the relationships between DVA and clients who are vulnerable, at risk and/or have complex needs.[77] This followed a Senate Estimates Hearing and a series of inquiries into the circumstances surrounding the suicide of an ex-service member in 2006,

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[72] Effective communication of the full range of benefits, including access to health services under the three compensation schemes administered by DVA, is a key means of supporting serving and former members of the ADF. The findings of the 2010 study into the prevalence of mental health and wellbeing in the ADF also reinforce the importance of effectively providing information relating to mental health services, as a means of supporting members with mental health conditions.

[73] Orima Research, *A report on qualitative communications developmental research about mental health literacy*, Department of Veterans' Affairs, Canberra, 28 July 2011, p. 4.

[74] The VVCS provides case management and group programs for mental health issues related to military service or peace keeping operations as well as assisting with lifestyle, health and family matters.

[75] Belsham, S & Associates P/L, *Final Report Review of the Veterans and Veterans Families Counselling Service Delivery Model*, July 2010, pp. 41–42.

[76] Hodson, SE, McFarlane, AC, Van Hooff, M. & Davies, C, [2011], op. cit., p. xxxii.

[77] Standing Committee on Foreign Affairs, Defence and Trade, *Budget Estimates*, Thursday 31 May 2007, pp. 118–139.

known as the Gregg Review.[78] DVA set up a Client Liaison Unit in 2007, to provide a more holistic service to entitled clients with complex needs who meet certain behavioural criteria.[79] Another important service adopted for vulnerable clients was Case Coordination, which was introduced in January 2010 to identify and case manage DVA clients at increased risk of self-harm or harm to others. Case Coordination was introduced in response to the important Dunt study into suicide in the ex-service community.[80]

41. Overall, both the Client Liaison Unit and Case Coordination programs have been effective in supporting vulnerable clients who are at risk and/or with complex needs, whose relationship with DVA has either broken down or who have mental health issues that require a more client-centric service. Both the Commonwealth Ombudsman and the courts have publicly recognised and commended the Client Liaison Unit and the support it provides to clients. However, administrative weaknesses were identified in the Client Liaison Unit and Case Coordination programs, including limited documented procedures, a lack of performance indicators and no quality assurance programs. In particular, as both programs provide a primary point of contact into DVA for vulnerable clients with complex needs, all relevant information systems require a reliable facility (supported by the necessary procedural controls) to alert staff of the program's involvement in the case, prior to their contacting the client. However, where the facility was available it had not been activated in all cases and it had not been implemented in all relevant DVA systems.

Chapter 6—Integrity of mental health data

42. As at 28 June 2011, DVA had identified 107 311 clients in its mental health cohort, of which 50 271 had an accepted service-related mental health disability and 57 040 had received mental health treatment for an accepted mental health condition. The ANAO identified 3748 younger veterans with an

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[78] The three-part review into the circumstances surrounding Signaller Gregg's death comprised: an independent inquiry into his deployment and management of his transition/discharge arrangements; the handling of Signaller Gregg's DVA compensation claims and Comsuper's military superannuation benefits; and the whole-of-government approach to handling his case. Available from: <http://www.dva.gov.au/health> [accessed 17 January 2011].

[79] Department of Veterans' Affairs, *Policy and Procedures Manual, Client Liaison Unit*, p. 42.

[80] Dunt, D, *Independent Study into Suicide in the Ex-service Community*, January 2009.

accepted mental health condition, but found that the numbers are underestimated and it is not possible to establish DVA's mental health cohort with any certainty.

43. DVA clients with accepted mental health conditions are provided with a treatment card, either through the *Veterans Entitlements Act 1986* (VEA) and/or the *Military Compensation and Rehabilitation Act 2004* (MRCA) and these card holders constitute DVA's mental health cohort. However, many other client groups with mental health conditions accepted by the department are not included in DVA's mental health cohort, including three groups of significance. These groups are:

- approximately 4000 mainly younger SRCA and MRCA non-card holders with DVA accepted mental health conditions whose treatment is reimbursed by DVA;
- approximately 7000 clients with a recognised and recorded mental health condition but no established liability; and
- the unknown but substantial number of additional clients accessing VVCS and public hospital services.

44. The non-inclusion of VVCS data in DVA's mental health cohort is deliberate. It is intended to demonstrate to members of the ADF and ex-service communities that DVA is maintaining the confidentiality of VVCS services.[81] However, independent research has recommended the inclusion of VVCS data in a DVA consolidated report[82], while still maintaining client confidentiality.

45. DVA's information technology systems are complex and include a mix of siloed heritage systems and new systems, each with varying levels of functionality. There is consequently a need to replicate data across many DVA systems in order for the old systems to continue to function. The ANAO has previously identified that DVA's limited documentation and corporate

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[81] The VVCS is a confidential counselling service which DVA administers separately from its other services, to provide assurance to VVCS clients that disclosures made to VVCS counsellors will not inform DVA decision-making processes relating to claims.

[82] DVA Mental health Datamart, *Implications and recommendations for policy and planning*, undertaken for DVA's Mental Health Policy Unit by the ACPMH, 9 November 2006, pp. 4 and 20. DVA already has data exchange protocols in place to share de-identified data with external providers.

knowledge of its IT infrastructure can make it difficult to identify the source of truth of its data and the ownership within DVA of some data holdings.[83]

46. DVA has advised that there are difficulties in extracting data that accurately represents its client cohorts, and is considering how it can more accurately report on its mental health cohort and use that information to inform future planning and its new mental health policy.[84] To effectively coordinate its internal processes for improving the reliability and accuracy of its mental health data and performance reporting, there would be benefit in DVA assigning clear ownership and responsibility for mental health data.[85] As part of a departmental restructure implemented in March 2012, DVA established a dedicated Mental and Social Health Policy Branch to coordinate mental health and social policy issues, and there would be benefit in considering the merits of assigning responsibility for mental health data policy to that unit.[86]

Summary of agencies' responses

47. A copy of the proposed report was provided to DVA for formal comment. Relevant extracts of the proposed report were also provided to the Department of Defence for formal comment. The summary response of both departments is reproduced below.

Department of Veterans' Affairs

48. DVA agrees with the recommendations of this audit report, three with qualification, as generally confirming some of the directions and initiatives

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[83] ANAO Audit report No. 28 2008–09 *Quality and Integrity of the Department of Veterans' Affairs Income Support Records*, pp. 17–18.

[84] DVA client groups missing from its mental health cohort include public hospital admissions and treatments (especially in rural and remote locations where there are limited mental health services), VVCS clients, serving ADF members with accepted conditions, MRCA and SRCA non card-holders (many of whom are in the youngest cohort), and clients receiving new mental health treatments in the previous nine years.

[85] DVA advised that a departmental restructure implemented from 1 March 2012 would contribute to the development of a more consistent approach to mental health data reporting.

[86] A previous ANAO audit recommended that DVA develop an agency-wide strategy, assigning ownership for data management and integrity issues to business areas. See: ANAO Audit Report No. 28 2008–09 *Quality and Integrity of the Department of Veterans' Affairs Income Support Records*, p. 31.

already being undertaken by the department. This includes new approaches to engaging and communicating with veterans from contemporary era conflicts.

49. DVA is one of the largest purchasers of health care in Australia and continues to develop new policies and approaches to service delivery to meet the changing needs of clients. The department is adapting to reducing numbers of ageing clients, increasing numbers of clients from contemporary service (including women and reservists) and the changing needs of both. The department continues to deliver services effectively to its increasingly broad client base, including families and dependents.

50. The department notes that since the audit started in December 2010, there have been significant changes in the management structures and coordination of mental health policy and service delivery in DVA, including a new branch within the department's structure to enhance client communication capability.

51. This report through its examination of a selection of mental health initiatives demonstrates the complexity of mental health and the need for collaboration with the veteran and ex-service communities, research and provider agencies, and other government agencies, including the Department of Defence. This will continue to inform the department's approach to mental health policy and program development.

52. The department has a comprehensive range of mental health support and treatment available for clients, ranging from prevention and early intervention including online support such as *At ease* and *The Wellbeing Toolbox*, primary care, specialised counselling services and treatment, and hospital based care for those who need it including specialised programs for the treatment of post traumatic stress disorder.

Department of Defence

53. As a general comment, with some minor clarifications, the Extract accurately reflects Defence's processes. Defence would also like to note that both Defence and DVA have recently confirmed their commitment to working closely in the support of ADF members and veterans. In particular, Defence and the DVA are working hard to ensure the synchronisation of strategic communications.

Recommendations

Recommendation No.1

Para 2.18

To enable the development of communication and education strategies that effectively target and engage younger members of the ADF and veteran communities, the ANAO recommends that the Department of Veterans' Affairs defines the various cohorts in a way that meaningfully differentiates sub-groups, including by age and type of military service.

DVA response: *Agreed with qualification.*

Recommendation No.2

Para 3.32

In light of the low participation levels in the *Stepping Out* program, the ANAO recommends that the Department of Veterans' Affairs evaluates the efficiency and effectiveness of the program, including the program's marketing and promotional strategy.

DVA response: *Agreed.*

Defence response: *Agreed.*

Recommendation No.3

Para 4.9

To improve younger veterans' and members' awareness of the Department of Veterans' Affairs' mental health care services, the ANAO recommends that the department develops an appropriately targeted communication strategy in consultation with the Department of Defence.

DVA response: *Agreed.*

Defence response: *Agreed.*

Recommendation No.4

Para 5.33

To protect the interests of clients who are vulnerable or have complex needs, and support the staff who directly administer the Client Liaison Unit or Case Coordination program, the ANAO recommends that the Department of Veterans' Affairs implements a reliable facility on all relevant systems to alert other staff not to contact those clients directly unless authorised.

DVA response: *Agreed with qualification.*

Recommendation No.5

Para 6.26

To support the development and implementation of mental health policy, programs and services better tailored to the needs of younger members of the ADF and ex-service communities, the ANAO recommends that the Department of Veterans' Affairs:

- more fully and accurately identifies its mental health cohorts, particularly the younger sub-groups;
- uses a consistent methodology to define, standardise, collect and report on its mental health data; and
- regularly reconciles its mental health data with the source data to improve the completeness and integrity of its mental health information.

DVA response: *Agreed with qualification.*

Audit Findings

1. Introduction

This chapter provides the context for the audit, including an overview of the mental health of younger members of the Australian Defence Force (ADF) and ex-service communities, and the role of the Department of Veterans' Affairs in facilitating mental health care services for these communities. It also outlines the audit approach, including the audit objective, criteria and scope.

Overview of mental health in the ADF and ex-service communities

1.1 Mental health disorders are a major cause of reduced quality of life for many members of the Australian Defence Force (ADF) and veteran communities. Over half the members of the ADF have experienced a mental health disorder[87] at some stage in their lives (54 per cent), which is higher than in the Australian community, where 49 per cent of individuals are estimated to have a mental health disorder.[88]

1.2 The delivery of mental health services to eligible members of the ADF and ex-service communities is a priority for the Department of Veterans' Affairs (DVA)[89] as a significant number of disability claims relate to mental health disorders. In June 2011, mental health disorders accounted for up to 40 per cent of total disabilities accepted by DVA as service-related.[90]

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87 The most common mental health conditions are anxiety, affective disorders (depression) and alcohol disorders: Hodson, SE, McFarlane, AC, Van Hooff, M, & Davies, C, *Mental Health in the Australian Defence Force—2010 ADF Mental Health Prevalence and Wellbeing Study*: Executive Report, Department of Defence: Canberra, 2011, p. 5.

88 ibid. The study adjusted Australian Bureau of Statistics data on the incidence of mental health disorders in the Australian community to match the demographic characteristics of the serving ADF population. The study considered the difference between the incidence of mental health disorders in the ADF and the Australian community to be significant, and noted that the types of disorder are reflective of the risks of military occupation.

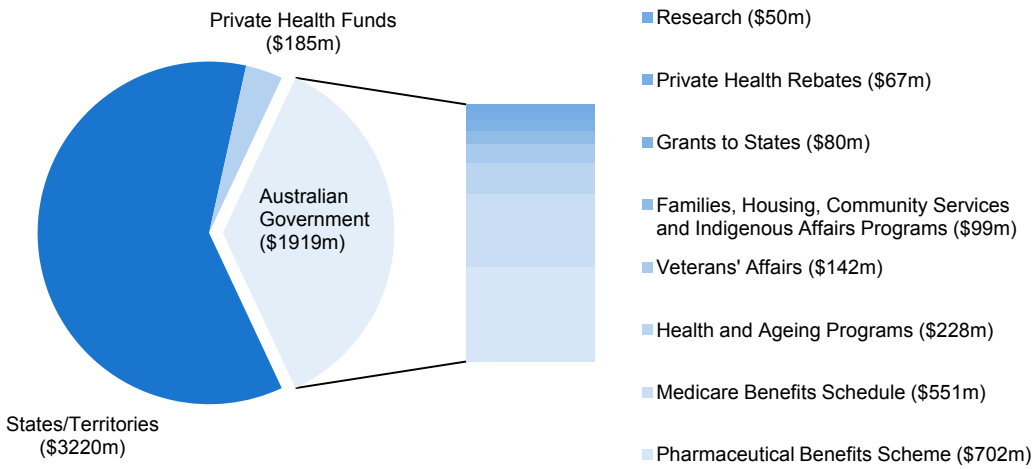
89 DVA provides a range of mental health services to veterans, war widows and widowers, current and former defence force members and their families, and eligible members of the Australian Federal Police with overseas service.

90 In the course of the audit, DVA provided the ANAO with data which, on analysis, indicated that mental health disorders accounted for either 30 or 40 per cent of total disabilities accepted by DVA as service-related. The 40 per cent figure is based on source data provided by DVA on 28 June 2011 to enable the ANAO to validate DVA's reported mental health figures. The 30 per cent figure is based on subsequent DVA advice of 31 May 2012, which has not been validated.

1.3 In 2007–08, Australian governments collectively spent $5.1 billion on mental health, representing 7.5 per cent of total government health spending.[91] As shown in Figure 1.1, $142 million was for DVA mental health programs and initiatives.[92] By 2009–10, DVA's expenditure on mental health was estimated to have risen to $160 million. In addition to DVA-funded services and programs, DVA clients can access mental health services funded by Medicare Australia or private health insurance.

Figure 1.1

Distribution of recurrent spending on mental health, 2007–08



Source: ANAO, based on the Department of Health and Ageing *National Mental Health Report 2010*.

1.4 When the direct cost of service provision is taken into account, as well as the indirect costs of lost productivity, workforce non-participation and morbidity resulting from suicide, the overall cost of providing services to people affected by mental illness in Australia is estimated to be almost

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91 Department of Health and Ageing, *National Mental Health Report 2010: Summary of 15 Years of Reform in Australia's Mental Health Services Under the National Mental Health Strategy 1993–2008*, Canberra, 2010, p. 2.

92 The *National Mental Health Report 2010* records that DVA provided the following information in respect of its mental health-related expenditure in 2007–08: private hospitals $27.9m; public hospitals $22.6m; consultant psychiatrists $17.1m; Vietnam Veterans' Counselling Service (salaries, contracted providers and programs) $21.2m; pharmaceuticals $34.8m; private psychologists and allied health $1.5m; general practitioners $14.3m; and Australian Centre for Posttraumatic Mental Health $2.7m. Available from: <http://www.health.gov.au> [accessed 7 February 2011].

$20 billion a year.[93] Despite the substantial investment by all governments in mental health care in the past 10 years, it is estimated that around 65 per cent of Australians with a mental illness do not access support services[94], and this figure is likely to be higher for the ADF and ex-service communities because of their military training[95] and the stigma which can surround mental illness within Defence culture.

1.5 The profile of the Australian veteran and ex-service community has changed over the years with the decline in World War II, Korean War and war widow populations and the emergence of a growing younger cohort. The younger veteran[96] cohort includes the estimated 50 000 Defence personnel deployed across the globe since the East Timor deployment in 1999[97], which marked the beginning of a heightened operational tempo by the ADF that continues to the present day. Between 4000 and 6000 ADF personnel discharge each year, most of whom are relatively young—the average age of separation for officers is around 34 years, and 27 for other ranks. Many of these young members will have been deployed several times and more than half are married or in long term relationships, and also have children.[98] Using DVA's standard definition of younger veterans (those aged 45 years and less),

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93 National Advisory Council on Mental Health, *Discussion Paper: A Mentally Healthy Future for all Australians*, Canberra, 2009, p. 8. Available from: <http://www.health.gov.au> [accessed 7 February 2011].

94 Senate Committee Report, *The Hidden Toll: Suicide in Australia*, The Senate, Community Affairs References Committee, June 2010, Canberra, p. *xiii*, available from: <http://www.aph.gov.au> [accessed 22 May 2011].

95 ADF personnel are trained in resilience and coping skills to deal with the environmental challenges they face in both war and non-warlike deployments. This includes military training and exercises that can involve prolonged separation from family and social support networks and the hierarchical nature of the military culture. See: Hodson, SE, McFarlane, AC, Van Hooff, M, & Davies, C, [2011], op. cit., pp. 138–139.

96 The ANAO uses the term veteran for ease of reference in the report and consistency with DVA's terminology. The ANAO notes, however, that younger members of the ADF and ex-service communities have reported that they do not necessarily identify with this term.

97 The Hon. Warren Snowdon MP (Minister for Veterans' Affairs), Address to RSL National Congress, Media Release, 20 September 2011, p. 5. Available from: <http://minister.dva.gov.au/media_releases> [accessed 22 September 2011].

98 ibid., p. 3.

3748 had a mental health condition accepted by DVA[99], with many more receiving mental health treatments or remaining undiagnosed.

1.6 The members of this younger cohort have demonstrated different needs and expectations compared to their more elderly counterparts (who are the majority of DVA beneficiaries), placing pressure on DVA to adapt its programs and services.[100] In particular, they: can be hard to engage and may have a sporadic relationship with DVA; desire increased access to benefits and services online; and expect services to be more streamlined and address their immediate needs.

1.7 The mental health environment in which DVA operates is complex and challenging, with the mental disorder profile and service usage of members of the ADF and ex-service communities differing from that of the mainstream mental health population.[101] These differences relate to the unique demands of military service and culture, and the changing profile of the veteran community.

Delivery of mental health services to veterans

1.8 Responsibility for delivering mental health services in Australia is shared across governments, and community and private sector providers. The Department of Health and Ageing is the lead agency responsible for implementing and managing Commonwealth mental health care policies and measures. At the national level, mental health care and services are informed by the Council of Australian Governments' framework for mental health care in Australia. The strategy is working towards a mental health care system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the

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[99] ANAO analysis of DVA data, as at 28 June 2011. However, this figure is understated because it does not include all DVA clients with a DVA accepted mental health condition, or receiving mental health treatments.

[100] Department of Veterans' Affairs, *Annual Report 2009–10*, Canberra, p. 14. Available from: <http://www.dva.gov.au/aboutDVA/publications/corporate/annualreport> [accessed 13 April 2011].

[101] Department of Veterans' Affairs, *Mental Health Update Report*, 2008, p. 8.

community.[102] Within the context of the national framework, DVA provides programs and services to support the mental health and wellbeing of members of the ADF and ex-service communities.

Department of Veterans' Affairs

1.9 DVA is part of the Defence portfolio and is responsible for developing, implementing and administering government policy and programs to fulfil Australia's obligations to the veteran and ADF communities. The department's day-to-day activities are directed by two Commissions—the Repatriation Commission and the Military Rehabilitation and Compensation Commission. Established in 1917, the Repatriation Commission is responsible for providing support to veterans under the *Veterans' Entitlements Act 1986* (VEA) and delegates its powers to DVA to grant pensions and benefits, and provide treatment and other services to eligible clients. The department's formal role of supporting the Repatriation Commission has evolved over the years to meet the needs of subsequent generations of veterans. The Military Rehabilitation and Compensation Commission was established in 2004 to support the more recent generations of serving and ex-serving members, and their families.[103]

1.10 DVA also administers the Veterans and Veterans Families Counselling Service (VVCS), which is a specialised and free counselling service for eligible ADF members, veterans (and their families) for service-related mental health conditions.

1.11 DVA's client population is made up of several broad cohorts, each with their sub-groups and special needs. These populations include: aged World War II veterans, and war widows/widowers; Korean War veterans; Vietnam veterans; peacekeepers, reservists and the younger ADF and ex-serving members (and their families).[104]

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[102] Department of Health and Ageing, *National Mental Health Policy 2008, National Mental Health Strategy*, 2009, p. i.

[103] Department of Veterans' Affairs, *Annual Report 2009–10*, p. 22.

[104] The Hon. Warren Snowdon MP, Minister for Veterans' Affairs, 'Address to RSL National Congress', Media Release, 20 September 2011, p. 2. Available from: <http://minister.dva.gov.au/media_releases> [accessed 22 September 2011].

1.12 In 2011–12, the department's Budget appropriation was $12.2 billion, of which $5.2 billion was targeted to maintaining and enhancing the physical wellbeing and quality of life of eligible veterans and their dependants through health and other care services. More than $6.4 billion was allocated for compensation and income support.

Audit objective, criteria, scope and methodology

1.13 The objective of the audit was to examine the effectiveness of DVA's administration of mental health programs and services to support younger veterans.

1.14 The focus was on DVA's administration of mental health care programs and services in the context of the mental health policy objectives and implementation plan set by government, to determine the extent to which these provided accessible and appropriate support to younger members of the ADF and ex-service communities. In particular, the audit examined the extent to which DVA has:

- established an effective management framework to provide mental health services to younger veterans;
- informed and supported younger members of the ADF when transitioning to civilian life;
- engaged with key stakeholders to support the provision of integrated and accessible mental health services for younger veterans;
- developed and implemented programs to identify younger veterans at risk and/or with complex needs who require intervention; and
- developed and applied effective systems to monitor and report the performance of mental health programs.

