WHITE PAPER

A Broken Promise:
The $5,000 Allied Health Cap, Veteran Mental Health, and the Shadow of Preventable Suicide

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Executive Summary

The 2026–27 Federal Budget announced the introduction of a $5,000 Annual Monetary Limit on Department of Veterans' Affairs (DVA) allied health services for Veteran Card holders, effective 1 July 2027. The Government has framed this measure as a means of reducing overservicing while simultaneously funding an increase in allied health provider fees — the largest such increase in over two decades.

This white paper argues, from a registered psychological and clinical evidence base, that the proposed cap as it applies to mental health treatment represents a fundamental policy error with foreseeable, preventable, and potentially fatal consequences for Australia's most vulnerable veteran population.

> *Veterans do not have siloed bodies or compartmentalised minds. The $5,000 cap forces an impossible choice between physical rehabilitation and the psychological care that stands between a veteran and the abyss.*

The central concerns are threefold. First, the arithmetic of mental health treatment is irreconcilable with a $5,000 annual ceiling. Evidence-based psychological therapies for PTSD and complex trauma — the defining mental health burden of the veteran population — typically require between 20 and 40 sessions per year in the active phase of treatment. At post-cap NDIS-aligned rates of approximately $260 per session, a veteran attending weekly psychology exhausts the cap in fewer than 20 weeks, well before the financial year ends. Second, the Government has simultaneously increased the per-session fee by approximately 60 per cent while holding the annual envelope constant — guaranteeing fewer sessions, not more. Third, by exempting its own provider (Open Arms) from the cap while applying it exclusively to private registered psychologists, the Government has introduced a structural market distortion that warrants examination by the Australian Competition and Consumer Commission.

The Royal Commission into Defence and Veteran Suicide recommended specifically — in Recommendations 31, 33, 35, and 66 — that the Commonwealth strengthen, not restrict, veteran access to psychological services. The current measure is materially inconsistent with those recommendations.

This paper calls for the exclusion of psychological and mental health services from the $5,000 cap, an independent clinical impact assessment, a suicide risk impact assessment, a defined clinical override protocol, and a referral of the competitive neutrality question to the ACCC.

CLINICAL RISK ADVISORY

The author of this paper, as a registered psychologist with clinical experience in military and veteran populations, is formally on record that rationing of psychological services for veterans with active PTSD, complex trauma, suicidal ideation, or treatment-resistant mental health conditions constitutes a foreseeable clinical risk. The introduction of the $5,000 cap without a robust and independently verified clinical override pathway is inconsistent with the duty of care owed by the Commonwealth to veteran card holders.

1. The Policy and Its Context

1.1 What the Budget Announced

On 12 May 2026, the Albanese Government released the 2026–27 Federal Budget. Buried within the Department of Veterans' Affairs portfolio was a measure that will reshape how Australian veterans access health services for the remainder of their lives. From 1 July 2027, a $5,000 Annual Monetary Limit will replace the existing treatment cycle model for allied health services, including physiotherapy, psychology, occupational therapy, podiatry, and exercise physiology — all within a single consolidated financial envelope.

The Government simultaneously committed $169.7 million over five years (with $58.8 million ongoing) to increase allied health provider fees, aligned with NDIS rates. The Budget papers characterised the cap as enabling savings of $748 million over three years from 2027–28 ($340.2 million per year ongoing) — savings that effectively fund the fee increase and generate a substantial net fiscal gain for the Commonwealth.

1.2 The Government's Stated Rationale

The DVA has publicly stated that the $5,000 Annual Monetary Limit is intended to reduce overservicing and to give veterans greater control over their individual treatment preferences. DVA has confirmed that veterans requiring care beyond the cap will not be cut off, and that funding may be extended above the limit where there is a valid, ongoing clinical need. The variable within that response is that the determination of “ongoing clinical need” is being taken away from the veterans known medical treatment team – and summarily transferred to an administrative bureaucratic system that is on record as causing greater damage to veterans – rather than positive interaction.

1.3 What the Policy Does Not Acknowledge

What the Government has not adequately addressed is the fundamental incompatibility between a single, consolidated financial cap and the treatment demands of veterans living with complex, chronic, and co-occurring mental and physical health conditions. The measure treats physiotherapy, psychology,

occupational therapy, exercise physiology, dietetics/nutrition and podiatry as interchangeable commodities within a shared budget. They are not. For veterans with active psychological conditions, the consumption of shared budget capacity by physical health services directly displaces mental health treatment.