1.15 The audit did not assess the quality of clinical information and services provided by DVA.

Audit methodology

1.16 To form an opinion against the audit objective, the audit team:

- examined a wide range of DVA documentation and mental health data, including DVA Commission and Ministerial submissions, operational policy, program guidelines and departmental advice, current research, and program reviews and evaluations;

- interviewed key personnel at DVA's national and state offices;
- consulted with key stakeholders, such as serving and former members of the ADF, staff in the ADF, peak health bodies, ex-service organisations, and relevant mental health experts;
- assessed the adequacy of DVA's service provision across Australia; and
- examined the capacity of DVA's systems to monitor, report and evaluate mental health performance activities.

1.17 The audit was conducted in accordance with the ANAO's auditing standards, at an estimated cost to the ANAO of $650 781.

Structure of the report

1.18 The structure of the report reflects the audit criteria outlined in paragraph 1.14. Accordingly, there are five further chapters, as outlined in Table 1.1.

Table 1.1

Structure of the report

Chapter 2 Framework for Providing Mental Health Services	Examines the framework for providing mental health services to younger members of the ADF and ex-service communities with mental health conditions.
Chapter 3 Supporting Younger Members to Transition to Civilian Life	Examines DVA's support for younger members discharging from the ADF and resettling in the community.
Chapter 4 Engaging with Key Stakeholders	Examines DVA's engagement with key stakeholders to support the provision of integrated and accessible mental health services for younger members of the ADF and ex-service communities.
Chapter 5 Targeted Support to Vulnerable Clients	Examines DVA's administration of mental health care programs and support tools targeted to the needs of vulnerable clients or those with complex needs, particularly younger members of the ADF and ex-service communities.
Chapter 6 Integrity of Mental Health Data	Examines the integrity and reliability of DVA's mental health data to identify younger members of the ADF and ex-service communities with mental health needs.

Source: ANAO.

2. Framework for Providing Mental Health Services

This chapter examines the framework for providing mental health services to younger members of the ADF and ex-service communities with mental health conditions.

Introduction

2.1 As discussed in Chapter 1, the national mental health strategy sets the directions of the Australian Government's framework for mental health care in Australia. DVA's mental health policy is positioned within this national strategy and guides departmental planning and the delivery of mental health services to improve mental health care for serving and former members of the ADF and their families.[105]

2.2 The ANAO examined the effectiveness of the mental health framework to support the mental health and wellbeing of younger members of the ADF and ex-service communities, including:

- DVA's mental health policy and strategic directions; and
- DVA's definition of 'younger veterans'.

DVA's mental health policy and strategic directions

2.3 In November 2000, the Repatriation Commission endorsed the adoption of the DVA mental health policy framework, *Towards Better Mental Health for the Veteran Community*. This framework was developed for the purposes of: guiding the future planning and delivery of mental health care and services to DVA clients; and improving mental health care for serving and former members and their families, through a collaborative approach with DVA's key partners—such as the Departments of Health and Ageing and

[105] Department of Veterans' Affairs, *Towards Better Mental Health for the Veteran Community*, Mental Health Policy and Strategic Directions, January 2001, p. 2.

Defence.[106] The policy was released in 2001 and was positioned in the context of the 1992 National Mental Health Strategy framework.[107]

2.4 In keeping with the 1992 national mental health reforms, DVA's mental health policy had a key focus on the population level—that is, early intervention, prevention, and mental health literacy, as well as better equipping the 'first point of contact' such as general practitioners and allied health providers, while strengthening other levels of mental health treatment.[108] DVA's 2001 policy remains the department's key mental health policy statement in 2011–12.

2.5 Since DVA's policy was released, there have been significant developments within the national mental health strategy[109], emphasising the need for: better coordinated and integrated programs at the individual, community and system levels; improved monitoring and surveillance of people with mental health conditions; and development of short and long term outcome measures and indicators (to enable comparisons to be made with the prevalence of mental health in the Australian community).[110]

2.6 DVA's 2001 mental health policy reflected the changing profile of the veteran community at the time. The policy was underpinned by 1997–98 data that is now out of date, which focused on the future needs of Vietnam veterans, considered to be the 'younger' cohort at the time, and whose accepted mental health compensation claims then accounted for 55 per cent of

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[106] ibid.

[107] The strategy has guided a changing national mental health reform agenda over time, reflecting the evolution of mental health policy in Australia. See: Department of Health and Ageing, *National Mental Health Report 2010, Overview of the Strategy*, available from: <http://www.health.gov.au/internet/publications> [accessed 3 April 2012].

[108] Department of Veterans' Affairs, *Overview of mental health arrangements*, 21 January 2011, p. 2.

[109] The national mental health policy has evolved since 1992, particularly with the introduction of service standards and the routine monitoring of consumer outcomes. In 2008, the strategy was extended through a new policy that promotes an integrated, whole-of-government response to the improvement of mental health care services through the Council of Australian Governments National Action Plan (the COAG action plan).

[110] COAG, *National Action Plan on Mental Health, 2006–11*, July 2006. DVA is not currently in a position to report against the outcomes agreed by all Australian governments under the national mental health strategy.

new DVA cases.[111] With the passage of time and Australia's involvement in operations almost continuously since East Timor in 1999, a new generation of young members has emerged, whose needs are not explicitly addressed in DVA's 2001 policy.

2.7 While not explicitly recognised in DVA's mental health policy, much of the department's approach to mental health care has been driven by the needs of this recent generation, many of whom have been deployed in the past decade.[112] DVA has either commissioned or responded to research in addressing the needs of this group. Of particular note, DVA mental health reforms announced in the 2006–07 Budget were designed to improve access to preventative and community-oriented mental health care, particularly for the younger veteran cohort, by providing: a greater level of shared mental health care coordination between GPs, the VVCS, allied health providers and the ADF; improving mental health literacy and awareness, through communication, education and awareness strategies; and increasing the use and awareness of VVCS services and implementing new VVCS programs specifically targeting younger veterans.

2.8 DVA has undertaken research and initiated evaluations of service usage by the younger cohort and other client groups which have found that implementation of initiatives has not been well-coordinated or integrated internally.[113] The implementation of change through a large number of small and fragmented programs that are not well targeted,[114] has been found to have limited reach and impact within the ADF and the ex-service communities, with the consequence that the mental health needs of young members and others have not been supported as fully as they could have been by DVA. Of

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[111] Department of Veterans' Affairs, *Towards Better Mental Health for the Veteran Community,* DVA, Canberra, January 2001, pp. 5–7. By June 2011, Vietnam veterans with accepted mental health disabilities accounted for approximately 30 per cent of DVA's total mental health treatment population.

[112] Many of the members aged in their twenties and early thirties are most at risk of having a mental disorder. Most will serve in the ADF for around five years and be in the high risk groups when they discharge, and may not have visibility with DVA. See: Hodson, SE, McFarlane, AC, Van Hooff, M, & Davies, C, [2011], op. cit., pp. 5, 24. The importance of DVA better understanding and more effectively responding to the needs of the younger cohort was documented in DVA's corporate documents, including its Strategic Plan, as early as 2002–03.

[113] Australian Centre for Posttraumatic Mental Health, *Evaluation of the Department of Veterans' Affairs Mental Health Initiatives 2007–2010*, Final Report, December 2010, pp. 9, 75, 79, 108 and 110.

[114] ibid, pp. 108–110.

particular note, the evaluation of the 2006–07 Budget initiatives found that many DVA business areas are involved in mental health activities—such as program development, delivery and data management—but they are uncoordinated internally and in their external delivery[115], and the combination of these factors is limiting the programs' impact and effectiveness.

2.9 DVA has informed the ANAO that the release of the ADF's new mental health strategy in 2011 provides the opportunity for the department to update its own mental health policy in 2012.[116] Further, DVA advised of a substantial restructure of its administrative arrangements on 1 March 2012 that included the establishment of a dedicated Mental and Social Health Policy Branch that encompasses mental health review. The restructure is intended to improve the collaboration and integration of client services, with 'client-facing' functions brought together under the Client and Commemorations Division from that date. DVA is also trialling a Rehabilitation and Compensation Business Redesign, to enable the delivery of a more consistent, client-centric approach to service delivery, and to reduce the use of unwieldy, fragmented and complex multiple IT systems and business processes in the longer term.[117]

2.10 While DVA's recent restructure is intended to improve the coordination and integration of mental health initiatives and services, Figure 2.1 shows that many departmental business areas continue to have a direct or indirect involvement in mental health-related activities.

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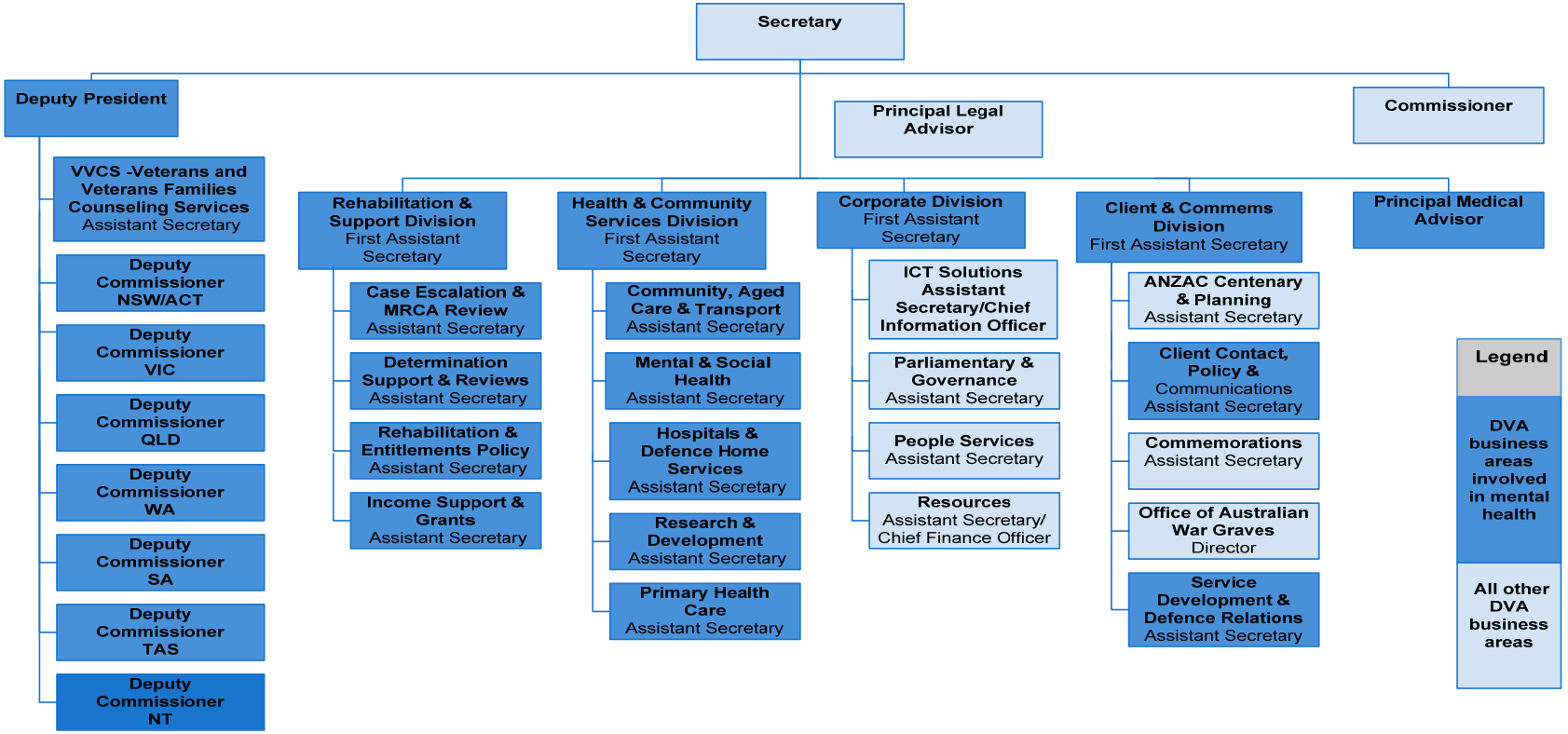
[115] ibid., p. 9.

[116] Department of Defence, *Australian Defence Force Mental Health and Wellbeing Strategy*, October 2011. DVA first advised the ANAO that its mental health policy was under review in December 2010.

[117] Department of Veterans' Affairs, (Acting Deputy President), *Organisational Change Narrative*, Canberra, 21 October 2011.

Figure 2.1

DVA business areas involved in mental health, March 2012



Source: DVA, March 2012.

The younger veteran concept

2.11 A key challenge faced by DVA is to effectively support a range of client groups with differing demographic characteristics, experiences and expectations.[118]

2.12 DVA has used the 'younger veteran' concept since at least 2001 to describe the cohort of 'Vietnam veterans and younger veterans' in the department's mental health policy, and to differentiate this group from the majority of its clients, who are ageing and elderly. However, most of the Vietnam veterans are now aged in their 60s and 70s and the 'younger veteran' concept is no longer a meaningful descriptor for this group.

2.13 The 'younger veteran' concept was subsequently applied in various forms to other veteran cohorts, in the post-Vietnam war period, and continues to be applied to the present day. DVA has defined younger veterans as those aged 45 years and less since 2005, in order to separately survey their satisfaction with departmental services, and to inform and tailor communications, interventions and services that better meet their needs.

2.14 Although DVA generally defines younger veterans as those aged 45 years and less, the department also uses many other definitions of younger veterans for various purposes, including in its Annual Reports to differentiate the younger cohort from previous wars:

> Younger veterans—A term used in the context of the ageing veteran population. While Second World War veterans are the majority of the DVA client base, the term 'younger veterans' can encompass veterans of more recent years, conflicts and peace operations from Korea to the present day.[119]

2.15 Applying this definition of 'younger veterans', the age of DVA's 'younger cohort' ranges from 17 to over 100 years, illustrating the difficulties of using relative terms such as 'younger' for policy and program purposes. DVA has recognised the methodological and practical challenges arising from the

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[118] These separate cohorts include, but are not limited to: young serving personnel (with some differences between officers and other ranks); peacekeepers; reservists; Vietnam veterans; partners; dependents; World War II veterans; Korean war veterans; and war widows and widowers.

[119] Department of Veterans' Affairs, *Annual Report 2010–11*, p. 385. The VVCS has also adopted its own various definitions of 'younger veterans', including less than 35 years and less than 50 years.

'younger veteran' concept, and is considering the use of a more flexible concept of 'contemporary' veteran group.[120] The new approach is intended to better capture and reflect the changed demographic of the ADF—including members with multiple deployments, the deployment of women, couples and reservists—and the newer generation of veterans, which DVA surveys indicate are more difficult to reach and harder to engage than previous generations.[121]'

2.16 While the concept of a 'contemporary' veteran or group may temporarily overcome some methodological issues, it too is a relative concept. Further, it does not differentiate between the younger and older members of the 'contemporary' cohort, whose ages may range from late adolescence to the mid-fifties.[122]

2.17 There would be benefit in DVA clearly identifying the various client cohorts, to strengthen its capacity to engage with the different client groups[123], and for the purpose of planning, identifying trends and undertaking comparative analysis with similar age cohorts in the community.

Recommendation No.1

2.18 To enable the development of communication and education strategies that effectively target and engage younger members of the ADF and veteran communities, the ANAO recommends that the Department of Veterans' Affairs defines the various cohorts in a way that meaningfully differentiates sub-groups, including by age and type of military service.

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[120] In the course of the audit, DVA advised that it is redefining the younger veteran cohort to the 'contemporary veteran group' to better capture all veterans from recent deployments including veterans of retirement age or recently retired. The description has yet to be formalised by DVA.

[121] Following lower levels of satisfaction with DVA services expressed by younger veterans in client surveys, they have been separately surveyed by DVA since 2005–06 and the results inform departmental policies, programs and improvements to service delivery specifically targeting younger veterans.

[122] In addition, a recent review of the VVCS service delivery model indicated the need for DVA to consider options other than the use of the term 'veteran' in its marketing and promotional materials, because younger members do not identify with the term. The review emphasised that the sensitivities related to the naming of the service and use of the term veteran cannot be underestimated. See: Belsham. S., & Associates P/L., Final Report, *Review of the Veterans and Veterans Families Counselling Service Delivery Model,* July 2010, p. 43.

[123] Australian Centre for Posttraumatic Mental Health, *Pathways to care in veterans recently compensated*, Creamer M, Hawthorne G, Kelly C, Haynes L, Melbourne, 2004, p. 114.

Department of Veterans' Affairs response: *Agreed with qualification.*

2.19 DVA has developed a range of communication and education strategies for clients, including those cohorts from contemporary era conflicts. DVA's On-Base Advisory Service is a recent example of how the department is engaging directly with ADF personnel at over 35 bases around Australia. This on base presence assists serving and discharging members find out about DVA services, including compensation, health services, rehabilitation and support. DVA also provides a range of online support, including for mental health, which may be found at www.at-ease.dva.gov.au.

2.20 DVA will continue to work on new platforms for communication and engagement, such as use of social media and phone applications in order to provide more effectively targeted information and support.

2.21 In terms of defining its client cohorts, DVA considers that definitions need to be multi-dimensional and tailored for the purpose intended. DVA currently targets its communications and program development activities according to the needs of clients. DVA's strategic plan also identifies a range of characteristics that describe the department's broad client base, including service experience, life stage, expectations, and interaction preferences with the department.

3. Supporting Younger Members to Transition to Civilian Life

This chapter examines DVA's support for younger members discharging from the ADF and resettling in the community.

Introduction

3.1 Separating from a career in the military is challenging, particularly for members discharging with complex mental health or other medical conditions. In recognition of the challenges, the government committed, in 2007, to improve access to whole-of-government transition-related services and implement a 'whole-of-life' framework, intended to support ADF members from enlistment through to their return to civilian life. Key priorities of the initiative included: a focus on mental health prevention and early intervention, especially for younger veterans; developing a better understanding of the pressures on young veterans transitioning out of the services[124]; and the need to be more proactive in providing the support and care required by younger members during the separation process.[125]

3.2 Many younger members, particularly those with mental health issues, find the transition process difficult to navigate and the DVA claims process (for health and other benefits) to be complex and overwhelming. Recent research reinforces the importance of transition support and services through meaningful engagement with all discharging members, and particularly the youngest cohort.[126] Table 3.1 summarises the key ADF and DVA transition services at 31 September 2011, designed to provide a seamless transition process and support for ADF members, during their separation from the military and readjustment to civilian life.

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[124] Retired Major-General John Cantwell, 'Transition is the most dangerous phase', *Lateline*, Australian Broadcasting Corporation, 17 April 2012, p. 5. Transcript available from: <www.abc.net.au/lateline/content/2012/s3479770.htm> [accessed 18 April 2012]. See also: Dodd, M, 'Troops face mental health risks', *The Australian*, 19 April 2012, p. 2.

[125] Rudd, K, Federal Labor Leader and Griffith, A, Shadow Minister for Veterans' Affairs, *Labor's Plan for Veterans' Affairs*, Policy Document, 2007, pp. 12, 22. Available from: <http//:www.alp.org.au> [accessed 20 August 2011].

[126] Hodson, SE, McFarlane, AC, Van Hooff, M, & Davies, C, op. cit.

Table 3.1

Key services for ADF members transitioning to civilian life

Entity	Service	Brief description of the service
ADF	Transition Support Services and ADF Transition Centres	The Transition Support Service aims to ensure a successful transition for all separating members and their families. Nineteen regional ADF Transition Centres assist members, and their families, to transition from Defence to civilian life by preparing the member for separation, as well as linking them into other support services such as relevant ADF programs, DVA, ComSuper and Centrelink.
	Integrated People Support Strategy (IPSS) whole-of-life framework[127]	The IPSS was developed in 2007, in recognition of the need to provide an enhanced transition support service and improve access to whole-of-life cross-agency transition-related services. Under the IPSS, enhancements were made by the ADF and DVA to separation processes, by streamlining transition-related services and strengthening linkages with other service providers.
DVA	Transition Management Service	The service aimed to facilitate a seamless transition process to medically discharging members to deal with the changes they would experience returning to civilian life, including prioritising their claims to be processed quickly so the member received DVA benefits in a shorter timeframe.
	Stepping Out program	The program is voluntary and aims to assist separating ADF members to successfully transition from the military culture to civilian life and is delivered by the VVCS.
	Lifecycle Transition Mental Health and Family Collaborative	The pilot of the *Lifecycle* Transition Mental Health and Family Collaborative in Townsville was completed during the audit in 2010–11 with outcomes to be announced in 2011–12.

Source: ADF and DVA advice.

3.3 To assess the effectiveness of DVA's support for younger members with mental health conditions discharging from the ADF and returning to civilian life, the ANAO examined:

- the whole-of-life framework for coordinating mental health services;
- the Transition Management Service;

[127] The initiative, then known as the Integrated People Support Model, was announced on 23 August 2007 in the CDF/SEC Joint Directive 08/2007, *Secretary and Chief of the Defence Force Directive on Support to Our Australian Defence Force Personnel*.

- the *Stepping Out* program;
- issues veterans identified as important; and
- monitoring and reporting transition performance and outcomes.

3.4 The ANAO assessed the effectiveness of the overarching whole-of-life framework to deliver seamless, cross-agency support to members, and the effectiveness of DVA specific programs in terms of: accessibility, visibility, promotion and coordination with other services.

Framework for coordinating mental health services

3.5 Several major reviews and research projects have significantly influenced the ADF's and DVA's current approach to transition and mental health-related services and support. These include two independent reviews in 2009 conducted by Professor David Dunt: the DVA *Independent study into suicide in the ex service community;* and the ADF *Review of Mental Health Care in the ADF and Transition through Discharge.* The reviews found that a seamless transition process is particularly important for ADF members discharging from the military for mental health or other medical reasons.[128] In the ADF review, Professor Dunt stated that a seamless transition:

> …is important for all ADF members, transitioning-out for medical reasons…Services should start as soon as possible after first notification of intention to discharge and should continue for a period well beyond discharge...It is important that these services provide information to members on the full range of services and benefits available to them...Members transitioning-out of the ADF with chronic mental health conditions have special needs beyond comprehensive provision of information.[129]

3.6 The ADF review was also the impetus for the Defence mental health reform agenda and new research in 2010 on the prevalence of mental health and wellbeing in the ADF, released in October 2011.[130] The new research identifies the youngest cohort as being particularly at risk of having a mental

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[128] Dunt, D, *Review of Mental Health Care in the ADF and Transition through Discharge,* 2009, p. 9.

[129] ibid., p. 19.

[130] Hodson, SE, McFarlane, .C, Van Hooff, M, & Davies, C, [2011] op. cit.

disorder—many of whom will leave the military 'without their disorder being diagnosed or treated'.[131] This research reinforces the importance of transition support and services to be well-coordinated and integrated, particularly for the younger members during transition. More recently, a former Major-General in Afghanistan indicated that we must do better to ensure the thousands of young returning Australian service men and women, particularly those directly exposed to combat and mortar fire, have access to the support and environment where they are able to request the help they need to get back to a normal life.[132]

3.7 Supporting affected younger veterans through the health system as early as possible (before discharge) is consistent with the Government's early intervention and prevention approach to mental health.[133] This approach is considered to be both efficacious and cost effective, as early intervention and treatment can reduce the severity of a mental health condition and the need for long term government support.[134]

3.8 As indicated in Table 3.1, the ADF and DVA have shared responsibility for the provision of transition services to members discharging from Defence to civilian life. Transition services are legislated within the *Military Rehabilitation and Compensation Act 2004*. The ADF is responsible for pre-discharge duty-of-care responsibilities and DVA is primarily responsible for post-discharge entitlements and support.[135] In practice, there can be considerable overlap between Defence and DVA in the delivery of transition services, to accommodate individual circumstances.

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[131] ibid., p. 25.

[132] Retired Major-General John Cantwell, 'Transition is the most dangerous phase', *Lateline*, Australian Broadcasting Corporation, 17 April 2012, p. 5. Transcript available from: <www.abc.net.au/lateline/content/2012/s3479770.htm> [accessed 18 April 2012]. See also: Dodd, M, 'Troops face mental health risks', *The Australian*, 19 April 2012, p. 2.

[133] Both the ADF and DVA mental health strategies recognise the importance of prevention and early intervention programs to assist in identifying and supporting members of the ADF and ex-service communities with mental health conditions as early as possible, and this approach is consistent with the *National Mental Health Policy* (and COAG Action Plan).

[134] Hodson, SE, McFarlane, AC, Van Hooff, M, & Davies, C, op. cit., p. 25 and Dunt, D, op.cit., p. 84.

[135] Department of Veterans' Affairs, *Review of Military Compensation Arrangements*, Volume Two, Report to the Minister for Veterans' Affairs, February 2011, p. 49. Available from: <http//:www.dva.gov.au> [accessed 23 August 2011].

3.9 Since 1999, DVA and the ADF have collaborated through a high-level Defence/DVA Links Steering Committee to consider and coordinate matters of shared strategic and policy concern for serving and ex-service members. This includes improving the support for medically discharging members and their access to transition services. In 2000, the Committee endorsed the introduction of the DVA Transition Management Service to assist members separating from the ADF for medical reasons, if they chose to avail themselves of the service.[136] DVA also expanded VVCS services and programs to eligible ADF serving members and their families to promote opportunities for joint ADF and DVA programs. These improvements were to be achieved through more seamless continuity of care, particularly for members separating on medical grounds and transitioning to DVA health care responsibility.[137]

3.10 The ADF implemented a new framework of coordinated services and support in 2007. It aimed to provide comprehensive individual services, with shared responsibility primarily between the ADF and DVA for the mental health and wellbeing of ADF and ex-serving members (and their families), enabling integrated cross-agency support throughout the member's life—from enlistment, throughout their career, during transition and post-discharge.[138]

3.11 Increased surveillance through support and care for young veterans during the transition process is a priority of the framework, as is improving links with other government agencies, particularly DVA, to ensure the smooth transition of case management services—including those relating to mental health conditions—for people transitioning from the ADF on medical grounds.[139] The involvement of families/partners throughout the ADF lifecycle, including all aspects of a member's transition and adjustment to civilian life, is

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[136] Departments of Defence and Veterans' Affairs, Joint Working Group Submission to the Defence/DVA Links Steering Committee, *Future Support to ADF Members,* Version 1.0, 5 February 2010, p. 2.

[137] Memorandum of Understanding, Department of Defence and the Department of Veterans' Affairs, *For a Strategic alliance in regard to counselling services by the Vietnam Veterans' Counselling Service to Australian Defence Force members and their families*, 2004, p. 1.

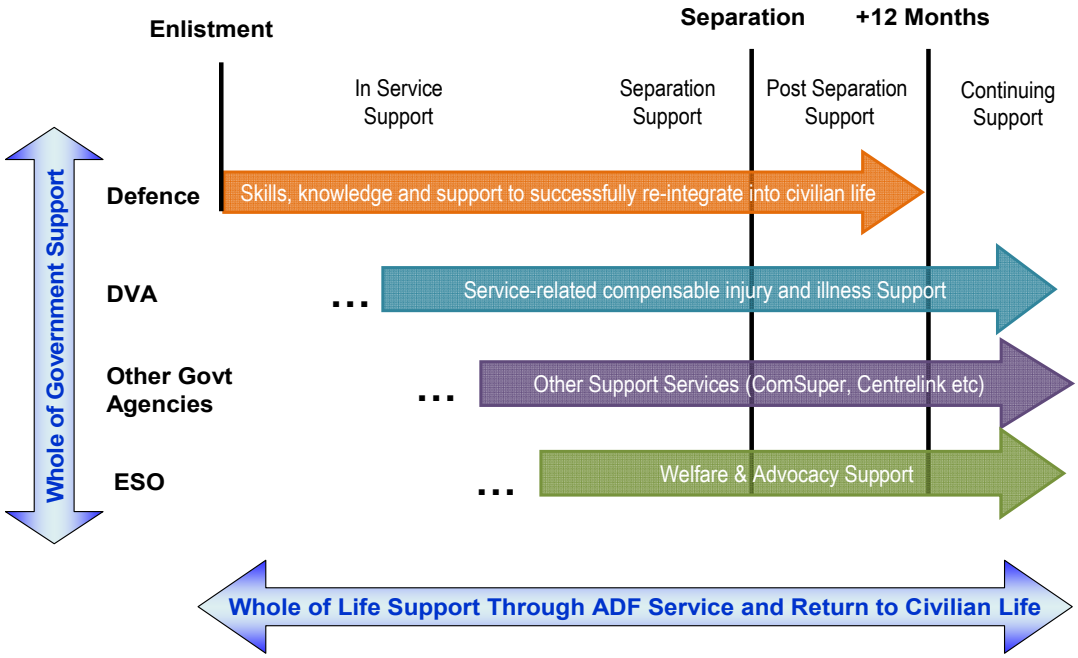
[138] ibid, pp. 2–5. The 2007 IPSS whole-of-life support model was still current in 2010, as illustrated in the Joint Working Group Submission to the Defence/DVA Links Committee in February 2010 approved by both agencies.

[139] Department of Defence, CDF I SEC Joint Directive 08/2007, Secretary and Chief of the Defence Force Directive on Support, 23 August 2007, p. 3. Also see: Department of Veterans' Affairs, *Mental Health Update Report*, 2008, p. 5.

important to the ongoing health and wellbeing of members beyond the military, particularly for members in high risk categories.[140] The IPSS whole-of-life support model is shown in Figure 3.1.

Figure 3.1

Whole-of-life-support for the ADF and veteran communities



Source: Departments of Defence and Veterans' Affairs, Joint Working Group Submission to the Defence/DVA Links Steering Committee, *Future Support to ADF Members*, Version 1.0, 5 February 2010, p. 6. The document identifies the foundations of the 2007 IPSS whole-of-life framework as an appropriate basis for the ADF and DVA to continue to manage transition services, rather than adopting an alternative model. It also identifies the need for enhancements to the framework to better meet contemporary circumstances.

3.12 While the whole-of-life framework has the potential to provide more complete mental health support to members its effectiveness is still to be realised as it has not yet been fully developed and implemented. In March 2012, roles and responsibilities had not been documented, and the framework

[140] This is consistent with the findings of the SIIP Review—Department of Defence, *Support for Injured or Ill Project (SIIP)*—Review of current practices, Final, v1.0, KPMG, December 2010, p. 3.

had not separately identified the VVCS even though it has a major role in improving younger members' access to preventative and community-oriented care and was to be a referral pathway for members transitioning from the ADF to civilian life.

3.13 On 7 January 2010, the Defence/DVA Links Steering Committee established a Joint Working Group to develop a future support model for ADF members. This led to major reforms being introduced by the ADF and DVA on 1 October 2011, to address service gaps for injured members identified in the review of transition services for medically discharging members[141] and research commissioned by the government.[142] The reforms included the implementation of the Support for Wounded, Injured or Ill Program (SWIIP), to support wounded, injured and ill members and a DVA on-base advisory service.[143] The SWIIP plan identifies key changes that are needed to achieve a more integrated and streamlined system, with the Defence and DVA system owners accountable for governance, implementation and performance (including performance measures and performance reporting). To implement the reforms, organisational commitment was required from Defence and DVA in the form of a renewed partnership.[144] However, as at March 2012, the milestones, reporting mechanisms and performance measures for SWIIP were still to be agreed, developed and documented, and DVA was still to develop reporting mechanisms and performance measures for its on-base advisory service.[145]

3.14 Documenting the operational framework for whole-of-life support would assist in: clarifying each agency's roles and responsibilities; reducing

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[141] Department of Defence, *Support for Injured or Ill Project (SIIP)*—Review of current practices, Final, v1.0, KPMG, December 2010.

[142] In particular, Dunt, D, *Review of Mental Health Care in the ADF and Transition through Discharge* and *Independent Study into Suicide in the Ex-service Community*, January 2009, and more recently, Hodson, SE, McFarlane, AC, Van Hooff, M, & Davies, C, [2011] *Mental Health in the Australian Defence Force—2010 ADF Mental Health Prevalence and Wellbeing Study*: Department of Defence: Canberra, 2011.

[143] There are more than 80 ADF bases Australia-wide and another 60 overseas. The DVA advisory service is provided on 35 bases assessed as having the greatest need.

[144] Departments of Defence and Veterans' Affairs, *Support for Wounded, Injured or Ill Program (SWIIP) Phase 2, Program Management Plan*, 24 February 2011, Version 0.9, Draft, p. 6.

[145] DVA advised in May 2012 that relevant performance measures would only be developed on completion of 20 projects launched as part of the SWIIP.

the risk of agencies operating in isolation or duplicating services; and helping members and their families to clearly identify which agency to approach and in what circumstances. In addition, jointly developed and well-targeted performance indicators would assist in monitoring and measuring ongoing cross-agency performance, and inform the achievement of outcomes.

3.15 Currently the ADF provides DVA with information about the number of members who exit Defence each year. This information is at a highly aggregated level and does not provide a basis for DVA to: understand the characteristics of its future client base; identify and monitor the groups most at risk and in need of support; and effectively plan future services modelled around the needs of the high-risk groups. To support DVA's communication and marketing strategies to effectively engage members in the high-risk mental health categories, there would be benefit in reaching agreement with Defence for the annual provision of de-identified exit data on issues such as the following:

- the service and deployment patterns of exiting members including their involvement in conflicts;
- the numbers of veterans who were medically discharged with a service-related mental health and/or other condition(s), and the pattern of their deployment;
- the numbers of members medically discharged with a workers' compensation mental health-related injury; and
- the pattern of mental health conditions and related treatments observed by Defence among the exiting members.

Transition Management Service

3.16 In 2000, DVA implemented a Transition Management Service (TMS) for full-time serving members separating from the ADF on medical grounds, under a service level agreement with the ADF. The initiative was established in recognition of the potential stress on ADF members and their families caused by unplanned medical separations.

3.17 The service aimed to provide a seamless transition process to affected members to help identify and deal with the changes they would experience returning to civilian life, by facilitating informed decisions about their transition including DVA entitlements and services.[146] The objective was a higher level of service from DVA for these members, including prioritising their claims to be processed quickly so the member received benefits in a shorter timeframe.[147] The cost of the TMS to the ADF under the service level agreement for the six years to 30 June 2010 was estimated to exceed $4.2 million.[148] The TMS ceased on 30 September 2011, and was followed by an on-base advisory service.

3.18 TMS coordinators (DVA staff) prepared a personal Transition Action Plan for each ADF member who chose to participate in the TMS, in order to identify the support the member could access for successful transition to civilian life. TMS coordinators provided services at major Defence establishments and worked closely with ADF areas administering member discharges. They also made home or hospital visits as required. A key benefit of this approach was early engagement and support for medically discharging members.

3.19 Unlike the compulsory attendance at ADF Transition Centres for all exiting personnel, the TMS was voluntary, although the ADF made some referrals.[149] Given its voluntary nature, the service needed to be well-marketed and promoted among ADF personnel to achieve high uptake, as it was left to the member's discretion to use the service. One indicator that the service was adequately marketed was that DVA met or exceeded its annual benchmark of

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[146] TMS aimed to provide assistance with: civilian employment options; compensation; superannuation; financial planning; transition adjustment issues; health insurance; and community support arrangements. However, the service only supported medically separating full-time Defence personnel, whereas the Defence transition centres provide support to all discharging Defence members (regardless of the circumstances surrounding their separation). See: Department of Veterans' Affairs, *DVA Factsheet MRC06, Transition Management Service*, updated 12 July 2010, previously available from: <http://www.dva.gov.au> [accessed 11 February 2011].

[147] Departments of Defence and Veterans' Affairs, Joint Working Group Submission to the Defence/DVA Links Steering Committee, *Future Support to ADF Members,* Version 1.0, 5 February 2010, pp. 17–18.

[148] The cost of TMS services could not be confidently determined, however, due to inconsistencies in, and incompleteness of, the data reported by the ADF and DVA.

[149] Defence advised that the Defence Transition Support Service process specified that every medically separating member transitioning through an ADF Transition Centre was to be referred to DVA's TMS.

600 completed Transition Action Plans each year from 2004–05 until 2009–10, when completed action plans fell to 433.[150] Conversely, an indicator that the service was not adequately communicated to those discharging from the ADF on medical grounds was the finding from DVA's 2010 survey of younger members that only 41 per cent (143 of 347) of members eligible for the TMS had accessed the service (as shown in Table 3.2).[151]

Table 3.2

Use of TMS by eligible younger members surveyed in 2010

Younger members survey, 2010	Total
Veterans surveyed	1028
Veterans identified as eligible for the TMS	347
Eligible veterans who accessed the TMS	143
Veterans who had accessed the TMS and found it very, or mostly useful	60%[A]

Note: (A) The survey found that 86 of the 143 eligible veterans who accessed the TMS found it very, or mostly useful (60 per cent).

Source: DVA, *Under 45s Client Satisfaction Survey*, 2010.

3.20 One means of better communicating the service would have been to reference it on the ADF website and in other relevant sources of transition information. The ANAO reviewed the ADF's Transition Support website in June 2011, and found no link or reference to the TMS on the site, or in the ADF Transition Handbook.[152] The ADF Transition Handbook (under Mental Health)

[150] Subsequently, in 2010–11, the annual benchmark was reduced to 400 Transition Action Plans, reflecting the ADF's increased focus on rehabilitation and retention programs.

[151] Stakeholder input to a review of mental health care and transition support in the ADF commented that transition services generally require greater promotion and support by commanding officers to be most effective. See: Department of Veterans' Affairs, Under 45s Satisfaction Survey, Final Report, June 2010, pp. 44–52 and Dunt, D, *Review of Mental Health in the ADF and Transition Through Discharge*, January 2009, p. 121.

[152] Department of Defence, *ADF Transition Handbook to assist ADF families with moving forward*, p. 58. Available from: <http://www.defence.gov/transitions/> [accessed 1 June 2011]. The only reference to DVA on the ADF Transition Support website was through the link 'who does what in the separation process' and this was limited to material on DVA entitlements and eligibility for treatment and compensation.

did link to some relevant sites, including the VVCS, but did not link to or mention the TMS or DVA's mental health sites and help-seeking tools.[153]

3.21 As also shown in Table 3.2, DVA's 2010 survey found that 60 per cent of the eligible younger members who had used the TMS considered the assistance provided to be very or mostly useful. However, 40 per cent had not reported finding the service so useful, which was consistent with other evidence acquired during the audit[154], and suggested that the quality and service delivery of TMS varied depending on location, and could have been improved overall.

3.22 While some limited feedback about the TMS was collected through DVA surveys of younger veterans, it was not possible to analyse whether the service was effective in expediting the claims of ADF personnel using the service as no mechanisms were in place to obtain direct feedback from members (and their families) about the quality of the TMS and related services and there were no performance measures in place for the TMS.

3.23 In summary, while the TMS was considered to be useful by younger members surveyed who had accessed it, the service could have been better communicated and promoted to members, both within the ADF and by DVA. In particular, there would have been merit in the ADF and DVA considering a jointly developed communications strategy to market this voluntary program with a view to improving take-up rates.

The *Stepping Out* program

3.24 DVA's *Stepping Out* program aims to assist ADF members to successfully transition from military service to civilian life. All separating or separated ADF members and their families/partners are eligible for the *Stepping Out* program from three months prior to discharge to 12 months after discharge. The *Stepping Out* program is free and voluntary and accommodates the different needs of separating members, who may be at different stages in

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[153] On 20 February 2011, DVA advised that 'the department is in discussions with Defence that will assist in ensuring that its website material can become better known to those who are discharged, before they are discharged—to ensure a continuity of use across the "lifecycle of service".

[154] Other evidence of the usefulness of the TMS included advice provided in interviews with TMS Coordinators and stakeholders, and ANAO analysis of selected Transition Action Plans that found considerable variability in the quality of the services to be provided.

the transition process. The program integrates mental health care across recruitment, service and transition, or discharge and rehabilitation. DVA, through the VVCS, manages the program and contracts out the delivery of *Stepping Out*.[155]

3.25 The initial pilot program implemented in Townsville in 2004 received a 95 per cent approval rating from participants. Following the success of the pilot, the program was expanded through a 2006–07 Budget measure—*Improving access to preventative and community-oriented mental health care for the veteran community, particularly younger veterans.* The Government committed $2 million over four years to expand *Stepping Out* to a national, ongoing program. In 2007–08, the *Stepping Out* program was finalised after extensive consultation between the VVCS and the ADF and was delivered through its new format in Townsville and Adelaide from 2008.[156]

Participation in the *Stepping Out* program

3.26 In 2009, the ACPMH conducted an evaluation of the program and concluded that the program 'appears to be reaching its intended target group of ADF members at different stages in the process of discharging'.[157] The ACPMH suggested the findings be further explored to refine and develop the program, as follow-up with participants three months later suggested that the intended effects of the program on the participant's ability to cope with transition were variable.[158]

3.27 The 2006–07 Budget funding allocation for *Stepping Out* was based on the provision of 100 courses to 1000 participants nationally each year, subject to the outcomes of an evaluation. The ANAO examined the number of *Stepping Out* sessions and participation levels over the four years of its national operation, as shown in Table 3.3.

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[155] The *Stepping Out* program was developed in consultation with the ADF and the Australian Centre for Posttraumatic Mental Health (ACPMH).

[156] Department of Veterans' Affairs, *Annual Report, 2007–08,* p. 107. Available from: <http://www.dva.gov.au/aboutDVA/publications/corporate/annualreport> [accessed 9 March 2012].

[157] Department of Veterans' Affairs, *Stepping Out Program, Evaluation of pilot program rollout,* ACPMH, September 2009, p. 5.

[158] ibid. The data could only give a preliminary indication of the short term effects of the program due to the low number of respondents at the time of the three month follow-up.

Table 3.3

Participation in the *Stepping Out* program, 2006–07 to 2009–10

Financial year	Budgeted sessions	Actual sessions	Budgeted participant numbers	Actual participant numbers
2006–07	100	No data	1000	No data
2007–08	100	7	1000	8
2008–09	100	24	1000	246
2009–10	100	36	1000	362
Total	**400**	**67**	**4000**	**616**

Source: ANAO analysis.

3.28 The *Stepping Out* program has not delivered the number of sessions or attracted the number of participants expected from the government funding. While the Budget provided for 400 sessions and 4000 participants in total over four years, only 67 sessions were delivered, involving 616 participants to 30 June 2010. This represents 17 per cent of the sessions funded and only 15 per cent of the expected participant numbers.[159] Moreover, participant numbers under the program were very low when compared to the number of ADF members discharging—between 4000 and 6000 annually.

3.29 A 2009 review found that *Stepping Out* was not well known by the ADF, could be better promoted and the focus of its marketing as a psycho-social program may be off-putting for some members.[160] While DVA has not further reviewed the program as part of an evaluation under the 2006–07 Budget measure[161], it considers that client satisfaction with this program is high and the low number of participants is due to a number of factors, particularly the voluntary nature of the program and the inclination of

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[159] The increase in the number of participants in 2008–09 and 2009–10 is due to the inclusion of partners and families in the program and its promotion to all exiting ADF personnel in the ADF transition seminars and the ADF's Transition Handbook.

[160] Dunt, D, *Review of Mental Health Care in the ADF and Transition through Discharge*, 2009, p. 22.

[161] The 2006–07 Budget measure included funding for an evaluation of most of the DVA budget initiatives progressively across the forward years. While DVA contracted the ACPMH to evaluate some of the initiatives between 2007 and 2010, the *Stepping Out* program (and other VVCS programs funded in the Budget) was not included.

discharging members to exit the ADF without attending such seminars and workshops, despite VVCS, DVA and ADF support and promotion.