2. The Mental Health Burden of Australian Veterans

2.1 Epidemiological Profile

The mental health burden carried by Australia's veteran population is disproportionately severe and well-documented. Research published in peer-reviewed literature and confirmed through the Royal Commission's proceedings establishes the following epidemiological reality.

Metric	Value	Clinical Significance
PTSD prevalence — transitioned ADF personnel	**17.7%**	Compared with 5.2% in the Australian general community (Transition and Wellbeing Research Program)
PTSD prevalence — currently serving ADF	**8.7%**	Still markedly elevated versus civilian baseline
12-month suicidality — transitioned personnel	**21.7%**	More than double the rate for currently serving members (8.8%), and ten times the civilian rate
Depression — transitioned ADF personnel	**11.2%**	Significantly elevated versus general population baseline
Veterans with PTSD as a factor in suicide	**~26.6%**	Consistent with international veteran cohort data

These are the veterans currently presenting to DVA-registered psychologists, physiotherapists, and occupational therapists across Australia — the veterans whose treatment will be financially rationed under the proposed cap. For a significant cohort, psychological services are not supplementary; they are life-sustaining.

2.2 The Nature of Psychological Treatment for PTSD and Complex Trauma

Evidence-based treatment for PTSD and complex trauma in the veteran population is well-established. Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), EMDR, and Acceptance and Commitment Therapy (ACT) are the primary modalities supported by DVA and Phoenix Australia's clinical guidelines. These are not brief interventions. Clinical guidelines recommend a minimum of 12 to 16 sessions for first-

episode PTSD, with many veterans requiring 20 to 40 sessions in the active treatment phase, and ongoing maintenance sessions thereafter.

> *A veteran with active PTSD who attends weekly psychology sessions will exhaust a $5,000 annual cap within approximately 19 sessions at post-cap rates — before mid-year, and before evidence-based treatment is complete.*

The arithmetic is stark. At post-cap NDIS-aligned DVA rates of approximately $260 per session, a veteran attending one session per week exhausts a $5,000 cap in approximately 19 weeks — fewer than five months into the financial year. For veterans requiring concurrent physical rehabilitation, the cap is exhausted sooner still.

CLINICAL NOTE — THE OVERSERVICING MYTH

The Government's framing of the cap as a remedy for 'overservicing' warrants direct challenge. There is no clinical basis for characterising ongoing psychological treatment of veterans with chronic PTSD or complex trauma as overservicing. The defining nature of these conditions — their chronicity, their relapse risk, the neurobiological and cognitive changes associated with repeated trauma — means that ongoing therapeutic engagement is clinically appropriate, not excessive. Overservicing occurs where services are provided without clinical justification. The cap sets a financial limit irrespective of clinical justification. These are categorically different concepts.

3. The Suicidality Risk of Rationed Mental Health Treatment

3.1 What the Evidence Shows

The relationship between interrupted or inadequate mental health treatment and increased suicidality is one of the most robust findings in clinical psychology. Continuity of therapeutic relationships is among the strongest protective factors against suicide in individuals with PTSD and complex trauma. The forced termination or reduction of treatment due to financial limitations — rather than clinical determination — introduces an iatrogenic risk; that is, harm caused by the healthcare system itself.

The imposition of a mid-year financial cap that terminates or truncates active treatment represents a predictable, scheduled, and policy-manufactured disruption. Research has consistently found elevated suicide risk in periods of transition, disruption, and

loss of support. The period immediately following the enforced reduction of clinical support is one of the most vulnerable phases for individuals with suicidal ideation.

3.2 The DVA's Own Royal Commission Obligations

The Royal Commission into Defence and Veteran Suicide, which concluded in 2023, made findings and recommendations that are directly material to the present measure. Among its most relevant recommendations are the following:

- Recommendation 31: That the Commonwealth strengthen accountability mechanisms for DVA's management of veteran mental health cases, with particular attention to continuity of care.
- Recommendation 33: That DVA ensure veterans are not required to repeat or interrupt evidence-based psychological treatment due to administrative or financial barriers.
- Recommendation 35: That DVA improve its responsiveness to veterans with complex needs, including those requiring long-term psychological support beyond standard referral cycles.
- Recommendation 66: That the Commonwealth treat suicide prevention as a whole-of-system responsibility and remove structural barriers to veteran access to mental health services.