3.30 In light of the low participation in the program and limited sessions delivered as compared to the budgeted targets and number of ADF members discharging each year, an evaluation of the national program is timely as a means of assessing its efficiency and effectiveness, including the promotional activities. An evaluation would also be consistent with the 2006–07 Budget funding requirements.[162]

3.31 In conclusion, stakeholder feedback was relatively positive about the *Stepping Out* program, and the evaluation of the pilot in 2009 indicated that the program appeared to be meeting its target audience. However, DVA was slow to implement and deliver the expanded program and while the number of program sessions and participants has increased each year since 2006–07, DVA is still only achieving a fifth of the number of program sessions and 15 per cent of participant numbers funded, four years into the program.

Recommendation No.2

3.32 In light of the low participation levels in the *Stepping Out* program, the ANAO recommends that the Department of Veterans' Affairs evaluates the efficiency and effectiveness of the program, including the program's marketing and promotional strategy.

Department of Veterans' Affairs response: *Agreed.*

3.33 *Stepping Out* is a free, two-day program developed for ADF members and their partners who are about to leave the military, or those who have recently done so. As a voluntary program, it is offered as an option that ADF members may undertake. The program is administered by the VVCS.

3.34 VVCS has previously identified that participation rates have been lower than anticipated. In response, VVCS has increased marketing of *Stepping Out* over the past three years, including presenting at all transition seminars and more broadly on key ADF bases, resulting in some growth in participation

[162] DVA advised that it has entered into discussions with Defence about conducting an evaluation of the *Stepping Out* program later in 2012.

rates. The new On-Base Advisory Service also provides an opportunity to bring this program to the attention of separating ADF members.

3.35 VVCS has already advised its intention to review *Stepping Out* in 2012 and this review will address the marketing aspects of the program and how these may be improved. *Stepping Out* is one of a number of transition support activities, and VVCS is liaising with the ADF to review *Stepping Out* in the context of these other activities. Terms of reference for this review are currently being drafted.

Department of Defence's response: *Agreed.*

3.36 *Stepping Out* is a DVA run program. Defence supports the availability of the program to ADF members and their families. Defence will collaborate with DVA in their evaluation of the program to assess the effectiveness of the program including marketing and promotion.

Issues veterans identified as important

3.37 The ANAO interviewed or sought the views of almost 50 veterans including representatives of ex-service organisations (ESOs), younger serving and ex-serving men, and some women and partners[163], regarding DVA's programs and services to support younger veterans with mental health issues. Veterans and members identified a range of issues but typically focused on transition as the most important issue, consistently citing the fragmentation of transition services and the absence of appropriate support to facilitate their readjustment and re-engagement with civilian life. The ADF and DVA transition services were considered to do little to ameliorate feelings of grief and loss often felt by younger veterans who had been discharged on mental health grounds.[164]

3.38 The younger veterans interviewed by the ANAO were unanimous in their views that once their mental illness rendered them medically unfit for military service, a lack of compassion for their circumstances and the speed of

[163] Some of the younger members interviewed had recently been medically discharged and some younger veterans reported up to six separate deployments.

[164] Similar views were expressed by the DVA case coordinators when describing the types of issues they are dealing with in case managing vulnerable DVA clients identified at risk and/or with complex needs.

their discharge left them feeling 'abandoned' and 'rejected' by the ADF.[165] Health professionals, DVA case coordinators and ESO representatives working with younger members expressed similar sentiments to the ANAO during structured interviews.

3.39 Mental health screening is an important tool in helping to identify ADF members in need of support and treatment after returning from deployments. While the veterans stated that they were willing to participate in post-deployment assessment and screening processes, they also reported that they were able to manipulate these by 'ticking all the right boxes' because at that stage they just 'want to get home'. A recent study concluded that these types of screening tools can miss the soldiers most in need of mental health treatment and that this is related to the stigma of reporting mental illness.[166] The difficulty in identifying the mental health conditions of serving ADF members, who may fear the implications to their careers if they are diagnosed with mental illness, emphasises the importance of DVA having systems in place to effectively communicate with and engage members after they have discharged from the ADF, as a means of supporting veterans with mental health conditions. More recently, a former commander of Australian forces in Afghanistan also drew attention to cultural and attitudinal factors which may inhibit ADF members seeking assistance for mental health conditions:

> What worries me though is that the vast majority of people coming home hide these problems. No one encourages them to hide them; it's built into the psyche of the young warrior. They don't want to admit weakness, and I expect that the inclination to cover this up, pretend you're OK, will be a continuing one as we bring our troops home from the Middle East.'[167]

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[165] These were the terms used by the veterans themselves during interviews with the ANAO.

[166] In addition, those most in need (who met the criteria for post traumatic stress disease or depression) were most uncomfortable in answering honestly and were significantly less willing to seek care because of the fear that it could affect their careers. See: Warner, et al., *Importance of Anonymity to Encourage Honest Reporting in Mental Health Screening After Combat Deployment*, Archives of General Psychiatry, 68, (10): 1065–1071, October 2011, pp. 1065–1068.

[167] Retired Major-General John Cantwell, 'Transition is the most dangerous phase', *Lateline*, Australian Broadcasting Corporation, 17 April 2012, p. 5. Transcript available from: <www.abc.net.au/lateline/content/2012/s3479770.htm> [accessed 18 April 2012]. See also: Dodd, M, 'Troops face mental health risks', *The Australian*, 19 April 2012, p. 2.

Monitoring, reporting and evaluating performance

3.40 Neither Defence nor DVA have developed an evaluation framework for the whole-of-life transition services. This includes the DVA on-base advisory service implemented when TMS ended.

3.41 The ADF conducts a survey of members three months after their discharge, as part of the ADF/DVA commitment to the ADF community, to identify the extent to which they have been supported by the transition support services implemented in 2008. The provision of information on support services, such as those provided by DVA, is one of the services surveyed.[168] However, the survey was not found to be effective in providing a snapshot of how former members are coping since their return to civilian life and whether or not successes or issues are related to transition support services provided in the lead-up to separation from the ADF, as only 69, or 3 per cent, of the 2284 ADF members discharged between 1 June and 31 August 2010 responded to the survey. Further, the survey was not a useful guide to elicit the views of younger personnel, as most responses were from retiring members who had served for 19 or more years, rather than younger veterans and members.

3.42 In February 2011, the *Review of Military Compensation Arrangements* identified the need for KPIs to be developed to measure the performance of the transition services implemented after TMS and beyond 30 September 2011.[169] While the ADF will develop agreed milestones, reporting mechanisms and a recommended model to monitor the performance of transition support for the new (SWIIP)[170], the review of compensation arrangements recommended that revised reporting arrangements should include comprehensive monthly performance reports on transition services to the Military Rehabilitation and Compensation Commission.[171] The government responded to the review of

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[168] Departments of Defence and Veterans' Affairs, *Transition success—A part of the Defence/DVA commitment to the Australian Defence Force community*, February 2007, p. 6.

[169] Department of Veterans' Affairs, *Review of Military Compensation Arrangements*, Volume Two, Report to the Minister for Veterans' Affairs, Canberra, February 2011, p. 50.

[170] SWIIP was announced by the Minister in August 2011 to support injured members with the full range of services during transition, as discussed in paragraph 3.13.

[171] Department of Veterans' Affairs, op. cit., February 2011, p. 50.

compensation arrangements in the 2012–13 Budget context, but the SWIIP milestones, reporting mechanisms and a performance model are yet to be agreed and developed.[172]

3.43 More broadly, there is no ongoing evaluation framework in place for any of the programs and services in the whole-of-life framework including DVA's on-base advisory service. An effective evaluation strategy would help to identify where the system requires strengthening to better support the younger members who are not necessarily visible to DVA when they leave the military, but are most at risk of discharging with an undiagnosed and untreated mental health condition.

[172] The government accepted 98 of the review's 108 recommendations and committed $17.4 million to implement them over the next four years.

4. Engaging with Key Stakeholders

This chapter examines DVA's engagement with key stakeholders to support the provision of integrated and accessible mental health services for younger members of the ADF and ex-service communities.

Introduction

4.1 DVA relies heavily on a range of partnerships with stakeholders—including the ADF, the ex-service community, health care providers and ex-service organisations (ESOs)—to communicate information and facilitate access to appropriate services for its clients, particularly those with mental health disorders, their families and carers. The Minister for Veterans' Affairs has recently highlighted the need for strategies to effectively communicate with serving, separating and former members of the ADF, and particularly to target these activities to the younger generation.[173]

4.2 To assess the effectiveness of DVA's engagement with key stakeholders to support the provision of integrated and accessible mental health services for younger members of the ADF and ex-service communities, the ANAO examined DVA's:

- stakeholder communication and engagement framework;
- engagement and education of the ADF and ex-service communities;
- engagement and education of the health care sector;
- self-help tools to improve mental health literacy; and
- VVCS communication strategies.

4.3 The ANAO's assessment had regard to the challenges reported by DVA in communicating with younger members. DVA's younger veteran satisfaction surveys have found that the younger cohort has different needs to the older client groups, and the department has acknowledged that the needs of

[173] The Hon Warren Snowdon MP (Minister for Veterans' Affairs), *New program to strengthen Defence families*, Parliament House, Canberra, 23 August 2011. Available from: <http://minister.dva.gov.au/media_releases/2011> [accessed 7 October 2011].

younger clients are not well understood.[174] That said, DVA's experience is that the following are the key characteristics of the younger group: the ADF is their chosen career and therefore they do not welcome unplanned and involuntary discharge; they have unknown and unmet needs; they are difficult to reach and hard to engage; many will experience multiple deployments; and they are generally not linked into the ex-service organisations or necessarily responsive to the department's traditional channels of communication, making them a difficult cohort to reach and engage.[175]

Stakeholder communication and engagement framework

4.4 DVA has a long history of engaging with ESOs and service delivery agencies, and more recently with health care providers. DVA's mental health policy provides a framework that guides the work of the department in relation to strengthening partnerships, working collaboratively and consulting with its key stakeholders in areas such as: health promotion and prevention activities; health education and awareness programs; and developing an information and awareness strategy. DVA's mental health policy looks ahead to the needs of future clients and peacekeepers for effective prevention and early intervention, and identifies a number of engagement strategies.[176] The 2006–07 Budget measure also included reforms to DVA's mental health communication activities, particularly for younger members of the ADF and ex-service communities, such as: developing an awareness and education communication strategy; and educating and training health service providers to improve younger veterans' access to mental health services.[177]

4.5 Effective communication channels are important because DVA's mental health policy area is focused on increasing the mental health literacy of various groups at the population level within the veteran community, rather than at

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[174] Department of Veterans' Affairs, *DVA's Strategic Plan 2010–15*, p. 10.

[175] In contrast, older cohorts such as World War I and II and Vietnam veterans were more likely to join ESOs, leading DVA to engage with ESOs as an effective vehicle for communicating with the ex-service community.

[176] Department of Veterans' Affairs, *Towards Better Mental Health for the Veteran Community*, Mental Health Policy and Strategic Directions, January 2001, pp. 1–21.

[177] The objective of the Budget measure was to improve access to preventative and community-oriented mental health care of the veteran community, particularly younger veterans.

the individual level. DVA advised that this approach is intended to improve the mental health literacy of the veteran community and their take-up of services.

4.6 Although DVA consults with, informs and elicits stakeholder feedback and input from the ADF and veteran communities through a range of channels, evaluations and reviews have found that DVA's communication strategies have not been effective in targeting specific messages to the different cohorts, both within the ADF and ex-service communities, particularly the younger cohorts. In this regard:

- an ACPMH evaluation found that DVA's mental health initiatives conducted between 2007 and 2010 had little impact for veterans and stakeholders, and proposed the establishment of communication pathways with clients and health providers that are well-coordinated internally and better targeted and tailored to each particular group[178];
- a 2011 study into the prevalence of mental health and wellbeing in the ADF identified the importance of DVA establishing systems to communicate with, and ensure visibility of younger members, many of whom will leave the military with an undiagnosed and untreated mental disorder[179]; and
- a 2010 review of the VVCS counselling service model identified the importance of increasing the profile of the VVCS within the ADF and developing a VVCS marketing and promotion plan that connects with the target audience, a key target being serving members in transition.[180]

4.7 DVA has acknowledged that it has difficulty engaging with some client groups such as the younger cohort and peacekeeper groups, but has not yet

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[178] Australian Centre for Posttraumatic Mental Health, *Evaluation of the Department of Veterans' Affairs Mental Health Initiatives 2007–2010*, Final Report, ACPMH, Melbourne, December 2010, p. 118. In particular, the evaluation found that communication materials and activities were uncoordinated across departmental programs, and this was reducing their impact. For instance, awareness of DVA's mental health activities was low among health providers and service users, particularly younger veterans, and communication needed to be better coordinated within DVA as well as better targeted to the different veteran groups.

[179] Hodson, SE, McFarlane, AC, Van Hooff, M, & Davies, C, [2011], op. cit., p. xxxii.

[180] Belsham, S & Associates P/L, *Final Report Review of the Veterans and Veterans Families Counselling Service Delivery Model*, July 2010, p. 42.

developed and implemented the communication, awareness and education strategies funded through the 2006–07 Budget for this purpose. This includes the development of a VVCS communication strategy for younger veterans, to increase their use and awareness of VVCS services. During the audit, DVA commissioned research to inform the design of a communications campaign to meet the requirements of the 2006–07 Budget measure and to better identify and target communication activities to the relevant cohorts.[181] However, the campaign was still to be developed in March 2012.

4.8 These aforementioned reviews have consistently emphasised the importance of DVA and the ADF closely collaborating on the development and implementation of a communication strategy aligned with the cross-agency, whole-of-life support framework (discussed in Chapter 3) for ADF members. A well-structured communication strategy would incorporate appropriate strategies and tailored messages, targeted to support specific cohorts within the ADF so that members are fully apprised of the various DVA entitlements and services available to them—while serving, during transition and post-separation.[182]

Recommendation No.3

4.9 To improve younger veterans' and members' awareness of the Department of Veterans' Affairs' mental health care services, the ANAO recommends that the department develops an appropriately targeted communication strategy in consultation with the Department of Defence.

Department of Veterans' Affairs response: *Agreed.*

4.10 In May 2012, the Secretaries of the Departments of Veterans' Affairs and Defence and the Chief of the Defence Force agreed key principles for delivering the best possible outcomes for all our members past and present, including communication with ADF members and their families.

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[181] Orima Research, Australian Government, Department of Veterans' Affairs, *A report on qualitative communications developmental research about mental health literacy*, 28 July 2011, p. 4.

[182] Working collaboratively and in partnership with the ADF to reach into the sub-groups within Defence may also assist in supporting greater uptake of transition, DVA on-base support services and the *Stepping Out* program. The VVCS could also play a greater role in improving younger members' access to preventative and community-oriented care, pre and post-discharge.

4.11 DVA has a diverse range of client groups including discharged and currently serving members of the ADF and family members with ages ranging from under one year to over 100 years. This means there are a range of different expectations and clients who interact with DVA in different ways.

4.12 Accordingly, the department will continue to expand its range of communication channels. This includes initiatives with Defence including the On-Base Advisory Service, as well as offering clients the option to undertake more of their dealing with the department online. These new channels are complementary and will not replace the traditional ways of communication, as veterans will still be able to contact the department via telephone, face-to-face, fax, email or mail.

4.13 On 1 March 2012, DVA established a Client Contact, Policy and Communications Branch. This will help focus DVA's continued efforts in developing communication strategies and materials.

Department of Defence's response: *Agreed.*

4.14 DVA and Defence have recently agreed to the synchronisation of strategic communications in support of veterans and members. Defence has identified, as part of the 2011 ADF Mental Health and Wellbeing Strategy, the requirement for a comprehensive communication strategy with specific messages targeting key population groups within the ADF. Defence recognises the benefits of a collaborative approach with DVA in the development, implementation and evaluation of a consistent and coordinated communication strategy that will inform ADF personnel on the range of mental health care available to them while they are ADF members and following their discharge from the ADF.

Engagement and education of the ADF and ex-service communities

4.15 DVA supports the work of ESOs through grants, training and information, and active engagement with them to provide veterans with appropriate care and support. ESOs provide a valuable, service to the veteran and ADF communities in relation to pension and compensation matters, as well as the provision of welfare support, referral and information. At the national and local levels, ESOs provide a link into the ADF and veteran communities through feedback and commentary on issues affecting current and ex-serving members and their families, including mental health issues.

4.16 The formal consultative framework of national and local forums in each state and territory was implemented to consult with all stakeholders as it relates to the operation of, and the dialogue between, the Repatriation and Military Rehabilitation and Compensation Commissions, DVA and the ex-service and defence communities. The framework is designed to better inform departmental policy and program development and enhance DVA's relationship with the veteran and ADF communities.[183] Several ESOs advised the ANAO that they appreciate the opportunity the forums offer but membership is restricted to the larger well-established ESOs. They suggested that the smaller and newer ESOs may have better links to younger members and be better placed to represent their views. There would be merit in DVA broadening the current membership of the forums, as appropriate, to incorporate newly emerging ESOs.

4.17 DVA has reported difficulties in engaging and meeting the needs of younger veterans, as have some of the ESOs. The ESO representatives are also ageing, and without the involvement of younger veterans the ability of ESOs to continue to provide the same level of support through voluntary activity is likely to diminish.

Training and support for ex-service organisations

4.18 The Training and Information Program (TIP) is a collaborative ESO and DVA program of welfare and compensation training. TIP provides authorised ESO practitioners[184] with training on pensions, welfare and advocacy, to facilitate the veteran community's access to compensation and other benefits administered by DVA.[185] TIP educates ESO representatives through structured training on the legislated compensation schemes and how claims are determined.

4.19 TIP is administered by National and State Committees under a charter to ensure a high standard of training and consistency with DVA requirements. The department supports ESOs for costs associated with improving the quality

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[183] Department of Veterans' Affairs, *Annual Report 2009–10*, pp.14–18. Available from: <http://www.dva.gov.au/aboutDVA/publications/corporate/annualreport> [accessed 31 May 2011].

[184] ESO practitioners can be volunteers or paid practitioners.

[185] TIP Training Consultative Group (Victoria), *TIP training policy, 1 January 2011*, p. 1.

of claims, reviews and appeals, and for welfare work through the Building Excellence in Support and Training (BEST) grants program. To qualify for BEST grant funding, ESOs have to ensure that practitioners have undertaken the required TIP training so that their skills are up-to-date with developments in the repatriation system, the welfare system and in the use of electronic tools.[186] DVA advised that in 2011–12, it will provide approximately $2.67 million in core funding in BEST grants, and TIP funding of $1 million of administered monies plus $0.6 million for department funding.[187]

4.20 DVA approves the content of TIP training and the department advised that the TIP subject matter delivered by the states and territories is similar across locations with common learning outcomes. However, each state and territory develops its own course content and delivery can be variable across the country.[188]

4.21 DVA reviewed the advocacy and welfare services provided through BEST and supported by TIP in 2010. A key objective of the review was to ensure the program provides appropriate services for younger members in the future.[189] In this regard, the review team noted the low percentage of ESO representation for *Military Rehabilitation and Compensation Act 2004* (MRCA) claims submitted to the department[190], suggesting that younger veterans either do not record this information or are submitting their own claims.[191] While young members may attend the basic pensions and welfare TIP training, they often subsequently disengage.[192]

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[186] Department of Veterans' Affairs, *Review of DVA-funded ESO Advocacy and Welfare Services*, Final Report, December 2010, p. 18.

[187] Between the 2005–06 and 2010–11 financial years, 13 610 participants were trained under the TIP and more than 1100 courses were conducted.

[188] An important element of the welfare officer course was the development and delivery of TIP mental health modules by the VVCS. However, participation in the delivery of TIP training by the VVCS can vary across states and territories. In the case of Victoria, the VVCS is not involved in delivering any of the modules.

[189] Department of Veterans' Affairs, *Review of DVA-funded ESO Advocacy and Welfare Services*, Final Report, December 2010, p. 10. Available from: < http://www.dva.gov.au/DVASearchResults> [accessed 20 June 2011].

[190] ibid., p. 115. About 18 per cent of MRCA claimants for permanent impairment had used a representative, compared to 25 per cent of *Safety, Rehabilitation and Compensation Act 1988* (SRCA) claimants.

[191] Department of Veterans' Affairs, ibid., p. 41.

[192] ibid, p. 101.

4.22 Some ESO representatives acknowledged gaps in their knowledge of the DVA administered schemes, such as a limited knowledge of the more recent MRCA legislation, although the TIP National Chairman considered that the knowledge of ESOs is gradually improving in this regard.[193] A new and standardised TIP training package had been developed and was planned to be rolled out nationally in 2011–12[194], to further support ESOs by applying standardised training content regarding the legislated pension schemes and welfare issues such as mental health. However, DVA subsequently decided not to roll it out in 2011–12. A nationally consistent program of TIP courses, and more targeted training in areas of known skill deficit, will deliver more effective training.

4.23 DVA has been moving towards simplifying the claims system since 2007, through the introduction of a single claims process, and has conducted a small number of trials. Once implemented, this process may help reduce some of the interpretation issues for ESOs and DVA. There may also be merit in DVA taking steps to improve its monitoring of claims submissions and re-submissions for mental health benefits, as a means of identifying (and avoiding) delay in addressing individual cases[195] and identifying systemic issues that require further clarification in the TIP training material.

Engagement and education of the health care sector

4.24 DVA's mental health policy and the reforms announced in the 2006–07 Budget measure emphasise the need to improve access to integrated and community-oriented care, tailored to the needs of the veteran community, through a shared care model based within the primary health care sector.[196] DVA has sought to improve its communication with health providers by raising the profile of DVA and of issues involving the ADF and ex-service

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193 TIP National Chairman advice to the ANAO of 7 April 2011.

194 Department of Veterans' Affairs, ibid., p. 25.

195 The TIP review acknowledges this issue, recommending that DVA investigate and develop a quality assurance system to provide appropriate feedback on claims quality to advocates, ESOs and TIP Chairs. See: Department of Veterans' Affairs, ibid., p. 85.

196 Department of Veterans' Affairs, *Mental Health Policy and Strategic Directions*, 2001, p. 14.

communities, focusing on critical pathways and shared mental health care coordination.[197]

4.25 Research commissioned by DVA in 2004 found that 93 per cent of a sample of 669 veterans recently compensated by the department for a mental health disability had consulted a GP in the previous six months.[198] Accordingly, DVA has sought to develop programs and initiatives that directly engage and educate GPs and allied health workers, as these professionals do not generally have an awareness of veterans' health care issues because they tend to have few patients who are veterans.

4.26 Funding for shared care initiatives was the major element of a $19.7 million package in the 2006–07 budget for DVA to improve access to preventative and community-oriented mental health care (as discussed further in paragraph 4.45). Funding for shared care initiatives had an expected outcome of achieving a greater level of shared mental health care coordination between GP's, the VVCS, and allied health providers and the ADF (particularly for younger veterans).[199] DVA engaged the Australian General Practice Network[200] to develop initiatives for delivery through the Divisions of General Practice[201] and other GP networks. The ANAO examined two initiatives

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[197] Pagnini, D, '*Can Do' 2006–09 Final Evaluation Report*, May 2009, p. iii. Shared care emphasises the benefits of collaboration between local services to provide appropriate and coordinated access to the full range of care required. The participants necessary to give effect to this model include GPs, mental health professionals, community health workers, community pharmacists and other local non-government services.

[198] Australian Centre for Posttraumatic Mental Health, *Pathways to care in veterans recently compensated*, Creamer M, Hawthorne G, Kelly C, Haynes L, Melbourne, 2004, p. 3.

[199] Department of Veterans' Affairs, Explanatory notes for *Improving access to preventative and community–oriented mental health care for the veteran community, particularly young veterans*, 2006, p. 5. DVA was unable to advise of the allocation and expenditure for the shared care initiatives.

[200] The Australian General Practice Network represents a network of 111 local organisations (GP networks), as well as eight state and territory-based agencies. More than 90 per cent of GPs and an increasing number of allied health professionals and practice nurses are members of their local General Practice Network.

[201] The Divisions of General Practice are professionally led and regionally based voluntary associations of GPs that seek to provide professional support for GPs and to coordinate and improve local primary care services to achieve health outcomes for the community that would not otherwise be achieved on an individual GP basis.

designed to achieve a greater level of shared care coordination—*Can Do* and *Mind the Gap*.[202]

The *Can Do* initiative

4.27 DVA funded a veteran component of the government's *Can Do* national co-morbidity education and training initiative, with the aim of educating health professionals and community health teams about the needs of the veteran community. Improved linkages between GPs, the VVCS, drug and alcohol groups, and mental health sectors at the local divisional level were expected, providing longer-term benefits for consumers in the provision of improved pathways to care and shared care practices.[203]

4.28 The Australian General Practice Network developed and implemented *Can Do* for delivery across 17 targeted Divisions of General Practice. Networking workshops were used to build local knowledge and relationships with a view to reducing barriers between GPs, local allied health workers and the VVCS. The workshops attracted a variety of health professionals and groups, with a total of 3617 participants attending the workshops and 788 GPs attending the clinical education sessions.

4.29 The C*an Do* training was fully accredited and the total funding for the project was $1 137 546. DVA advised that overall, *Can Do* has made a major contribution to the provision of mental health care service for veterans in the primary sector. However, the ACPMH evaluation found that *Can Do* has not been implemented as intended in most locations, and was not a successful mechanism for: developing sustained interest in veterans within the peak Divisions of General Practice; and establishing relationships between the VVCS and Divisions of General Practice at the local level.[204] Further, the evaluation found that little evidence existed in the literature to indicate that increasing the knowledge and skills of health professionals through peak

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[202] The *Can Do* project was delivered through 17 of the 119 Divisions of General Practice, while *Mind the Gap* was delivered in 48 General Practice networks that included 19 Divisions of General Practice.

[203] Key outcomes sought included: the needs of young persons are understood and the stigma of working with those who have mental health and substance use co-morbidity is reduced; shared care arrangements are understood and strengthened; referral processes and protocols are identified; and care plans are streamlined.

[204] Australian Centre for Posttraumatic Mental Health, *Evaluation of Veterans' Affairs Mental Health Initiatives 2007–10*, December 2010, pp. 73–74.

health bodies (such as the Australian General Practice Network) is cost-effective when promoting issues that affect smaller population groups such as the veteran community.[205]

The *Mind the Gap* initiative

4.30 DVA also funded the Australian General Practice Network to develop and implement *Mind the Gap*—targeting training designed to raise awareness of the prevalence of physical and mental health co-morbidities[206] in patients and provide pathways to care, with GPs, practice nurses and other primary care professionals working in multi-disciplinary teams to manage such patients.[207] One of the four learning objectives of the workshops was increased awareness of, and confidence in, accessing local services and referral pathways for veterans, including the VVCS.

4.31 In implementing *Mind the Gap*, 48 GP networks around the country hosted 55 two-hour workshops between 2009 and 2010, as part of Phase 1 of the national rollout. Over 1000 health care professions attended, of which 252 were GPs, representing about 1 per cent of GPs in Australia.

4.32 An evaluation of the initiative concluded that the GP teams that participated in the workshops were more aware of the availability of specialised services and referral pathways for veteran groups and their families[208], including the VVCS. Reported outcomes included the accreditation of the training and further expansion of the project to a six-hour course by the Australian General Practice Network, which was subsequently accepted by DVA and is scheduled to be completed in 2012. DVA informed the ANAO that the workshops were 'very successful with a high number of participants and a geographical spread covering where veterans are located'.

4.33 To assess whether the workshops had influenced the rate of GP referrals to the VVCS, the ANAO reviewed the number of GP referrals to the

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[205] Australian Centre for Posttraumatic Mental Health, *Evaluation of the Department of Veterans' Affairs Mental Health Initiatives 2007–2010*, Final Report, ACPMH, Melbourne, December 2010, p. 13.

[206] Multiple health conditions are known as co-morbidities and may include physical and/or mental conditions.

[207] Australian General Practice Network, *Mind the Gap: a physical and mental health co-morbidity education and training package*, AGPN, Final Report, October 2010, p. 1.

[208] ibid., p. 4.

VVCS for the period 2001 to 2011. The analysis found that formal GP referrals to the VVCS dropped substantially (rather than increasing) in the years since the commencement of the workshops in 2009, in the case of both younger and older veterans, as highlighted in grey in Table 4.1.

Table 4.1

GP referrals to the VVCS, 2001–02 to 2010–11

Financial year	Veteran referrals—45 years and less	Veteran referrals—46 years or more	Total referrals
2001–02	5	12	17
2002–03	23	86	109
2003–04	23	50	73
2004–05	18	54	72
2005–06	13	64	77
2006–07	17	61	78
2007–08	19	56	75
2008–09	26	61	87
2009–10	15	38	53
2010–11	12	40	52
Total	**171**	**522**	**693**

Source: ANAO analysis.

4.34 DVA could not fully account for the small number of GP referrals but advised that underreporting was likely because GPs would not formally refer clients, as there was no clinical or financial imperative, and instead would informally advise clients to access the VVCS (which is not recorded by the VVCS).

4.35 The first phase of *Mind the Gap* cost around $433 000, while the second phase has a budget of around $737 000 and is scheduled for completion in 2012.[209] The ANAO findings indicate that it may be unrealistic to assume that education and networking initiatives will readily translate to outcomes such as additional referrals by GPs to the VVCS. There would be merit, therefore, in

[209] The identified outcomes for the second phase are similar to the first and include attendance, health provider coverage, workshop satisfaction, increased knowledge and relevance.

DVA assessing the likely outcomes of the Phase 2 deliverables and training for the *Mind the Gap* program in future evaluations.[210]

Self-help tools to improve mental health literacy

4.36 The internet is playing an increasingly significant role in the delivery of self-help treatments for mental health disorders[211], with trials showing that web-based tools can be effective in areas such as 'anxiety disorders, phobias and post traumatic stress disorder', and some trials have found good results for major depression.[212] DVA's survey results of the satisfaction of its younger veterans consistently reveal that they have higher expectations of DVA services, particularly in relation to the delivery of services electronically.[213]

4.37 The ANAO examined three DVA websites—*The Right Mix, At Ease* and *Touchbase*.[214] The ANAO's analysis focused on the visibility of the websites, including the: level of usage, particularly by younger members; number of site visits; and the length of time users spent on the site, indicating whether the site was meeting their needs. The cost of providing these websites was around $5 million in total from 2001 to 2011, as indicated in Table 4.2.

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[210] This approach would be consistent with the views of the ACPMH, which found health providers' awareness of DVA information and resources was poor, which 'warrants further exploration around the quality of their materials, their dissemination strategy, and the needs of their provider community'. See: Australian Centre for Posttraumatic Mental Health, *Evaluation of Veterans' Affairs Mental Health Initiatives 2007–2010*, ACPMH, Melbourne, December 2010, pp. 76—78.

[211] Andersson, G, 'Will the Internet change the way we access psychology therapy?' Australian Psychological Society, Media Release, Melbourne, 29 September 2005. Available from: <http://www.psychology.org.au/news/media_releases/29sep2005/> [accessed 3 August 2011].

[212] Australian Psychological Society, *Will the internet change the way we access psychological therapy*? 29 September 2005. Available from: <http://www.psychology.org.au> [accessed 3 August 2011].

[213] Ipos-Eureka Social Research Institute, *Department of Veterans' Affairs Under 45 Satisfaction Survey, June 2010*, p. 3.

[214] The ANAO was unable to audit DVA's *Wellbeing Toolbox* site as it was implemented during audit fieldwork as a pilot, which is not due for completion until mid-2012. The *Wellbeing Toolbox* is designed to be an online interactive tool designed to assist veterans, former defence force members and their families to identify any mental health concerns they may have, engage in self-care interventions and/or seek professional help as required.

Table 4.2

Cost of selected DVA internet-based mental health self-help websites

The Right Mix	*At Ease*	*Touchbase*
$330 000 (per year)[A]	$993 475[B]	$800 000[C]

Notes: (A) The site has been provided since 2001. The cost includes printing of paper-based resources such as brochures, posters and guidelines.

(B) Part of the 2006–07 Budget measure. The cost includes paper-based resources and the development and start-up cost of the website. The current annual expenditure for maintaining and hosting the site is approximately $50 000.

(C) Suicide prevention funding in the 2009–10 Budget measures. The cost includes one-off development and start-up costs.

Source: DVA advice.

The Right Mix

4.38 *The Right Mix* website was launched by DVA in 2001. The project aimed to reduce alcohol-related harm in the ADF and veteran communities and promoted the message of 'low-risk drinking, a healthy diet and regular exercise'.[215]

4.39 The use of *The Right Mix* site was examined by the ACPMH in 2010, which found the usage by younger serving and ex-serving members was negligible, with 3–4 per cent of surveyed members reporting having used the site. DVA's younger veterans' survey results were lower, as less than 1 per cent of the 1028 veterans surveyed in 2010 had knowledge of, or accessed, this site.[216] The only recent exception to the recorded low levels of usage was in the lead up to Anzac Day in 2010, when a successful promotion strategy resulted in a significant increase in the number of site visits, from 800 in March 2010 to almost 10 000 a month later,[217] suggesting that communication and advertising are important aspects of any promotional activity.

At Ease

4.40 As part of DVA's commitment to improving the mental health literacy of the veteran community, the *At Ease* website was launched in May 2008. A

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[215] Department of Veterans' Affairs, *Annual Report 2006–07*, p. 109. Available from: <http://www.dva.gov.au/aboutDVA/publications/corporate/annualreport> [accessed 3 August 2011].

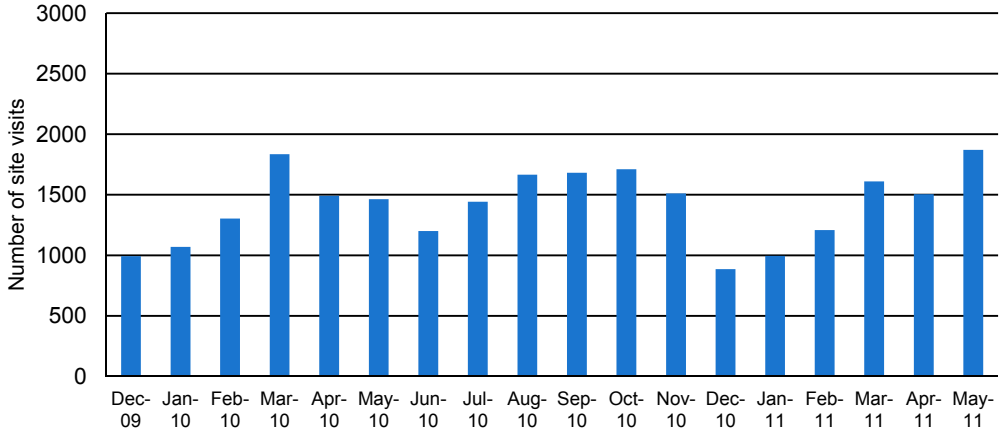
[216] Ipos-Eureka Social Research Institute, op. cit., p. 76.

[217] Department of Veterans' Affairs, *Annual Report, 2009–10*, p. 173. Available from: <http://www.dva.gov.au/aboutDVA/publications/corporate/annualreport> [accessed 3 August 2011].

key target group of the site is younger veterans returning from deployment to civilian life and beyond. The ANAO examined the site's usage where data was available, and identified 25 446 site visits from December 2009 to May 2011 (an average of 1414 per month), as shown in Figure 4.1.

Figure 4.1

Use of *At Ease* website



Source: ANAO analysis.

4.41 This relatively low 'hit rate' is consistent with the results of the ACPMH evaluation, which found awareness and use of these mental health sites (and materials) among veterans and other stakeholders is generally low because DVA clients 'just don't know about them'. The ACPMH evaluation found that less than 3 per cent of any DVA client group surveyed has used the *At Ease* website to find mental health information, but considered that the website 'would appear to have the potential to be a useful resource for DVA clients and the veteran community if there was greater awareness of it'.[218]

Touchbase

4.42 The *Touchbase* website was developed and implemented in response to the recommendations in the Dunt 2009 suicide study, which identified the

[218] Australian Centre for Posttraumatic Mental Health, *Evaluation of Veterans' Affairs Mental Health Initiatives 2007–10*, December 2010, p. 115.

need for a 'keeping in touch' program for young veterans following their separation from the military, as a means to help identify emerging mental health problems and ensure their early management.[219] The website covers a wide range of topics from jobs and hobbies to health and wellbeing, and allows veterans to establish an online community.

4.43 The *Touchbase* pilot was launched in December 2010. For the initial five-month period examined by the ANAO (December 2010 to May 2011), there were 13 560 site visits, averaging 2260 visits per month. The average time that users remained on the site was two minutes. While it was too early in the site's implementation to assess its effectiveness, these early results suggest the effectiveness of the *Touchbase* site may be similar to *The Right Mix* and *At Ease* sites.

4.44 In summary, DVA has designed a number of websites to meet the mental health needs of younger veterans and others, but they have had low rates of usage.[220] As proposed by the ACPMH, there would be merit in DVA reviewing its internet strategy for mental health literacy and support to better understand whether there is an unmet need in some of its client groups, and consider the lessons learned in the broader Australian health system to help avoid duplication of effort 'for minimal additional benefit.[221]

Veterans and Veterans Families Counselling Service communication strategies

4.45 In 2006–07, DVA received $19.7 million over four years through the Budget process to improve access to preventative and community-oriented mental health care for the veteran community, particularly younger members. More than a third of the funding ($6.5 million) was allocated for reforms to be directly administered by the VVCS.[222] The funding mainly related to

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[219] Dunt, D. *Independent Study into Suicide in the Ex-service Community*, January 2009, p. 17.

[220] DVA advised that these websites were established for a niche audience and were not intended to have the mass appeal of mainstream sites such as *beyondblue*.

[221] Australian Centre for Posttraumatic Mental Health, op. cit., pp. 9, 81, 109, 110 and 131. The ACPMH suggested that DVA adopts a clearly articulated communication strategy rather than taking a one-off approach to the range of materials available to support departmental initiatives.

[222] The VVCS also incurred costs in jointly providing Budget funded initiatives but DVA could not quantify the extent of these costs.

communication and education strategies, skills training and awareness-raising initiatives targeting younger members and health providers.

4.46 The ANAO examined five VVCS initiatives that were intended to improve communication and awareness of younger veterans' mental health issues and services. Table 4.3 outlines the initiatives and their specified outcomes.

Table 4.3

VVCS 2006–07 Budget initiatives to improve communication and awareness of younger veterans' mental health issues and services

Initiative	Expected outcomes
Improved shared mental health care coordination between GPs, the VVCS, allied health providers and the ADF	By 2007–08, VVCS should be well-placed to continue to support GPs without the need for veteran specific training. By 2008–09, the framework will be implemented into VVCS policy and procedures and will be a part of standard VVCS business. Effective management of the increased number of referrals to mental health services by GPs.
Increase awareness of VVCS services among younger veterans	Increase awareness of VVCS services among younger veterans. Evaluation across three forward years
Expand the Heart Health program to younger veterans	Additional four programs a year with 10–15 younger veterans in each.
Develop, implement and evaluate the Heart Health Correspondence Program	Estimated outcomes: • 2006–07—150 participants • 2007–08—200 participants • 2008–09—250 participants • 2009–10—300 participants
Facilitate access to videoconferencing infrastructure for VVCS clinical staff and rural and remote clients	Al least 500 sessions as shown in Table 4.4.

Source: ANAO.

4.47 The ANAO's analysis found that it was not possible to conclude that any of the VVCS initiatives examined had achieved their stated outcomes. While this was due to a lack of documentation about program implementation, measurement or evaluation in two instances (relating to the younger veterans Heart Health initiatives), the other three initiatives clearly had not been fully implemented or effective, largely because they were not sufficiently well-tailored to engage their target clientele.

Shared mental health care coordination

4.48 The shared care approach is designed to coordinate service delivery by health professionals, in order to deliver a more integrated system of care for individual members and veterans who often have multiple health conditions. It involves the development of an appropriate framework of protocols and referral systems to build and support a greater level of shared care practices and networks at the local level.[223] In the 2006–07 Budget, DVA (the VVCS) was funded to: achieve a greater level of shared mental health care coordination between GPs, the VVCS, allied health providers and the ADF; and to develop a framework of protocols, referral systems and quality assurance processes that support health providers, the VVCS and the ADF. The VVCS was to be the hub for a regional shared care model, linking with 'regional mental health teams, GPs, specialists and tertiary organisations'.[224] All of the shared care projects were to be independently evaluated under a framework that was to 'refer to the evaluation framework for the COAG agenda'—however, the VVCS Budget initiatives were not evaluated.[225]

4.49 The ACPMH evaluated other broad areas of activity of the Budget initiatives implemented by DVA between 2007 and 2010, such as mental health education and awareness activities for health providers.[226] Although the VVCS was excluded, the evaluation report states that it was not possible to exclude the influence of VVCS activities, one of which was to support a greater level of shared mental health care coordination between the VVCS, the ADF, GPs and

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[223] Department of Veterans' Affairs, *New Policy Proposal—Young Veterans Branch and VVCS Branch, Explanatory Notes*, DVA, Canberra, 2007, p. 13.

[224] Department of Veterans' Affairs, *Mental Health Update Report*, 2008, Attachment D.

[225] ibid.

[226] Expected outcomes of the shared care measure included: the development of a framework to support health providers, the ADF and the VVCS that was to be integrated into VVCS procedures so that shared care coordination practices, networking and local practices became standard VVCS practice; and by 2007–08 the VVCS was to be well-placed to support GPs without the need for ongoing veteran-specific education and skills training for health providers. See: Department of Veterans' Affairs, *New Policy Proposal—Young Veterans Branch and VVCS Branch, Explanatory Notes*, DVA, Canberra, 2007, pp. 5, 12 and 13.

health providers.[227] The ACPMH found very little evidence of improved mental health care coordination and integration of service delivery for members of the ADF and ex-service communities between the VVCS and other stakeholders identified.[228]

Younger veterans communication strategy

4.50 The 2006–07 Budget measure included the development of a communication strategy to increase the awareness and use of VVCS services among younger veterans.[229] Funding of $480 000 for the younger veterans' communication strategy was allocated to DVA for: developmental communications research; product design and development; focus testing of education materials; product promotion, distribution, revision and maintenance; and evaluation of the strategy to 2009–10.

4.51 DVA has not developed a VVCS communication strategy for younger veterans, but has implemented a range of national and local communication materials and initiatives funded by the 2006–07 Budget measure to increase veterans' mental health literacy, such as websites and fact sheets.

4.52 The ACPMH evaluated these initiatives between 2007 and 2010 and found that health providers were of the view that mental health literacy was 'quite poor' among veteran groups, particularly younger veterans.[230] The evaluation (and other research) shows that the differences between key demographic groups are such that they warrant separately targeted

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[227] Australian Centre for Posttraumatic Mental Health, *Evaluation of Veterans' Affairs Mental Health Initiatives 2007–2010*, ACPMH, Melbourne, December 2010, p. 8.

[228] ibid., pp. 66–67 and 75. The ACPMH evaluation did not include the VVCS but VVCS staff participated in the focus groups, and views were sought about VVCS linkages with other providers. The evaluation found little evidence to suggest that the shared mental health care coordination initiatives funded by the 2006–07 Budget measures had any impact within the health service system.

[229] Department of Veterans' Affairs, Explanatory notes, New Policy Proposal, *Improving access to preventative and community-oriented mental health care for the veteran community, particularly younger veterans*, Undated, p. 7.

[230] Australian Centre for Posttraumatic Mental Health, *Evaluation of the Department of Veterans' Affairs Mental Health Initiatives 2007–10*, Final Report, ACPMH, Melbourne, December 2010, pp. 48–49.

interventions for each cohort, if the communication activities are to successfully engage each group.[231]

4.53 In 2010, an independent review was conducted to provide advice on an appropriate service delivery model for the VVCS, given the changing demographics of the ADF and ex-service communities. This review found similar issues to those identified by the ACPMH evaluation of the 2006–07 Budget initiatives. These issues included the importance of the VVCS providing promotional materials that are highly relevant to, and connect with, the target audience.