The Government cannot simultaneously claim to be implementing the Royal Commission's recommendations and introduce a financial cap that structurally limits access to psychological treatment. The Budget papers' selective citation of Recommendation 71 (fee increases) while the cap materially undermines Recommendations 31, 33, 35, and 66 requires direct parliamentary and public scrutiny.

3.3 The Clinical Override Pathway: Reassuring Language, Unresolved Architecture

DVA has assured the veteran community that there will be a mechanism for funding allied health services above the $5,000 cap where there is a valid clinical need. However, the clinical override pathway currently exists as a policy intention, not a defined clinical protocol. DVA has not published the clinical criteria for override eligibility, the qualifications of the decision-maker, the processing timeframe, what happens to treatment continuity during assessment, or the appeals pathway where override is refused.

CRITICAL GAP IN POLICY DESIGN

A veteran with active suicidal ideation who exhausts their $5,000 cap in October and submits an override request cannot safely wait weeks or months for an administrative determination. The clinical override pathway must operate within timeframes consistent with acute mental health risk management — meaning days, not weeks. DVA has not committed to any processing standard that meets this clinical threshold. Until it does, the override mechanism is an administrative aspiration, not a clinical safeguard.

4. The Cost Calculation: What $5,000 Actually Buys

4.1 Worked Examples Under the Proposed Cap

The following worked examples model realistic treatment scenarios for veterans with common presentations. These are not hypothetical; they reflect the treatment profiles of veterans currently presenting to DVA-registered providers.

Scenario A: Veteran with PTSD and Chronic Lower Back Injury

A 42-year-old former Army officer. Accepted conditions: PTSD, lumbar disc injury. Current treatment: fortnightly physiotherapy ($150/session) and weekly psychology ($260/session at post-cap DVA rates).

- Physiotherapy (fortnightly, 26 sessions): $3,900
- Psychology (weekly, 4 sessions until cap exhaustion): $1,040
- Cap exhausted: approximately August — before the end of Q1
- Outcome: active PTSD treatment interrupted at 4 sessions — well below the minimum clinical threshold of 12–16 sessions

Scenario B: Veteran with Complex PTSD and Bilateral Knee Injury

A 38-year-old female Army medic. Accepted conditions: complex PTSD, major depressive disorder, bilateral knee osteoarthritis. Current treatment: weekly psychology, fortnightly occupational therapy, monthly physiotherapy.

- Psychology (weekly, $260/session): 12 sessions = $3,120
- Occupational therapy (fortnightly, $180/session): 12 sessions = $2,160
- Physiotherapy (monthly, $150/session): 4 sessions = $600
- Total projected annual cost: $5,880 — exceeds cap by $880 before year-end
- Outcome: either psychological or OT treatment must be curtailed; clinical decisions made by financial constraints, not therapeutic need

Scenario C: High-Risk Veteran

A 29-year-old former Navy clearance diver discharged on medical grounds. Accepted conditions: PTSD (severe), alcohol use disorder (comorbid). Weekly psychology essential; recent hospitalisation following acute crisis.

- Weekly psychology (post-cap, $260/session, 52 weeks): $13,520 — exceeds $5,000 cap by $8,520
- Override required within 19 weeks of treatment commencement
- Clinical risk during override processing period: HIGH
- Absence of published processing timeframe: duration of coverage gap is unknown

These are not edge cases. They represent the modal presentation profile of veterans engaged with DVA-funded psychological services. The cap, as designed, will routinely require override applications from veterans who are not outliers but who represent the core of DVA's mental health caseload.

5. The Broader Sector Response

5.1 Veterans' Organisations

The veteran support sector's response to the cap announcement has ranged from cautious concern to outright condemnation. RSL Australia described the outcome as a 'mixed result' and explicitly warned that savings measures risk undermining the overall benefit of the allied health investment. Soldier On acknowledged uncertainty about how override mechanisms would operate in practice. Families of Veterans Guild observed that the cap would affect war widows holding DVA treatment cards, and characterised the measure publicly as 'blunt and poor policy.'

5.2 Allied Health Peak Bodies

Occupational Therapy Australia welcomed the fee increase investment but noted it was seeking post-budget clarification from DVA. At the Australian Psychological Society's recommended fee of $318 per hour, the $5,000 cap would be exhausted in approximately 15 sessions — fewer than four months of weekly treatment. Clinical commentary following the Budget noted the fundamental problem that veterans do not have siloed bodies, and that a single financial envelope across multiple clinical needs structurally disadvantages mental health treatment.