4.54 The evaluation also saw merit in DVA developing and implementing a marketing plan to improve the visibility of the VVCS for the different cohorts, including younger members and to raise its profile within the ADF. With respect to the ADF, the review found that:

> …targeted marketing strategies best fitted to the lifestyle and demographic characteristics of the cohort…requires high level collaboration with the ADF to tailor and reach this group prior and post transition.[232]

Expansion of the Heart Health program to younger veterans

4.55 The Heart Health program was established in 2000[233] and designed to address health issues identified in the 1999 Vietnam Veterans Health Study, which reported that veterans were three times more likely than a comparable group in the community, to rate their health as poor.[234] ACPMH evaluated the program in 2010–11 and found that it is very popular among the participants, and improves veterans' mental and physical health not only in the short term,

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[231] ibid., p. 109. Also see: Belsham, S & Associates P/L, *Final Report Review of the Veterans and Veterans Families Counselling Service Delivery Model*, July 2010 and Hodson, SE, McFarlane, AC, Van Hooff, M & Davies, C, [2011] op. cit.

[232] Belsham, S & Associates P/L, *Final Report Review of the Veterans and Veterans Families Counselling Service Delivery Model*, July 2010, p. 42.

[233] The Heart Health program is contracted out by the VVCS and is offered in both group and outreach program formats and provides a program of structured physical exercise.

[234] The program currently consists of two physical exercise sessions per week for 52 weeks as well as 12 health seminars.

but also in the long term, for many participants.[235] DVA advised that it spent $166 914 on the Heart Health program between 1 July 2006 and 31 May 2011.

4.56 The 2006–07 Budget expanded the Heart Health program to include four additional programs a year that specifically targeted younger veterans. The cost of the additional programs in 2006–07 was $480 000 over four years and targeted 10 to 15 younger veterans a year. However, DVA has not been able to identify whether the expected outcomes for the program were achieved because it does not separately identify the younger veterans program within the general Heart Health program. DVA advised that it 'believes that the measure has at least been partially implemented and targeted'.

Heart Health correspondence or outreach program

4.57 The 2006–07 Budget measure included the development and implementation of a Heart Health outreach program, which enabled veterans living in rural and remote areas to access the program by correspondence and telephone-based support and advice. Funding of $900 000 was provided for service delivery over four years based on an estimated number of participants each year, starting at 150 in 2006–07 and increasing to 300 by 2009–10, achieving 900 in total over the four years.[236]

4.58 Although DVA identifies the correspondence program's performance within the Heart Health performance report, as with the younger veterans Heart Health program, the expected outcomes from the 2006 Budget could not be determined and overall participation fell by 55 per cent over three years, from 43 256 in 2006–07 to 23 716 in 2009–10.

4.59 Continuation of the correspondence Heart Health program in the 2006 Budget was subject to the outcome of ongoing evaluation across each of the four years funded. While the ACPMH did an independent evaluation of the Heart Health program in 2010–11 to assess its effectiveness to improve veterans' health outcomes[237], the evaluation did not separately identify and

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[235] Australian Centre for Posttraumatic Mental Health, *The Effectiveness of the VVCS Heart Health Program on Improving Veterans Health,* Final Report, February 2011, p. 6.

[236] In addition, $74 000 was provided for product promotion, evaluation and the development of self-help correspondence materials.

[237] Australian Centre for Posttraumatic Mental Health, op.cit.

comment on either the outreach/correspondence program or the younger veterans' Heart Health initiative, funded in the 2006 Budget.

4.60 DVA advised that it 'believes that the Heart Health correspondence program was implemented, although take up was significantly less than estimated, and was well-targeted for those who participated'.

Facilitating access to videoconferencing

4.61 A further initiative in the 2006–07 Budget measure was an expanded range of mental health care resources available to veterans and serving ADF members at the self-care, primary and secondary care levels. As part of this measure, DVA received funding of over $540 000 over four years to facilitate access to videoconferencing infrastructure for VVCS clinical staff and clients in rural and remote areas, to improve access to counselling support where no local services are available.[238] Funding for this initiative was based on the estimated number of sessions across the forward years. The ANAO examined the number of video counselling sessions delivered by the VVCS between 2006–07 and 2010–11, as shown in Table 4.4.

Table 4.4

Video counselling sessions delivered by the VVCS, 2006–07 to 2010–11

Financial year	Estimated number of sessions funded	Actual sessions delivered	ANAO comments
2006–07	80	Nil	No activity.
2007–08	120	Nil	No activity.
2008–09	150	4	DVA developed a videoconferencing pilot project to trial the program. Sydney and Perth sites were selected for the trials.

[238] Department of Veterans' Affairs, Explanatory notes, New Policy Proposal, *Improving access to preventative and community-oriented mental health care for the veteran community, particularly younger veterans*, undated, p. 17.

Financial year	Estimated number of sessions funded	Actual sessions delivered	ANAO comments
2009–10	150	66	Video counselling services commenced in Sydney and Perth. Sites selected in New South Wales and Western Australia based on local need, viability and access to suitable community videoconferencing facilities. Evaluation of the pilot completed.
2010–11	Not determined	17	The service was progressively expanded to other selected regions across Australia and arrangements are reportedly in place in all states.

Source: ANAO analysis of DVA Annual Reports 2007–08 to 2009–10.

4.62 DVA's implementation of the initiative did not meet the expected outcome of at least 500 videoconferencing sessions as only 70 sessions were delivered over the four years funded. DVA advised that all the session funding provided in the Budget was spent on the purchase of videoconferencing equipment and the delivery of video counselling sessions.

4.63 GPs working with veterans in regional areas advised that video conferencing was unlikely to meet the needs of veterans and their families in many regional and rural areas in Australia. One of the GPs working in Darwin with a very significant veteran caseload suggested that other options such as Skype may be more efficient, effective and convenient because most veterans have a computer and wireless access in rural and remote areas.[239]

4.64 In summary, there has been an uneven history of implementation and evaluation in respect of the VVCS initiatives, suggesting that there would be merit in DVA undertaking a holistic stock take of progress to date, as a basis for assessing achievement against the outcomes identified in the original 2006–07 Budget measure.[240]

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[239] Skype may also be an effective option to help engage ex-serving members considered to be socially isolated and at risk.

[240] DVA also has a program logic framework that the department can utilise for future evaluations, designed by the ACPMH, in consultation with DVA's mental health policy area, for the evaluation of the 2006–07 Budget measure.

5. Targeted Support to Vulnerable Clients

This chapter examines DVA's administration of mental health care programs and support tools targeted to the needs of vulnerable clients or those with complex needs, particularly younger members of the ADF and ex-service communities.

Introduction

5.1 In May 2007, the Minister for Veterans' Affairs committed to developing a more proactive approach to managing the relationships between DVA and clients who are vulnerable, at risk and/or have complex needs.[241] This followed a Senate Estimates Hearing and a series of inquiries into the circumstances surrounding the suicide of an ex-service member in 2006, known as the Gregg Review.[242] The Gregg Review confirmed the need to simplify access and service provision for ADF members transitioning to civilian life and was the impetus for the government-initiated ADF review of mental health care and transition services in 2008[243], known as the Dunt review.

5.2 The Dunt review also complemented other work on mental health issues, including a study into suicide in the ex-service community, which had found that veterans face difficulties in submitting mental health-related claims and 'react negatively' to delays and setbacks—in the worst possible case this can manifest itself in self-harm.[244] DVA accepted 20 of the 21 recommended administrative reforms of the Dunt suicide study, including the assignment of

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[241] Standing Committee on Foreign Affairs, Defence and Trade, *Budget Estimates*, Thursday 31 May 2007, pp. 118–139.

[242] A three-part review series was conducted into the circumstances surrounding Signaller Gregg's death—an independent inquiry into Gregg's deployment and management of his transition/discharge arrangements; the handling of Gregg's DVA compensation claims and Comsuper's military superannuation benefits; and the whole-of-government approach to handling his case. Available from: <http://www.dva.gov.au/health> [accessed 17 January 2011].

[243] Dunt, D., *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009.

[244] Dunt, D., *Independent Study into Suicide in the Ex-service Community*, January 2009, p. 86.

experienced case managers for clients identified as being at risk and/or with complex needs.[245] In January 2010, DVA implemented the Case Coordination program, to case manage clients identified as being at increased risk of self-harm or harm to others, often with multiple complex needs.

5.3 DVA had already established, in September 2007, a Client Liaison Unit to provide a more holistic service to entitled clients identified as vulnerable and/or with 'querulous' or complex behaviours.[246] These clients struggle with DVA's traditional service delivery approach and the complex claims process, and can respond with behaviours such as frustration, anger or complete withdrawal.

5.4 To assess the effectiveness of DVA's approach to targeting mental health care and support to vulnerable clients with complex needs, particularly younger veterans, the ANAO examined DVA's:

- Client Liaison Unit; and
- Case Coordination program.

Client Liaison Unit

5.5 The Client Liaison Unit (CLU) identifies, manages and assists in interactions between the departmental business areas and vulnerable or demanding clients, but has no decision-making powers.[247] DVA business groups are expected to make substantial attempts to manage the client's behaviour before involving (and referring) the client to the CLU.[248] Activity levels vary from ongoing monitoring of individual clients, to daily complex interactions with clients. The CLU cost around $2.4 million to administer over the four years to 2011–12.

5.6 The CLU is not considered to be part of DVA's mental health programs because clients are accepted into the program based on their behaviour, not a mental health condition. However, DVA advised that the CLU is within the

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[245] ibid., p.17.

[246] Department of Veterans' Affairs, *Policy and Procedures Manual, Client Liaison Unit*, p. 42. DVA also identities eligible clients for this program using terms such as 'at risk' and clients with complex needs.

[247] Department of Veterans' Affairs, *Businessline*, Client Liaison Unit, 1 October 2007, p. 2.

[248] Department of Veterans' Affairs, *Businessline—1199641E, Revised CLU Referral Process*, May 2011.

department's 'mental health umbrella' because the difficulties reflected in clients' relationship with DVA may overlay acute mental health problems. In February 2012, around 30 per cent of CLU clients were from the younger cohort.[249]

Implementation and communications strategy

5.7 A project team was appointed to oversee all aspects of the CLU's development, and the role of the CLU was formally communicated to all DVA staff through a departmental Businessline (formal internal advice)[250] for the first four years of its operations. Apart from the Businessline, DVA was unable to provide a documented implementation plan or change management process for the timing, rollout or communication of the CLU. A more comprehensive CLU Policy and Procedures Manual was implemented in June 2011.

Identifying behaviours that may trigger a program referral

5.8 In 2008, DVA commissioned the Samson report to better understand the patterns of behaviour and risk indicators relating to vulnerable or at risk clients and used the report to inform their approach to identifying the potential cause of relationship breakdown between the client and DVA.[251] The CLU has used the Samson report as the basis for developing a predictive modelling system to help identify 'at risk' client behaviours.[252] The CLU Policy and Procedures Manual sets out the primary and secondary behaviours that may trigger a referral to the CLU; such as the client's behaviour, and/or where their interaction with the department is preventing DVA from providing a service or achieving a successful business outcome. The behaviours are summarised in Table 5.1.

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[249] On 15 February 2012, DVA advised that of the 73 CLU clients, 22 were aged 45 years or less, 33 were aged between 46 years and 59 years, and 18 were 60 years or older.

[250] Department of Veterans' Affairs, *Businessline*, Client Liaison Unit, 1 October 2007, pp. 1–7.

[251] Department of Veterans' Affairs, *Policy and Procedures Manual*, Client Liaison Unit, pp. 12–13.

[252] The Samson report continues to guide the work of the CLU, in identifying clients that may benefit from CLU support. The report suggests how the predictive behaviours can be effectively utilised across DVA business areas to improve service delivery and business outcomes through better understanding and more effective management of clients exhibiting certain behaviours. DVA acknowledges the importance of this approach as it moves towards a more client-centric approach to service delivery, but has not used the report beyond the CLU. See: Samson, D, *Predictive factors of risk and querulous/complex needs behaviours in the DVA*, July 2008.

Table 5.1

Behavioural characteristics that may trigger a referral to the Client Liaison Unit

Primary:	Secondary:
• threats of harm to self or others; • persistent escalation of issues; • manifest frustration resulting from complex multiple needs; and • threats or aggression requiring critical incident management.	• persistent intimidatory behaviour; • unresponsive to repeated attempts by DVA to request action; and/or • thwarting attempts by DVA to provide assistance; and/or • other (has to be specified)—this enables negotiation to occur—in the first instance at the Director level.

Source: DVA, *Policy and Procedures Manual*, Client Liaison Unit, pp. 12–13.

5.9 While primary behaviours require some intervention from DVA, they do not trigger an automatic referral to the CLU unless secondary behaviours are also present. Referrals have to be approved by a DVA business area at the Director level and are only made after substantial efforts have been made to resolve the issue with the client in the business area. Clients are referred to the program by DVA internal business areas only, although ESOs may alert the program to potentially eligible clients.

5.10 A new online referral and assessment tool is currently being developed for the CLU, based on the aDVAnce tool developed for the Case Coordination program.[253] DVA has advised that while the Case Coordination aDVAnce system is not reliable or user friendly, the CLU has modified this system to better meet the program's requirements.[254] As the single point of contact, the CLU establishes the client's needs and facilitates the delivery of DVA services through collaboration with the relevant business area(s). Figure 5.1 shows the accepted referrals by month across the life of the program to August 2011.[255]

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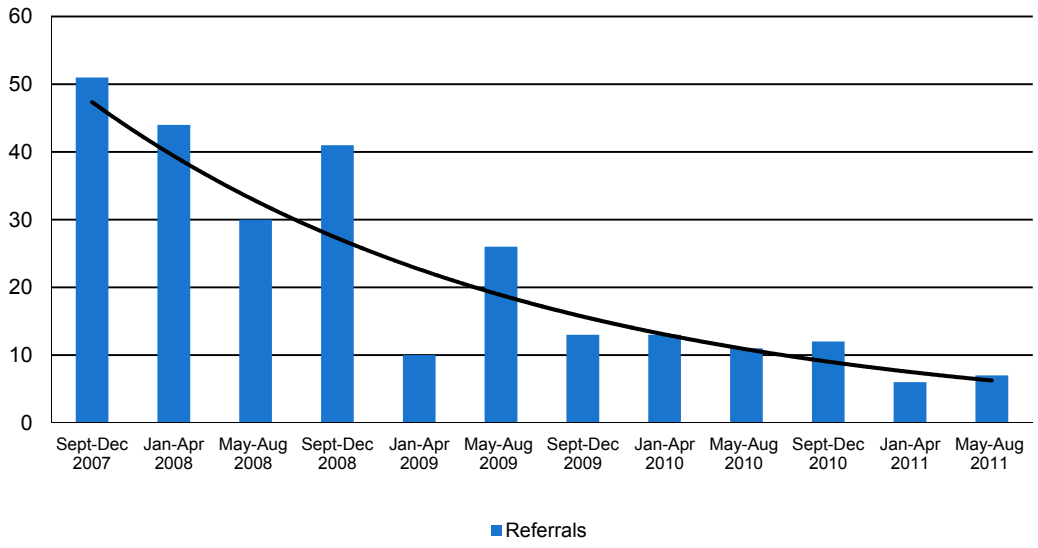
[253] aDVAnce is a software tool for service delivery environments, used to record and report on case managed clients in this instance.

[254] DVA advice of 8 September 2011 and confirmed in an internal audit of the post-implementation review of the Case Coordination program, September 2011.

[255] Of the total referrals, 168 did not have a referral date and could not be included in Figure 5.1.

Figure 5.1

CLU referrals from September 2007 to August 2011



Note: The exponential trend line shows referrals are trending downwards.

Source: ANAO analysis of DVA data.

5.11 Referrals have decreased substantially since the program's introduction in 2007[256], with referrals averaging 29 a quarter in 2008, 12 a quarter in 2009 and less than 10 a quarter in 2010. DVA advised that this is due to a number of factors, including that program staff are now more familiar with the program, closer adherence to the program's eligibility criteria, and the implementation of Case Coordination in January 2010. While referrals have decreased over the years, the number of clients under active management has increased significantly, from 47 in January 2011 to 77 in February 2012.

5.12 Once a referral is accepted by the CLU, the procedures require a notice to be placed on some of DVA's systems, alerting DVA staff of the CLU's involvement. However, not all DVA staff use or have access to the particular systems with the notice facility, which could result in a lack of awareness of a

[256] On 15 February 2012, DVA advised that 'at CLU implementation, DVA business groups were requested to nominate their clients whom they considered as vulnerable or with complex needs' suggesting that this explains the larger number of referrals at program implementation.

client's CLU status. This could place DVA's relationship with the client at risk if the client has expectations that the CLU is their single point of contact with the department. It also has the potential to undermine the CLU program as many CLU clients have complex issues in their lives and many already have a history of difficult relations with DVA (for a range of reasons). Given the role of the CLU—as a primary contact point to manage clients who have been identified as vulnerable with complex needs—it is important that the department implements a reliable facility on all relevant systems, supported by procedural controls, that alerts staff not to contact CLU clients directly unless authorised.

5.13 Overall, the CLU has been effective in managing clients with complex needs and whose relationship has broken down with DVA's core business areas, through a primary point of contact. External agencies such as the Commonwealth Ombudsman and the courts have publicly recognised and commended the benefit and support the CLU provides to clients. Nevertheless, the CLU would benefit from ongoing attention, focusing on its visibility within DVA, the appropriateness of referrals and ongoing evaluation. In addition, implementation of the draft performance indicators as well as a quality assurance program would further improve the administration of the program.

Case Coordination program

5.14 Whereas the CLU program manages clients whose relationship has deteriorated to the extent that business cannot be conducted through the traditional service delivery process, Case Coordination was implemented in response to the Dunt study into suicide in the ex-service community. As discussed in paragraph 5.2, under the Case Coordination program DVA identifies and case manages clients with complex needs who are at increased risk of self-harm or harm to others.

5.15 DVA was allocated $4.1 million in 2009–10 for the Case Coordination program over four years. While it was not possible to obtain the exact number of younger clients, most case coordinators advised that younger veterans (aged 45 years and less) represented around 50–60 per cent of their case loads.

5.16 Case coordinators provide case management support to clients who are identified and referred to the program—in most cases by Rehabilitation and Compensation staff processing compensation claims. Like the CLU, case coordinators are the primary point of contact for all of a client's DVA related business[257] and case coordinators do not exercise decision-making/delegation powers. Eligible program clients typically have a new or current compensation claim pending a decision, or the decision/claim is under review of some kind. However, clients at risk or with multiple physical injuries with no current claim or review may also be eligible for assistance under the program.[258]

5.17 The Case Coordination program began operating on 11 January 2010 with 14 staff located in small teams in Sydney, Perth, Melbourne and Brisbane. The ANAO examined the program's implementation in 2011 while it was still in the process of 'bedding down.'

Change management and communication

5.18 Successful program implementation relies on the commitment and support of those involved in its implementation, and this can depend on how well the changes are managed and communicated.[259] At the time of implementation, there was considerable guidance material available to DVA, including national case management standards and the lessons learned from the implementation of the CLU in 2007. In particular, the CLU had four years of operational experience managing vulnerable clients with complex needs. However, the CLU was not consulted in the planning or development of the Case Coordination program, and the extent to which the CLU experience informed the development of Case Coordination is not documented by DVA.

5.19 The ANAO assessed DVA's effectiveness in consulting with key internal and external stakeholders against the DVA communication plan developed for the Case Coordination project.[260] The communications plan set

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[257] Case coordinators have a case management role. However, due to concerns raised by health professionals, the positions are known as case coordinators to distinguish their role from case managers.

[258] Research shows complex and multiple physical injuries can lead to mental health issues.

[259] ANAO Better Practice Guide—*Implementation of Programme and Policy Initiatives*, October 2006, Canberra, pp.45–48.

[260] Department of Veterans' Affairs, *Communication Plan, RCG Case Coordination for At-risk Clients Project, Rehabilitation and Compensation Group, Version 2.0*, 4 February 2010.

out objectives relating to timing, targeting key stakeholders and key messages. In summary, none of the objectives set out in the plan were met, and the communications plan was rolled-out after the program commenced. The delay in communicating the new initiative and the absence of training of key personnel may explain the bulk referrals (240) to the program when it first commenced, most of which did not meet the program criteria.

5.20 The ANAO's interviews of claims staff from Rehabilitation and Compensation business units included questions about the effectiveness of the program's communication strategy to inform and market the program to key stakeholders.[261] Staff feedback indicated that the program would have been more positively received through more consistent communication and positive promotion to all DVA stakeholders with a role in the program.[262]

5.21 The lessons learned from the implementation process indicate that the late circulation of the communication plan resulted in gaps within DVA in the understanding of business processes and the roles and responsibilities of case coordinators.[263] Uncertainty over roles and responsibilities was reflected in the tension observed between some of the more senior Rehabilitation and Compensation staff (who provide the bulk of program referrals) and the case coordinators, in the course of the interviews conducted by the ANAO.[264] Both areas are required to collaborate on individual cases for the benefit of clients identified at risk and requiring the support of the program, and there would be benefit in DVA management improving the level of collaboration between the areas wherever possible. This would involve the two areas working together to reach agreement on goals, roles, responsibilities and strategies in regard to individual clients (as further discussed in paragraph 5.36).

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[261] More than 40 internal stakeholders were interviewed who are considered to be key to the success of the program including: the Rehabilitation Compensation & Systems Support National Manager; all 12 case coordinators and the program manager; claims decision makers/delegates working in incapacity, needs assessments, liability and determinations, rehabilitation, and registration; and some team leaders and line managers in these areas.

[262] On 15 February 2012, DVA advised that these issues were raised in the post-implementation review and action was in hand to develop a more comprehensive training strategy in relation to case coordination which will most likely consider staff outside case coordination.

[263] Department of Veterans' Affairs, *Dunt Case Coordination Project, Lessons Learnt Report version 1.0*, 6 January 2010, p.16.

[264] The September 2011 internal post-implementation review of the program also identified tensions between the two areas.

Program guidance and staff training

5.22 Advice to the DVA Executive dated 12 January 2010 was the key operational document guiding staff during the implementation and management of the program for the first 12 months of its operations. In December 2010, a more detailed Case Coordination Administration Policy and Procedural Manual was released in draft, and was still to be finalised early in 2011. Of the more than 40 Rehabilitation and Compensation staff interviewed by the ANAO four months after the release of the manual, very few were familiar with the manual or knew that it identified their role, and none had received training in the program or their own role. Program staff also raised concerns about the minimal training they had received. External staff recruited to the program advised that the initial two weeks induction training was very valuable but there was not enough time allocated to gain a sound understanding of the breadth of DVA's business, particularly the complexity of the legislated schemes and claims processes.[265]

5.23 As well as ongoing training, case coordinators indicated that they would benefit from more opportunities to share their expertise and experience with the rest of their team given the mix of skills and, most importantly, the nature of the program. A related issue raised during interviews of DVA staff was the lack of program training for the Rehabilitation and Compensation staff processing claims who provide the bulk of referrals to the program and whose role in identifying potential client behaviours is pivotal to the success of Case Coordination.[266] While some training has been provided to Rehabilitation and Compensation claims staff by case coordinators, it is important that all staff providing a service to clients are clear about their roles and responsibilities given the nature of the program.

5.24 There would be benefit in DVA reviewing the current approach to training, including refresher courses, to further support staff to identify and engage with vulnerable clients who may be at risk of self-harm or of causing

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[265] Case coordinators are the primary point of contact for clients whose claims are in this process and the coordinators need to understand the legislated schemes and processes.

[266] Claims staff reported that determining potential clients for case coordination is mainly through clients identified at risk of self-harm in medical reports but referrals can also be generated by oral threats of self-harm, or harm to family or others.

harm to others.[267] While the Employee Assistance Program is utilised by staff and reportedly effective, case coordinators also identified the importance of more structured opportunities to debrief, including with their colleagues.

Operational issues

5.25 Table 5.2 provides an overview of the five key steps in the Case Coordination process: referral and intake; assessment; wellness plans; monitoring and review; and follow-up and closure. This section examines operational issues arising at key stages in Case Coordination, focusing on data discrepancies that make it difficult to establish the total numbers of cases subject to Case Coordination, and the processes employed to insert system alert notices in relevant DVA systems to warn DVA staff of high risk cases.

[267] On 20 February 2012, DVA provided an outline of staff training in relation to awareness raising of the young cohort to increase the skills required by staff to respond appropriately. However, most of the training was online and passive. In 2010, the ACPMH recommended DVA 'should go beyond passive notification…there should be active engagement with staff to promote an understanding of the expectations that DVA has about mental health-related knowledge (including of relevant protocols and guidelines), attitudes and behaviours'.

Table 5.2

Case Coordination process

Referral and intake	• Most referrals from claims staff, triggered by risks identified in client medical reports or a threat against self/family/staff (the program only accepts internal referrals). • Client must be referred using the Referral Form, approved by a Team Leader and sent to the program manager for assignment to a case coordinator. • The client is contacted within five working days. The client is accepted (or declined) into the program within 10 working days. The referrer is notified by email of the decision to accept or decline the case. Program is voluntary. Client may elect not to participate (there is no monitoring of clients who refuse to participate). • If a case is declined, a system alert notice is put in VIEW and DEFCARE to re-refer should the client's circumstances change. • Urgent referrals are accepted immediately and escalated to the program manager.
Assessment	• Key criteria have to be met for a client to be considered at risk and accepted into the program, and additional criteria completed if applicable. • Client is accepted and assigned to a case coordinator. A system alert notice is put in VIEW and DEFCARE alerting staff of the program's involvement and contact details. • Formal assessment of client by case coordinator (interview and claims identified). • Case coordinator writes to client about the program and seeks their consent. Documented consent authorises the case coordinator to obtain and release client information to third parties.
Wellness plan	• All clients must have a wellness plan with agreed outcomes identified. • Case coordinators have no delegation powers and act as the navigator for all DVA services for the client and identify the relevant claim(s)/support streams. • Case coordinator collaborates with all staff (and health providers) via a case conference to identify outstanding issues, develop integrated solutions and agree to process and solutions. • Where possible case coordinator and client agree on mutually agreed goals in Wellness Plan that align with case conference agreed outcomes.
Monitoring and review	• Once the client successfully completes their goals, they are transitioned into the program monitoring phase for 12 months, with follow-up contact every 3 months. • The case coordinator monitors progress of clients' claims and services as well as client satisfaction and involvement with the process. • Wellness Plan revised if the need arises.
Follow-up and closure	• Case closure occurs at the conclusion of the 12 months monitoring phase providing the client has remained stable, or when a client's claim(s) is finalised. • Clients are placed in the program's follow-up phase and a management plan is developed. • If the need arises, the client may be referred back to the Wellness Plan phase.

Source: *DVA Case Coordination Administration Policy and Procedural Manual*, file reviews, staff interviews and DVA's *Post-Implementation Review of Case Coordination—2010–11 #30*.

Referral, intake and assessment

5.26 Key criteria have to be met, and additional criteria may also apply, for a referral to be made to the Case Coordination program.[268] DVA provided referral source data from the department's business intelligence reporting system for mental health and other statistics (Departmental Management Information System (DMIS)), for the period 11 January 2010 to 31 May 2011. However, the DMIS data did not reconcile with the data recorded in the program's case management system (aDVAnce), which recorded different numbers of total cases, declined cases and active cases (see Table 5.3).

Table 5.3

Case Coordination data discrepancies in DVA's systems

	Total referrals	Declined	Active
Data source			
DMIS January 2010–May 2011	697	257	440
aDVAnce report January 2010–May 2011	669	272	397

Source: DVA.

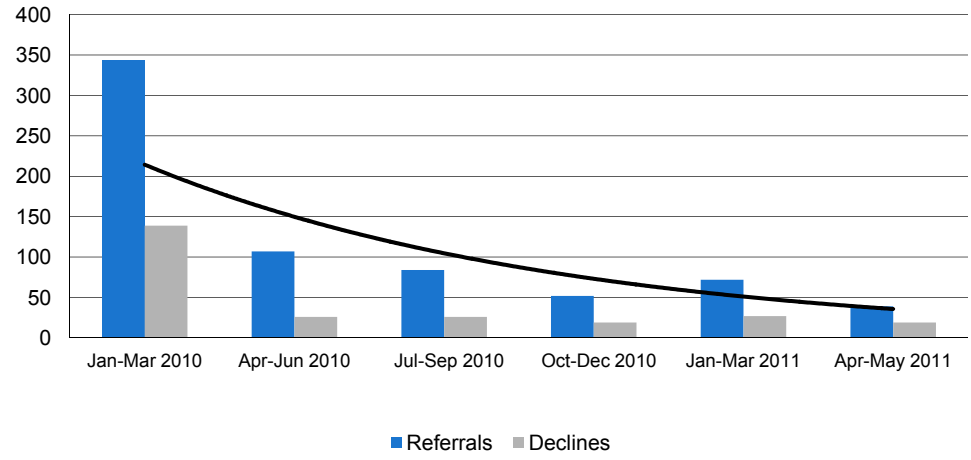
5.27 DVA could not explain the data differences in the two systems. However, the program area advised that it has to access daily aDVAnce reports to ensure the data is reliable and up-to-date. The discrepancy in the number of active cases reported in DVA systems is of concern because the department should be able to identify and report on the number of clients at risk (of harm to themselves or others) with complex needs.

5.28 As with the CLU program, there is a downward trend in relation to the number of clients being referred for case management. Figure 5.2 reflects the bulk referral of 240 cases when the program commenced in January 2010, and referral trends since.

[268] The key criteria are: severe psychological condition and/or severe injury; current or recent mental health hospitalisation; dangers to others; self-harm; recent suicide ideation; and unstable behaviour. Additional criteria relate to issues such as homelessness, social isolation, personal relationships and the client's health treatment regime.

Figure 5.2

Case Coordination referrals and declines January 2010 to May 2011



Note: The exponential trend line shows referrals are trending downwards.

Note: Declines show the number of referrals not accepted.

Source: ANAO analysis.

5.29 The stabilisation of the program since mid-2010 has seen referrals in the range of approximately 50 to 100 per quarter, with around three-quarters being accepted. With the bedding down of Case Coordination, it may be timely to consider whether gains in economy and efficiency can be made by streamlining the referrals to the CLU and Case Coordination programs, or the programs more broadly. While the two programs currently manage different client groups, they have a number of similarities. Each program takes a client-centric approach to service delivery by providing a single point of contact into DVA for all client business areas and supporting vulnerable clients with complex needs.[269]

System notices to alert staff of program involvement

5.30 The ANAO also examined the client electronic records in DVA's systems (VIEW and DEFCARE) for notices alerting staff of clients who are in the Case Coordination program, and the need to refer all enquiries relating to

[269] On 20 February 2012, DVA advised that the new departmental structure to be implemented from 1 March 2012 is intended to unify client-facing functions, including the CLU and Case Coordination programs, by placing them within the one administrative group.

those clients to the case coordinator. An effective alert system is important because the case coordinator is intended to be the client's primary point of contact in the department, and any contact by other DVA staff with the client must first be discussed with the case coordinator. Table 5.4 illustrates that, overall, only 59 per cent of clients involved in Case Coordination could be identified as such by DVA staff. Moreover, there was significant variation between regional offices, ranging from 48 to 70 per cent of program clients that could be identified by DVA staff accessing the VIEW and DEFCARE systems.

Table 5.4

System alerts notifying staff of the program's involvement

Location	Total case reviews	Case alerts in VIEW, and/or DEFCARE	Per cent of cases with one or more alerts
Brisbane	20	14	70
Sydney	19	11	58
Melbourne	24	15	63
Perth	31	15	48
Overall	**94**	**55**	**59**

Source: ANAO analysis.

5.31 While all staff can refer cases to the program, not all have access to DEFCARE and VIEW. Consequently, staff could inadvertently contact a client in the program because they do not have access to the necessary systems alerting them to the client's involvement in the program.[270] To effectively support the Case Coordination model, as well as CLU clients as discussed in paragraph 5.12, DVA systems require controls to ensure every case has a notice in the relevant systems that effectively alerts all staff of the identity of Case Coordination clients.

5.32 Another potential level of control is offered by the fortnightly updated list of program clients provided to Rehabilitation and Compensation claims areas. However, Rehabilitation and Compensation staff interviewed by the

[270] More than 80 per cent of recorded alerts were in the VIEW system, which is accessed by most DVA staff processing claims.

ANAO generally were not aware of these lists, or only knew of out of date lists. As this is a program for case managing vulnerable clients at risk of self-harm or harm to others, it is important that all DVA systems used by staff with direct or indirect contact with clients have a notice facility to alert staff, supported by controls to ensure fields are populated and viewed accordingly. Until such time as this is implemented, and the system is more reliable, program lists could be updated each week and drawn to the attention of the responsible Rehabilitation and Compensation Team Leaders and Line Managers.

Recommendation No.4

5.33 To protect the interests of clients who are vulnerable or have complex needs, and support the staff who directly administer the Client Liaison Unit or Case Coordination program, the ANAO recommends that the Department of Veterans' Affairs implements a reliable facility on all relevant systems to alert other staff not to contact those clients directly unless authorised.

Department of Veterans' Affairs response: *Agreed with qualification.*

5.34 DVA's new structure implemented on 1 March 2012, unifies client-facing functions including the Client Liaison Unit and Case Coordination programs into one Division within the department. This will better enable DVA to review the systems, procedures and program design to optimise the delivery of these programs.

5.35 It is usual practice for staff to refer to DVA's central client database (the Veterans Information Enquiry Window) when dealing with client enquiries as this system provides a central reference point about the client's contact details, service history and other entitlements. System alerts are placed on this system for clients who are being managed through either the Client Liaison Unit or the Case Coordination program.

5.36 DVA has recently re-issued its 'Protocol for Dealing with Clients at Risk'. Through this protocol, DVA will continue to ensure it has robust, understandable and consistent work practices in managing the delivery of advice to clients who may be seriously ill, vulnerable or at risk of self-harm or harm to others.

Wellness plans

5.37 Case Coordination procedures require a wellness plan to be developed for every client accepted into the program, which identifies outstanding DVA

issues (usually involving a compensation claim), integrated solutions and agreed goals. Clients are involved where practicable.[271] Wellness plans are designed to provide structure and focus to the support process.[272]

5.38 Case conferencing is employed as part of a structured process to develop the wellness plan and is intended to involve all DVA staff working on the client's case, depending on the resources involved and the capacity of DVA's client system.[273] Case conferences enable all stakeholders to contribute and commit to the agreed process and are an effective means to: reduce duplication; lessen the psychological impact for the client wherever possible; and agree on mutual goals, roles, responsibilities and strategies to achieve the goals.[274] The case coordinator involves the client in determining the mutually agreed goals in the wellness plan that align with the case conference agreed outcomes.

5.39 Very few of the cases reviewed by the ANAO used case conferences in the development of the wellness plan. During the structured audit interviews with case coordinators and other DVA staff, the issue of Rehabilitation and Compensation staff contacting program clients directly without consulting the case coordinator was raised. This potentially undermines the program in the eyes of the client and is not consistent with the program's design or objective. More effective use of collaborative case conferences with all staff involved in a case may help to resolve this issue.

Obtaining client consent

5.40 Case coordinators cannot effectively case manage their clients without first obtaining documented client consent, which is required 'prior to liaising with any other party'[275] such as the client's family, treating medical

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[271] Department of Veterans' Affairs, Support Division, *Draft Rehabilitation & Compensation Case Coordination Administration Policy and Procedural Manual*, August 2010, p. 8.

[272] ibid., p. 23. The level of service reflected in the plan depends on the client's needs and their capacity and support network. Wellness plans can change as the client's circumstances change and goals are achieved or updated.

[273] ibid., p. 8.

[274] The case coordinators' role may also involve liaison with other stakeholders such as: treating specialists and GPs and/or state based crisis and emergency mental health teams where appropriate; the VVCS; the client's family; the Parole Board; and ex-service organisations. ibid., p. 7.

[275] ibid., p. 22.

professionals, advocates, government departments and private businesses. The national case management standards confirm that clients need to understand their rights and responsibilities supported by documented client consent.[276] A key responsibility of any case management program is to establish trust with clients and clarify the process for them. This includes: an explanation about informed consent; how and why information is disclosed; and any limits to confidentiality (such as if the person threatens self-harm or harm to others).[277]

5.41 The ANAO reviewed a sample of 94 cases, 79 of which were active cases. In 41 of these cases (more than 50 per cent), there was no documented evidence of client consent. Case coordinators advised that it can be difficult to obtain consent from clients who may be hard to contact (and most client contact is by telephone, rather than face-to-face).

5.42 Program staff advised that either written or oral consent was acceptable and failing this, the program can rely on the client's authorised consent in their DVA claim application form(s). However, this claim authority is explicit to information gathering and sharing in relation to 'this claim or its review' only.[278] Moreover, oral consent is not accepted by the *Case Coordination Administration Policy and Procedural Manual* or the national case management standards.[279] It would be prudent for the program administrators to resolve the issue of client consent as soon as possible and to provide appropriate advice and training to DVA staff, and advice to clients as necessary. DVA has acknowledged the need to improve these aspects of the program's procedural guidance.

Risk management, performance measurement, evaluation and quality assurance

5.43 The Rehabilitation, Compensation and Systems Support Business Plan for September—June 2011 identified risks, risk treatments, controls and further

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[276] Case Management Society of Australia, *National Standards of Practice for Case Management*, 2008, p. 12.

[277] CRS Australia, *Case Management, A Framework for Success*, 2006, p. 12.

[278] DVA application form, *Claim for Liability and/or Reassessment for Compensation*, p. 8 Available from: <http://www.dva.gov.au> [accessed 2 September 2011].

[279] Under the national case management standards, evidence of informed consent is required at the program's commencement unless a client is unable to sign a document (because of an impairment), in which case this is to be accommodated and documented.

action required across the entire group that had potential to impact on the Case Coordination program's implementation and its ongoing effectiveness. These controls and risk treatments had not been fully implemented at the time of audit fieldwork. Further, none of the Rehabilitation and Compensation staff with direct responsibility for the delivery of parts of the program had been involved in a process to identify potential risks to the program.[280] Risk management is most effective when those with the direct responsibility for the delivery of project components contribute to the process[281], and it would have been prudent to have done so in the course of assessing risk and possible risk treatments.

Performance measurement for Case Coordination

5.44 Well-designed performance indicators can provide valuable information on the effectiveness of programs and enable measurement and assessment of the achievement of program objectives in support of respective outcomes.[282] DVA has developed performance measures for the Case Coordination program, and produced a report against the draft KPIs in December 2010[283], as summarised in Table 5.5.

5.45 The Case Coordination performance report found that two of the six indicators had been met, two had not been met and the other two could not be measured. However, the ANAO analysis of 94 cases subject to Case Coordination (of which 79 were active) found that one of the six KPIs was fully met. The main difference between the DVA and ANAO analysis was that the ANAO found that only 60 per cent of active cases reviewed had a documented wellness plan.

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[280] Evidence obtained from interviews with Rehabilitation and Compensation staff, including team leaders, case coordinators, line managers and other Rehabilitation, Compensation & Systems Support staff working in rehabilitation, liability, assessment, registration and incapacity.

[281] ANAO Better Practice Guide—*Implementation of Programme and Policy Initiatives*, October 2006, Canberra, p. 19.

[282] ANAO Audit Report No. 5, 2011–12, *Development and Implementation of Key Performance Indicators to Support the Outcomes and Programs Framework*, p. 47.

[283] Due to system limitations, DVA has not run the KPI reports since December 2010.

Table 5.5

Case Coordination performance, January 2010 to December 2010

Program element	KPI	KPI met - ✓ Not met - X
Accept/decline referral	1–5 days[A]	X
Wellness plan	100% of active cases[B]	✓
Client contact	95% of client contact accords with contact schedule	X
Referral to CLU	Less than 5 % of cases are referred to the CLU	✓
Support for exited clients	Less than 10% of exited clients require program services within 3 months	No clients had exited
Client goals	Achievement against identified client goals	Unable to measure due to system impediments

Notes: (A) The KPI of 1–5 days to accept or decline a referral was distorted by the bulk referral of cases in Brisbane and Perth at the program's commencement in January 2010.

(B) The KPI performance report states that 100 per cent of active cases had a wellness plan. Of the 79 active cases reviewed by the ANAO, 60 per cent had a documented wellness plan.

Source: Program KPI performance report, December 2010.

5.46 While the KPIs report on important elements of performance, they focus on achieving process milestones rather than program outcomes. As the program matures, there would be benefit in also developing indicators relating to the contribution made by Case Coordination to long term client health outcomes.[284] The ANAO's case reviews also identified significant and high-quality case management outcomes, which could inform the development of enhanced KPIs.[285]

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[284] A number of program outcomes were identified in the communication plan that are not currently measured, monitored or evaluated, including: increased client satisfaction; improved long term health and wellbeing; faster claim resolution; and decreased complaints and Ministerial correspondence. During the course of the audit, DVA advised that an early draft of a client satisfaction survey had been developed but was not finalised.

[285] These case management outcomes included: ongoing monitoring and timely follow-up of acute episodic hospital admissions; liaison with state mental health crisis teams and/or other health providers; assisting clients to relocate; resolving sensitive issues with recently deployed veterans; working collaboratively with ESOs to provide financial and other support to clients in need; and assisting and supporting clients to re-engage with the community and secure long term employment.

5.47 Quality assurance (QA) and evaluation processes have not, as yet, been fully integrated into the program's design. While the program manager undertakes ad hoc case file reviews to assess administrative compliance and national consistency, there is scope to develop and implement a QA process. A focus area could be to include declined cases to ensure that referral practices and criteria are consistent across all locations and cases.

5.48 In summary, the Case Coordination program is achieving significant outcomes for vulnerable clients 'at risk' with identified mental health issues, notwithstanding the administrative weaknesses identified in the audit. These included the need to: more broadly communicate the program to all staff before it was rolled out; provide sufficient program guidance for case coordinators in the first 12 months of the program's operations; appropriately train all staff with a role in the program to identify clients who are potentially 'at risk' beyond interpreting suicide risk in medical reports; train case coordinators in the importance of obtaining client consent; better use the range of case management tools provided such as wellness plans and case conferences; and have a facility in all relevant systems to alert staff of the program's involvement with the client, supported by appropriate procedural controls.

5.49 Since July 2010, program administration has been improving through initiatives designed to provide greater consistency, direction and guidance in case management. In addition, two internal reviews including the post-implementation review in 2011 may provide the impetus for further improvements to the program.

6. Integrity of Mental Health Data

This chapter examines the integrity and reliability of DVA's mental health data to identify younger members of the ADF and ex-service communities with mental health needs.

Introduction

6.1 Reliable information that accurately represents current performance is important for effective program administration. It provides a basis for the monitoring and reporting activities necessary to inform effective administration, and future planning. Reliable data requires consistent data definitions, data standards and collection methods in order to make accurate comparisons over time and across similar programs.[286]

6.2 In administering mental health policy and programs, it is important that DVA has reliable information to identify those veterans/clients with a mental health condition—the mental health cohort—to enable the cost of treatments and services to be determined and to identify the: prevalence of mental disorders and mental disorder clusters; pathways to care; treatment usage and patterns; and extent of unmet need.

6.3 To enhance the department's administration of its mental health programs and services, including those targeted at younger members of the ADF and ex-service communities, the ANAO examined:

- DVA's mental health cohort;
- the reliability of DVA's mental health data, including that of the VVCS; and
- the adequacy of information systems.