5.3 Parliamentary Criticism

The federal member for Dawson, Andrew Willcox, characterised the measure as 'a cruel cost-shifting exercise' that treats veteran healthcare as a budget-balancing instrument. He also identified the additional concern that the measure would strip more than 100 staff from DVA — a department already characterised by significant administrative backlogs that delay initial claim acceptance and, by extension, access to funded services.

6. Strategic Incoherence and Market Distortion: A Policy That Works Against Itself

The preceding sections have addressed the clinical and ethical failures of the $5,000 Annual Monetary Limit. This section addresses a different but equally serious problem: the policy's internal strategic logic is incoherent, and its structural design creates a competition distortion in the veteran mental health services market that warrants independent scrutiny, including by the Australian Competition and Consumer Commission.

6.1 The Rate Increase and the Cap: A Self-Defeating Combination

The Government has presented the 2026–27 allied health measure as a two-part benefit for veterans: an increase in provider fees (to approximately $260 per session, aligned with NDIS benchmarks) and the introduction of a $5,000 Annual Monetary Limit to reduce overservicing. These two elements have been publicly framed as complementary. They are, in fact, structurally contradictory — and the contradiction operates entirely to the disadvantage of veterans in active psychological treatment.

Raising the per-session fee from approximately $165 to $260 — an increase of $95, or approximately 58 per cent — while simultaneously holding the annual funding envelope at $5,000 produces a mathematically certain outcome: veterans receive fewer funded sessions, not more. At the pre-increase rate of $165, a veteran attending weekly psychology exhausted the $5,000 cap in approximately 30 sessions — roughly 30 weeks of treatment. At the post-increase rate of $260, the same veteran exhausts the same cap in approximately 19 sessions — fewer than five months into the financial year, and well before any evidence-based treatment protocol for PTSD reaches completion.

> *The Government is paying psychologists more per session and funding fewer sessions per year. The net beneficiary of this arithmetic is the Commonwealth's fiscal position. The net loser is the veteran in active treatment.*

There is no policy rationale under which increasing the unit cost of a service while reducing the total budget allocated to purchasing it constitutes an improvement in access. The Budget's projected savings of $748 million over three years make the fiscal logic transparent: the fee increase is funded by the cap, the cap produces savings well in excess of the fee increase cost, and the net effect is a significant reduction in Commonwealth expenditure on veteran allied health — achieved by limiting how much treatment veterans can access per year. To characterise this as a benefit to veterans is, at minimum, misleading.

6.2 The Open Arms Exemption: Government as a Competitor Outside Its Own Rules

Open Arms — Veterans and Families Counselling is the Commonwealth's own psychological services provider, operating under the DVA portfolio and funded directly by government appropriation. It provides free counselling, case management, and mental health support to veterans and their families. Under the current design of the $5,000 Annual Monetary Limit, Open Arms services are expressly excluded from the cap. Veterans can access Open Arms without any deduction from their annual allied health allocation.

On its face, this exemption appears protective of veterans. In structural terms, however, it creates an asymmetric competitive environment in the veteran mental health services market. Private registered psychologists — who currently provide the substantial majority of DVA-funded psychological treatment — are subject to a $5,000 annual cap on the services they can deliver to any individual veteran. The Commonwealth's own service provider faces no equivalent constraint. A veteran whose $5,000 cap is exhausted by October has a rational, financially-driven incentive to transfer their care to Open Arms — not because Open Arms is clinically preferable for their presenting condition, but because it is the only cap-free option remaining. The cap does not merely limit private provider access — it actively redirects veterans toward the Government's own service.

This is not a neutral design choice. Veterans with established therapeutic relationships with private registered psychologists — relationships that may have taken years to build and that constitute a primary protective factor against relapse — are financially incentivised to abandon those relationships and transfer to a service that may not offer the same evidence-based treatment modalities, the same continuity of care, or the same specialist clinical expertise in their particular presentation.

6.3 The Competition Dimension: A Question for the ACCC

The structural asymmetry described above raises a question that extends beyond clinical policy and into the domain of competition law and regulatory fairness. The Australian Competition and Consumer Commission (ACCC) has responsibility under the Competition and Consumer Act 2010 (Cth) for the promotion of competition and

the prevention of conduct that substantially lessens competition in markets. The market for DVA-funded veteran psychological services is not a typical open market — it is a government-funded, government-regulated market in which the Commonwealth simultaneously acts as funder, regulator, and service provider. In that context, the introduction of a financial cap that applies exclusively to private providers while exempting the government's own service is not a neutral regulatory instrument. It warrants scrutiny on at least three grounds.

- First, private psychological service providers face a $5,000 ceiling on the annual revenue they can generate from any individual DVA-funded veteran client. Open Arms faces no equivalent ceiling. This is an asymmetric competitive constraint that directly disadvantages private providers relative to the government's own service in the same market.
- Second, the cap creates a financial mechanism that, when exhausted, functions as an automatic referral pathway to the government provider. Veterans are not choosing Open Arms over private practitioners on the basis of clinical preference or service quality — they are being channelled there by the exhaustion of the cap. This is financially coercive market steering that operates through the design of the policy itself.
- Third, if private providers — faced with a $5,000 annual revenue cap per DVA-funded veteran — reduce their acceptance of DVA clients or exit the DVA provider market entirely (a rational commercial response), the concentration of veteran mental health service delivery in the government's own provider will increase over time. The long-term structural effect of the policy may be the progressive displacement of private providers from the veteran mental health market, not through competitive merit, but through regulatory design.

This paper does not assert that the competitive distortion was intentional. It is possible that the Open Arms exemption was designed with the welfare of veterans foremost in mind — ensuring that a free service remains available to veterans whose cap is exhausted. But intent does not determine effect, and the structural effect of the current design is a regulatory asymmetry that advantages a Commonwealth provider over private competitors in the same market. The ACCC, as the independent arbiter of competition fairness in Australian markets, is the appropriate body to assess whether the policy's design raises concerns under the Competition and Consumer Act 2010 (Cth).

POLICY INTEGRITY CONCERN

The Commonwealth Government simultaneously funds veterans' mental health care, regulates the market for that care, delivers that care through its own provider (Open Arms), and has now introduced a financial constraint that applies to every other provider in that market but not to its own. This is an extraordinary concentration of market power and regulatory control in a single entity. The ACCC, the Productivity Commission, and the relevant Senate Estimates Committee should each be invited to examine whether this policy design is consistent with the principles of competitive neutrality that the Commonwealth is otherwise committed to upholding.

6.4 Competitive Neutrality and the Commonwealth's Own Framework

The Commonwealth's Competition Policy Framework — anchored in the Competition Principles Agreement and the national competitive neutrality framework — establishes that government business activities should not enjoy competitive advantages over private sector competitors solely by virtue of government ownership. Competitive neutrality applies wherever the Commonwealth engages in activities in markets where private providers also operate.

Open Arms is not a government business enterprise in the formal statutory sense — it is a publicly funded counselling service. It operates in the same market as private registered psychologists, providing substantially similar services to the same population. The DVA's cap now places every private provider in that market at a structural disadvantage relative to Open Arms. If this arrangement were inverted — if a private insurer imposed a funding cap on government-sector services while exempting its own preferred provider — it would be immediately recognisable as a market distortion. The same logic applies here.

The long-term viability of private sector provision of veteran psychological services is itself a Commonwealth policy objective: DVA's provider network relies on private registered psychologists to deliver the overwhelming majority of funded psychological care. A policy that financially disadvantages private providers — and that at the margin incentivises clinicians to reduce their DVA caseload in favour of more viable income streams — undermines the supply-side foundations of that network. The workforce consequences of the cap may, over time, prove as damaging as the direct access consequences for veterans currently in treatment.

7. The Override Mechanism Cannot Work: Clinical Gatekeeping, Administrative Substitution, and a Depleted Workforce

Sections 3 and 6 of this paper have identified the clinical override pathway as an administrative aspiration without defined architecture. This section advances a more fundamental argument: the override mechanism is not merely undefined — it is structurally inappropriate, clinically unjustified, and operationally impossible given the concurrent reduction in DVA's workforce. It replaces a functioning, evidence-based clinical gatekeeping system with an administrative process that has no clinical foundation and no realistic capacity to operate at the volume and speed that veteran mental health need demands.