Estimating DVA's mental health cohort

6.4 DVA's mental health cohort was developed in 2002, 'primarily as a population base indicator for policy and program development, rather than to

[286] Department of Finance and Deregulation, *Performance Information and Indicators*, p. 3.

identify specific individuals per se'. To be included in DVA's mental health cohort, departmental clients must have:

- an accepted service-related[287] mental health disability; and/or
- been treated by a mental health professional in the past five years (according to Medicare Australia and private hospital data); and/or
- received a mental health treatment, including pharmacy prescriptions in the past five years (according to Medicare Australia data).[288]

Access to mental health treatment

6.5 To be eligible to access mental health treatment and services funded by DVA, and consequently to be included in the mental health cohort, clients are generally required to hold treatment cards.[289] There are a number of DVA treatment cards that provide various levels of benefits, with eligibility dependent on which of the three Acts applies. In this regard, the two treatment pathways for clients with accepted mental health disabilities or conditions are: the treatment cards for the *Veterans Entitlements Act 1986* (VEA) and the *Military Compensation and Rehabilitation Act 2004* (MRCA) accepted conditions; and the reimbursement of reasonable medical costs for accepted conditions under the *Safety, Rehabilitation and Compensation Act* (SRCA) and the MRCA.[290] As DVA's mental health cohort is limited to eligible clients with (health) treatment cards, neither the SRCA clients, nor MRCA non-card-holders with mental health conditions, are counted in DVA's mental health cohort.

6.6 Most of DVA's mental health treatment data, such as that relating to medication and service usage, is collected and sourced from third parties such as Medicare Australia and GPs.[291] Cumulatively, this data is known as DVA's

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[287] Key information missing from DVA's data bases includes client conflict details, which are required to determine eligibility.

[288] Includes those who received a service and/or treatment within the data period but who subsequently died.

[289] In a relatively small number of instances, clients request and receive prior approval for mental health treatment where they have no treatment card, depending on their particular circumstances.

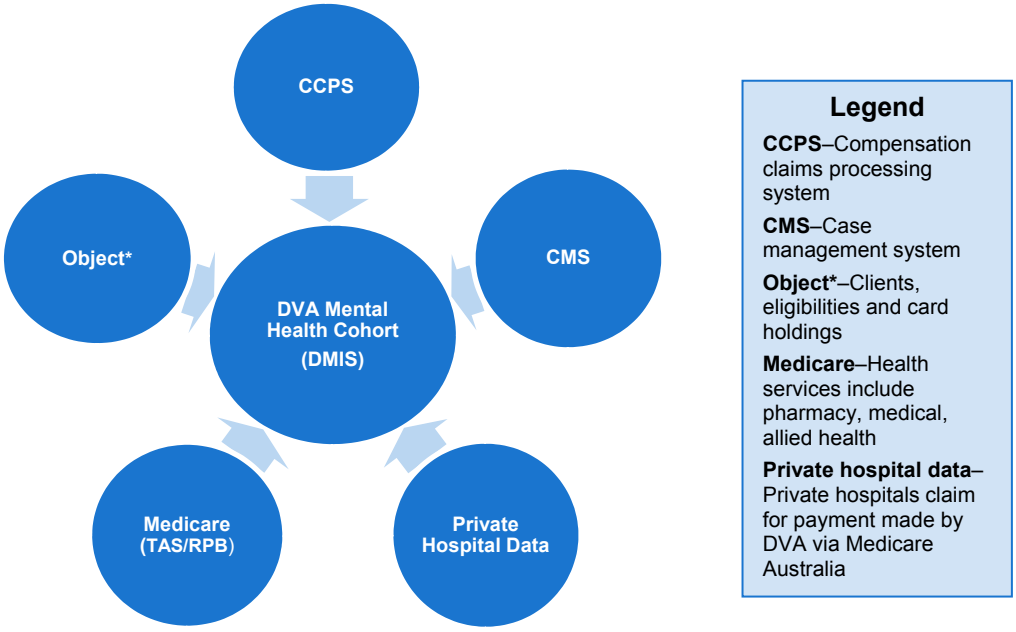
[290] All mental health costs of DVA 'gold' card holders are funded by the department, whereas clients with 'white' cards can only receive DVA-funded treatment for specified accepted conditions.

[291] DVA has been collecting data on mental health services (including service usage and prescribed pharmaceuticals) used by veterans and their families since 2000.

integrated (health) client data mart (DMIS).[292] DMIS reports all disabilities claimed, regardless of whether liability for compensation is accepted by DVA.[293] The ANAO analysed DVA's existing mental health cohort in DMIS, which is drawn from several databases as shown in Figure 6.1.

Figure 6.1

Systems holding mental health cohort data



Source: ANAO.

Validating DVA's mental health cohort

6.7 In order to validate DVA's mental health cohort, the ANAO analysed DVA's source data to establish its general health cohort population of 664 301

[292] The department's publicly reported mental health data is sourced from both DVA's heritage and aDVAnce systems. In addition, mental health treatment data is third party information provided by Medicare, based on treatment/service usage and prescribed/listed pharmaceuticals for mental illness. Department of Veterans' Affairs, Mental Health Datamart, *Implications and recommendations for policy and planning*, Undertaken for DVA's Mental Health Policy Unit by the ACPMH, 9 November 2006, p. 8.

[293] Department of Veterans' Affairs, *The Integrated Client Data Package*, DMIS, 2011, p. 13.

records.[294] These client records were matched with an active DVA treatment card to generate and establish DVA's total health treatment population of 244 842, at 28 June 2011 (see Table 6.1).

Table 7.1

Clients with an active treatment card

DVA client	Gold card	White card[A]	Total
Child	764		764
De-facto/partner	1293		1293
Spouse	95 724		95 724
Veteran	99 018	48 043	147 061
Total	**196 799**	**48 043**	**244 842**

Notes: (A) The veteran category includes 555 veterans who are labelled as partners for recording purposes but have a white treatment card due to their service related injuries.

Source: ANAO analysis.

7.8 As at 28 June 2011, DVA had identified 107 311 clients in its mental health cohort, of which 50 271 had an accepted mental health condition (includes those with non-liability mental health conditions) and an additional 57 040 clients had accessed a mental health treatment service who did not have an accepted condition related to mental health (as shown in Table 6.2).

[294] Data extracted on 28 June 2011. There were 1 591 414 clients identified by a unique identifier number (UIN) in the source data provided by DVA, of which 664 301 had no death indicator (and some reflected data integrity issues such as birthdates of 1890 or earlier). The ANAO matched the 664 301 active UINs to clients with an active treatment card to establish DVA's active treatment population.

Table 7.2

DVA mental health cohort

DVA mental health cohort			
Point in Time	Accepted mental health condition[A]	Mental health treatment services only[B]	Total clients
30 June 2007	55 756	62 952	118 708
30 June 2008	54 324	61 652	115 976
30 June 2009	53 075	60 598	113 673
30 June 2010	51 877	59 344	111 221
28 June 2011	**50 271**	**57 040**	**107 311**

Note: (A) Clients with accepted mental health conditions under the VEA and MRCA, who have been issued with a DVA treatment card.

(B) Clients who do not have an accepted mental health condition but have been issued with a DVA treatment card and have accessed a mental health service and/or treatment.

Source: ANAO analysis of DVA integrated (health) client data mart records, as at 28 June 2011.

Analysing data on usage of mental health treatments

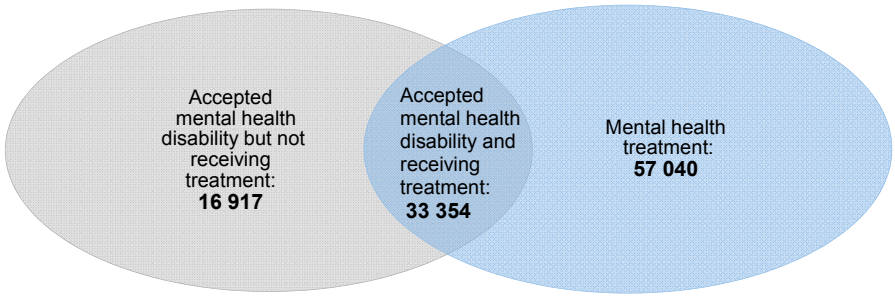
7.9 The ANAO analysed DVA's mental health cohort reported in Table 6.2 to assess the reliability of the two main groupings: clients with a DVA accepted mental health disability; and those receiving some form of treatment funded by DVA for an accepted mental health condition. Of note, and as represented in Figure 6.2:

- 57 040 or 63 per cent of the 90 394 DVA clients who received some form of mental health treatment did not have a DVA accepted mental health disability; and
- 16 917 or about 35 per cent of the 50 271 clients with an accepted mental health disability had not received a mental health treatment (includes prescribed pharmaceuticals) in the last five years.[295]

[295] However, some of these veterans and their families could be receiving other services directly through Medicare, private health insurance or from public hospital and community health services.

Figure 6.2

Mental health treatment received in the past five years



Source: ANAO analysis at 28 June 2011.

6.10 While there are many complexities relating to the operation of the three Acts, research suggests that indications of unmet need can arise where:

- veterans with an accepted mental health disability are not receiving treatment; and
- veterans are receiving treatment with no accepted mental health disability.[296]

6.11 There would be merit in DVA further analysing mental health usage data to better understand the information collected, the implications for the various veteran groups, and how it can best be utilised in program planning to minimise the potential risk of unmet need and improve service delivery.

Reliability of mental health data

6.12 DVA's collection of data on the mental health services used by its clients has improved over the years but its approach significantly understates

[296] Department of Veterans' Affairs, Mental Health Datamart, *Implications and recommendations for policy and planning*, Undertaken for DVA's Mental Health Policy Unit by the ACPMH, 9 November 2006, p. 26.

the mental health cohort, as it excludes at least three major client groups[297] with potentially significant populations, which are:

- those with accepted mental health conditions. While DVA's integrated (health) client data mart records and identifies VEA and MRCA card-holders as DVA's mental health cohort, it excludes around 4000 SRCA and MRCA non-card-holders who have accepted mental health conditions, where treatments are reimbursed by DVA, most of whom are younger veterans;
- the approximately 7000 clients with a mental health condition recorded and recognised by DVA where liability was not established, as no link to their service was found. However, these clients can be identified by DVA as being 'at risk' of self-harm or harm to others, with complex needs and referred to DVA's suicide prevention program (Case Coordination)[298]; and
- the unknown but very substantial number of additional clients accessing VVCS and public hospital services (the latter mostly includes veterans treated under compulsory orders, or receiving treatment in rural and remote areas where private treatment is not available).[299] This group alone comprised 40 per cent of DVA's mental health cohort in 2002.[300]

6.13 The non-inclusion of VVCS data in DVA's mental health cohort demonstrates to members of the ADF and ex-service communities that DVA is maintaining a confidential service.[301] However, independent research has

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297 These groups are not an exhaustive list of DVA clients who are not included in its mental health cohort.

298 Case coordination is discussed in Chapter 5.

299 Department of Veterans' Affairs, Mental Health Datamart, op. cit., p. 10.

300 Department of Veterans' Affairs, *Phase Zero Report, Mental Health Data Mart*, Canberra, April 2002, p. 6.

301 The VVCS is a confidential counselling service which DVA administers separately from its other services, to provide assurance to VVCS clients that disclosures made to VVCS counsellors will not inform DVA decision-making processes relating to claims.

recommended the inclusion of VVCS data in a DVA consolidated report[302], while maintaining its confidentiality.

6.14 Although the issue is complex and sensitive, and not directly related to estimation of mental health cohorts, DVA clients who suicide should be separately identified in some way by the department, where information is available, as it contributes to planning of future support programs and services for high risk groups. As in the general community and consistent with the National Mental Health Strategy framework, suicide can be an indicator of the adequacy of the mental health service system[303] to meet the needs of the broader veteran community.

Estimating the younger veteran cohort

6.15 To identify the number of younger veterans (aged 45 years and less) with a mental health condition, the ANAO sought to identify those with accepted mental health conditions. This group included the populations of VEA and MRCA card-holders, as well as MRCA non-card-holders and SRCA clients (who are excluded from DVA's mental health cohort)[304], as shown in Table 6.3.

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[302] DVA Mental Health Datamart, *Implications and recommendations for policy and planning*, undertaken for DVA's Mental Health Policy Unit by the ACPMH, 9 November 2006, pp. 4, 20. DVA already has data exchange protocols in place to share de-identified data with external providers.

[303] Department of Veterans' Affairs, Mental Health Datamart, op. cit., p. 11.

[304] To determine the size of this gap, the ANAO extracted MRCA non-card-holders and SRCA data and formulated cohort numbers based on the VEA mental health algorithm (which does not have official standing within DVA).

Table 6.3

Younger veterans with accepted mental health conditions

Group	Younger veterans with accepted medical conditions	Younger veterans with accepted mental health conditions	Share of younger veterans with mental health conditions (%)
VEA and MRCA card-holders	9328	2562	27.4
MRCA non-card-holders	3408	1209	35.5
SRCA	11 716	1072	9.1
Total	24 452	4843	19.8

Source: ANAO analysis of DVA data, as at 28 June 2011.

6.16 Some younger veterans are in more than one group because they have accepted mental health conditions under more than one compensation scheme or Act. The ANAO removed the duplicate client records from the 4843 total of clients, which left 3748 younger veterans with an accepted mental health condition under any of the three Acts. This is a very conservative estimate of the total number of younger veterans with mental health conditions, however, as it excludes some of those receiving mental health treatments only, almost 8000 younger veterans who are VVCS clients (many of whom will have mental health conditions and some may be DVA clients), and other groups of individuals discussed in paragraph 6.12.

VVCS data integrity issues

6.17 As discussed in Chapter 4, VVCS program data is incomplete or not sufficiently differentiated to report program performance funded through the 2006–07 Budget measure. This situation limits the ability of DVA to effectively monitor program performance and report against government objectives and program outcomes. Most significantly, DVA systems were not able to provide reliable data of the current client base supported by the VVCS with any certainty. This information is a potentially valuable means for DVA to understand the emerging needs and trends in service usage by the different

veteran groups and their families, including the needs of the younger cohort, as an input to DVA's planning, policy development and service delivery.[305][306]

6.18 Particular problems with the integrity of VVCS data include:

- usage—of the 74 130 total VVCS clients registered in the VMIS system since 1982, 33 158 are identified as veterans but it was difficult to determine how many DVA clients there are;
- eligibility—it is not clear whether those accessing the service are actually eligible;
- intake—limited and 'patchy' information about the details of clients accessing the service for the first time or after a prolonged period of non-use compromises the integrity of the data; and
- data controls—there were many examples of poor data input controls within the VMIS database, which can cast doubt on the reliability of the figures reported from the database.[307]

Improving the integrity of mental health data

6.19 The process of identifying all DVA clients receiving mental health treatment is complicated and reflects the complexities of the three separate compensation schemes and DVA's processes and practices for collecting and compiling the data. As a result, it is not possible to establish DVA's total mental health cohort population with any certainty.

6.20 While considerable progress has been made in developing DVA's integrated (health) client data mart, there are clear limitations in: the currency of the information; what is collected; and how it is stored, used and reported. DVA's data mart would benefit from a reconciliation of the data with the source data, to ensure the linkages are still relevant and the data is sourced

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[305] DVA advised that the quality of VVCS data is a direct by-product of the nature of its services which it likens to the 24 hour Lifeline telephone and counselling service. However, Lifeline obtains statistical information from clients at the end of each telephone counselling session.

[306] A recent review of the VVCS service delivery model highlighted the need to enhance the capability of its data management system to better support management information for planning and continuous improvement. See: Belsham, S., & Associates P/L, *Final Report Review of the Veterans and Veterans Families Counselling Service Delivery Model*, July 2010, p. 23.

[307] By way of illustration, the eligibility check flag was not recorded against all clients as this field was configured as an optional indicator. This limits DVA's ability to conduct in-depth analysis of its data.

correctly, as the business rules have not been updated for at least five years. Further, DVA's mental health treatment lists are out of date by five years and pharmaceuticals are out of date by nine years, with the consequence that clients reimbursed for new treatments since 2003 will not be identified in DVA's mental health cohort.

6.21 DVA has acknowledged the difficulties in extracting data that accurately represents its veteran and other client cohorts, and has advised that it is considering how it can more accurately report on its mental health cohort.[308] This is of particular importance in the context of developing DVA's new mental health policy, which will need to be informed by accurate and up-to-date data on the mental health cohort.

Information system issues

6.22 DVA's information technology (IT) systems are complex and include a mix of siloed heritage systems and new systems (aDVAnce), each with varying levels of functionality.[309] Documentation of the IT controls framework is integral to data integrity within DVA's IT environment, as is formal systems documentation. DVA's limited documentation and corporate knowledge of its IT infrastructure can make it difficult to identify the source of truth of its data.[310]

6.23 While recognising the challenges and costs associated with documenting DVA's IT controls framework and business logic, particularly for its older heritage systems, some strategic investment may contribute to addressing the issues associated with the department's limited corporate

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[308] For example, the Department of Veterans' Affairs *Mental Health Datamart, Implications and recommendations for policy and planning* report proposes the inclusion of VVCS and public hospital data.

[309] Department of Veterans' Affairs, Information Committee meeting, *Agenda Item 3.1—Legacy Replacement Program*, 8 March 2012. Pursuing the allocation of funding for a Legacy Replacement Program was discontinued by DVA and the focus is on decommissioning the Information Management System. The ANAO identified that most of the Information Management System business functions were redundant in 2003–04: ANAO Audit Report, No. 41, 2003–04, *Management of Repatriation Health Cards*, p. 50.

[310] The difficulty for DVA in identifying the source of truth for its data has been raised in previous ANAO audits related to DVA's data integrity, which are: ANAO Audit Report No. 41, 2003–04, *Management of Repatriation Health Cards*, and ANAO Audit Report No. 28, 2008–09, *Quality and Integrity of the Department of Veterans' Affairs Income Support Records*, pp. 17–18.

knowledge of the infrastructure supporting its systems.[311] Further, the mapping of DVA's business warehouse product (DMIS) back to source systems would provide DVA with a greater level of assurance of the data reported from DMIS.

6.24 DVA has advised of difficulties in extracting data that accurately represents its client cohorts, and is considering how it can more accurately report on its mental health cohort and use that information to inform its planning and new mental health policy. In 2006, DVA commissioned two independent reports to better understand its mental health data including the demographic profile, service usage and performance of the mental health services provided to this group. These reports address many of the data integrity issues raised in this audit, and identify the implications of the quality of DVA's mental health data and service usage for policy and planning purposes. Implementation of the reports' recommendations, including the periodic review of DVA's data integrity, would address many of the data issues raised in this report.

6.25 Effective policy development, service delivery and performance measurement require reliable data. Developing reliable data holdings requires consistent data definitions, standards and collection methods, which in turn requires technical expertise and effective coordination between the relevant business owners and system areas within organisations. To effectively coordinate its internal processes to improve the reliability and accuracy of its mental health cohort, there would be benefit in DVA assigning clear ownership and responsibility for mental health data. As part of its restructure in March 2012, DVA established a dedicated Mental and Social Health Policy Branch, to coordinate mental health and social policy issues, and there would be benefit in considering the option of assigning responsibility for mental health data policy to that unit.[312] This would help to provide more certainty that DVA's mental health standard reports are consistent with its mental

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[311] This issue was identified in a previous ANAO report of DVA's data integrity in 2008–09, No. 28, *Quality and Integrity of the Department of Veterans' Affairs Income Support Records.*

[312] A previous ANAO audit recommended that DVA develop an agency-wide strategy, assigning ownership for data management and integrity issues to business areas in order to improve the governance of its income support data. See: ANAO Audit Report No. 28, 2008–09, *Quality and Integrity of the Department of Veterans' Affairs Income Support Records*, p. 31.

health policy objectives. At present, changes can be made to the parameters of these reports by the area that manages mental health information[313], without always consulting with the responsible policy area.[314]

Recommendation No.5

6.26 To support the development and implementation of mental health policy, programs and services better tailored to the needs of younger members of the ADF and ex-service communities, the ANAO recommends that the Department of Veterans' Affairs:

- more fully and accurately identifies its mental health cohorts, particularly the younger sub-groups;
- uses a consistent methodology to define, standardise, collect and report on its mental health data; and
- regularly reconciles its mental health data with the source data to improve the completeness and integrity of its mental health information.

Department of Veterans' Affairs response: *Agreed with qualification.*

6.27 Through its data systems, DVA is able to accurately determine the number of veteran clients with a mental health condition by identifying:

- clients with an accepted mental health disability; and
- clients who hold a white card for post traumatic stress disorder, depression or anxiety, whether service related or not.

6.28 DVA is also able to infer mental health conditions for the remainder of the DVA health treatment population who are accessing mental health treatments. This includes veterans who have a gold card but do not have a mental health accepted disability and dependents who have gold cards, based on treatment charge and pharmaceutical data.

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[313] The business area that manages the integrated client (health) data mart within DVA is known as the DMIS (Departmental Management Information System) area.

[314] In the course of the audit, the DMIS area advised that it removed eligible clients from the mental health cohort who have DVA accepted mental health conditions and are eligible for reimbursement of mental health treatment costs but who reside overseas, without consulting the mental health policy area.

6.29 DVA has a consistent methodology to define, collect and report on its mental health data within business rules agreed by relevant business groups. Additionally, DVA extracts data from source into its Departmental Management Information System by defined business rules. This information is reviewed by technical and relevant policy areas and if discrepancies are identified then either the source data is corrected or business rules amended appropriately.

6.30 DVA seeks to improve its data holdings and will ensure that learnings from this audit will be taken into account when revising and updating business rules around the definition and collection of its mental health data.

6.31 DVA notes that VVCS client records are kept separately from DVA, and are stored securely. Clinical information is not released to DVA. VVCS is scoping the development of a new management information system that will enhance data management and reporting.

Ian McPhee
Auditor-General

Canberra ACT
22 June 2012

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