7.1 The Existing Clinical Gatekeeping System

Australia's mental health system has a well-established, nationally consistent model for determining access to and continuation of psychological services: the General Practitioner. Under the Medicare Better Access to Mental Health Care initiative, a GP completes a Mental Health Treatment Plan and issues a referral to a registered psychologist. The GP reviews the patient's progress at 6 sessions and again at 10 sessions, and re-referral at 12 months resets the annual allocation. This model places the gatekeeping decision — is this patient's ongoing psychological treatment clinically justified? — with the clinician who has the patient's full medical history, who has an established treating relationship, and who is legally and professionally accountable for the clinical decisions they make.

DVA's own historical referral architecture has operated on substantially the same principle. A D0904 or equivalent referral initiates funded psychological treatment under DVA. The treating psychologist manages the ongoing clinical relationship, adjusting modality and frequency in accordance with the patient's presentation. The GP, as the coordinating clinician, holds the overview of the patient's full health picture — physical, psychological, and social. This is not a bureaucratic convenience. It is the internationally recognised best-practice model for primary mental health care coordination.

> *The GP is not a gatekeeper by accident. They are the gatekeeper by design — because no other single clinician in the health system has the breadth of clinical relationship, the full medical history, and the coordinating role to make that determination safely.*

The GP referral and review model functions precisely because it places the access decision with a qualified clinician who knows the patient. It is the same gatekeeping

model used for every other complex medical pathway in Australia: specialist referrals, surgical authorisations, chronic disease management plans. There is no pathway in Australian medicine under which an administrative employee of a funding body determines whether a patient requires continued specialist treatment. The principle is settled. The cap's override mechanism violates it.

7.2 Administrative Substitution: Replacing Clinical Judgement with Bureaucratic Determination

The DVA cap override mechanism, as currently framed, transfers the gatekeeping decision from the treating GP and psychologist to a DVA employee. That employee will be required to assess whether a veteran's ongoing psychological treatment beyond $5,000 per year is clinically necessary. This is a clinical determination. It requires clinical training, access to the patient's full history, understanding of the specific treatment modality being delivered, and appreciation of the risk profile of interrupting treatment at that particular point in the therapeutic process.

DVA employees are not clinicians. They are not the treating practitioners. They have no established relationship with the veteran. They do not have access to the therapeutic record in the way a treating psychologist or supervising GP does. They are being asked to make a determination that the existing health system — by design and by evidence — vests in qualified medical practitioners for the specific reason that unqualified administrative determination of clinical necessity produces unsafe outcomes.

This substitution is not a minor administrative adjustment. It is a structural inversion of the clinical gatekeeping model that governs every comparable pathway in Australian healthcare. If the Commonwealth were to propose that Medicare Better Access session decisions be made by Services Australia employees rather than GPs, the clinical and professional backlash would be immediate and conclusive. The same logic applies here — and the population is more vulnerable, the conditions more complex, and the consequences of error more severe.

THE CORE ADMINISTRATIVE ABSURDITY

The DVA override mechanism asks an administrative employee — without clinical training, without a therapeutic relationship, and without access to the full clinical record — to make a determination that the Australian health system reserves, by law and by professional standards, for registered medical practitioners. This is not a gap in the policy design. It is the policy design. It should not be refined. It should be abandoned, and the gatekeeping decision should be returned to where it has always belonged: the treating GP, in consultation with the treating psychologist.

7.3 The DVA Workforce Reduction: Incapacity by Design

The internal contradiction of the override mechanism is compounded by a second Budget measure announced simultaneously: a significant reduction in DVA's workforce. The same 2026–27 Budget that introduces the $5,000 cap and creates the administrative override function also cuts DVA staffing by more than 100 positions, with further efficiency dividend impacts across the portfolio.

This matters for the override mechanism in a direct, operational sense. DVA currently takes years — in many documented cases, multiple years — to finalise initial liability claims. Veterans applying for DVA acceptance of a service-related condition routinely wait 18 months, two years, or longer for a determination. During that waiting period, they have no access to DVA-funded treatment for the accepted condition. The DVA claims backlog is one of the most consistently reported and most severely criticised features of the current system, and it is a direct factor in veteran mental health deterioration and crisis escalation.

The proposed override mechanism will generate a high-volume, time-sensitive, clinically urgent stream of additional administrative work. Every veteran who exhausts their $5,000 cap before the financial year ends — and the worked examples in Section 4 demonstrate that this will occur for a substantial proportion of veterans in active psychological treatment — will need to submit an override application. Each application will require assessment, determination, and communication. Many will require clinical evidence gathering, liaison with the treating psychologist and GP, and potentially a formal appeal process.

> *A department that takes years to process an initial liability claim is being asked to process urgent clinical override requests within the days that responsible mental health risk management requires. This is not a resourcing gap. It is a structural impossibility.*

The DVA workforce reduction does not merely make the override mechanism slower. It makes it clinically unsafe. The processing timeframe for an override request is not a matter of administrative convenience — it is a clinical risk variable. A veteran with active suicidal ideation who exhausts their cap in October and waits weeks or months for a determination is a veteran whose treatment continuity has been interrupted by the very system designed to protect them. The Royal Commission identified treatment continuity as a primary protective factor against veteran suicide. The Government's own Budget design actively undermines it.

7.4 A System Structurally Incapable of Equitable Outcomes

Taken together — the cap, the unarchitected override mechanism, the administrative substitution of clinical gatekeeping, and the depleted DVA workforce — the policy

creates a system that is structurally incapable of delivering equitable outcomes for veterans requiring psychological treatment.

Veterans with straightforward, low-frequency physical health needs — those whose allied health requirements fall comfortably within $5,000 — will be largely unaffected. Veterans with complex, co-occurring psychological and physical conditions — the highest-need, highest-risk cohort — will be disproportionately impacted. The cap, by design, disadvantages complexity and chronicity. It disadvantages the veteran whose condition is most severe.

Within the group of veterans who exhaust the cap, outcomes will be further inequitably distributed by capacity to navigate the override process. Veterans with strong social support, high health literacy, an engaged GP, and a treating psychologist willing to invest time preparing override documentation will have better prospects of approval. Veterans who are socially isolated, whose cognitive or psychological functioning is impaired by their condition, who have limited English proficiency, or who are in regional and remote areas with constrained provider access, will be systematically disadvantaged in their ability to engage the override process — even before DVA's workforce constraints introduce further delays.

This is not a theoretical equity concern. It is a predictable, structural distributional consequence of the policy's design — and it runs in precisely the wrong direction. The veterans least able to advocate for themselves are most likely to fall through the gap between cap exhaustion and override approval. No equitable health system deliberately introduces a high-stakes administrative barrier at the point of maximum clinical vulnerability, staffed by non-clinicians, processed by a depleted workforce, and weighted against the patients whose condition most impairs their capacity to navigate it. The $5,000 cap override mechanism, as currently designed, does exactly that.

8. Confidentiality, Trust, and the Collapse of the Safety Net

Sections 7.1 through 7.5 have established that the override mechanism is clinically unjustified, administratively impossible, and structurally unprecedented. This section identifies two further and equally serious failures in the policy’s design: the override mechanism fundamentally compromises the confidentiality architecture that makes psychological treatment effective for veterans, and the Government’s designated alternative — Open Arms — is one that a significant and well-documented proportion of the veteran population will categorically refuse to use. Together, these failures demonstrate that the safety net the Government believes it has provided is, for a substantial cohort of the highest-risk veterans, no safety net at all.

8.1 The Confidentiality Architecture the Override Mechanism Destroys

The therapeutic relationship between a veteran and their treating psychologist is governed by one of the most robust confidentiality frameworks in Australian professional practice. The Privacy Act 1988 (Cth), the Psychology Board of Australia's Code of Conduct, and the Australian Psychological Society's Ethical Guidelines collectively establish that clinical disclosures made in the course of psychological treatment are held in strict confidence between the veteran, their treating psychologist, and their referring GP. That confidentiality is not a courtesy extended to patients. It is a clinical precondition for effective treatment — and for veteran populations in particular, it is the precondition on which treatment engagement depends.

The content of psychological sessions with veterans is frequently of the most sensitive nature imaginable: the details of operational trauma, moral injury arising from specific incidents, interpersonal violence, experiences that may carry classification implications, and disclosures that veterans have made to no other person. The confidential therapeutic space exists so that veterans can disclose what they need to disclose in order to be treated effectively, without fear that those disclosures will be seen by, reported to, or used by any party outside the treating relationship.

The override mechanism shatters this architecture. For DVA to determine whether a veteran's ongoing psychological treatment beyond $5,000 is clinically necessary, it will require clinical information. The Government has not published what that information will consist of — whether it will require session notes, diagnostic formulations, treatment plans, risk assessments, or specific disclosure content. The question of what DVA shall demand in order to approve further services is one the Government has conspicuously not answered. That silence is not reassuring. It is alarming.

> *A veteran should never be required to choose between the confidentiality of their most sensitive disclosures and the continuation of the treatment that depends on those disclosures being made safely. The override mechanism, as currently designed, forces exactly that choice.*

DVA is a large government bureaucracy with established data-sharing arrangements across the Commonwealth — including with the Australian Defence Force, the Australian Federal Police, the Department of Home Affairs, and other agencies that intersect materially with veterans' lives, security clearances, and employment prospects. Whatever clinical information DVA receives in the course of an override assessment enters a bureaucratic data environment fundamentally different from the confidential clinical environment in which it was generated. The Privacy Act provides baseline protections, but it cannot replicate the ethical and professional obligations of

the treating clinician. Once clinical information crosses from the therapeutic relationship into the DVA administrative system, the veteran has lost control of it.

Research on veteran help-seeking behaviour consistently identifies fear of disclosure to government as one of the primary structural barriers to mental health treatment engagement. Veterans — particularly those with service in sensitive roles, those with active compensation claims, those with security clearances, and those who have had adversarial experiences with DVA — are acutely attuned to the potential consequences of their psychological disclosures being seen by parties outside the treating relationship. The override mechanism does not merely create a privacy risk. It creates a perceived privacy risk that will suppress treatment-seeking in a population for whom that risk perception is clinically rational, historically grounded, and already a documented barrier to care.

The chilling effect on treatment engagement is the override mechanism's most dangerous second-order consequence. A veteran who chooses not to submit an override application — not because their clinical need has resolved, but because the confidentiality cost is perceived as too high — is a veteran whose treatment ends by design of the policy. That outcome will not appear in any metric the Government currently plans to monitor. It will, however, eventually appear in clinical deterioration, crisis presentations, and the mortality statistics that the Royal Commission was convened to address.

UNANSWERED QUESTIONS THE GOVERNMENT MUST ADDRESS

Before the override mechanism can be considered fit for clinical purpose, the Government must publicly answer the following: What clinical information will DVA require to assess an override application? Will session notes, risk assessments, diagnostic formulations, or treatment content be required? Who within DVA will have access to that clinical information, and what are their qualifications? Under what circumstances can that information be shared with other Commonwealth agencies, including the ADF, the Australian Federal Police, or the Department of Home Affairs? What are the veteran's rights if they decline to provide clinical information? How long will information submitted in support of an override application be retained in DVA's systems? What independent audit mechanism will govern DVA's handling of clinical information received through the override process? Until these questions are answered in a published, legally binding information governance framework, the override mechanism cannot be regarded as either clinically safe or ethically acceptable.

8.2 The Open Arms Trust Deficit: A Safety Net Many Veterans Will Refuse to Use

The Government's implicit position is that Open Arms — Veterans and Families Counselling serves as the safety net for veterans whose $5,000 cap is exhausted. Open Arms is exempt from the cap, it is free to access, and it is presented as a

clinically available alternative to private psychological services. This framing has a fundamental and well-documented flaw: a significant proportion of the veteran population will categorically refuse to engage with Open Arms, not because of any deficiency in the quality of its clinical staff, but because of its structural and perceived relationship with DVA.

Veterans' distrust of Open Arms is not anecdotal. It is a consistently reported finding across veteran community surveys, peer support networks, Royal Commission testimony, and the direct clinical experience of private practitioners working with this population. The core of the distrust is structural: Open Arms sits within the DVA portfolio, is funded by DVA, is administered by DVA, and is perceived — consistently, and across significant numbers — as insufficiently independent from the bureaucratic system that many veterans regard as adversarial, unreliable, or actively damaging to their interests. For veterans who have experienced prolonged claims delays, disputed liability decisions, or inadequate compensation outcomes, the structural proximity of Open Arms to DVA is disqualifying. They will not disclose psychological material to a service they regard as DVA-adjacent, regardless of the clinical quality of that service.

> *The Government's safety net is built on the assumption that veterans will use Open Arms when their cap runs out. Many will not. They will disengage from treatment entirely, deteriorate clinically, and present in crisis — outcomes that are not merely foreseeable but predicted by the clinical literature on treatment disengagement in this population.*

The cohorts most likely to refuse Open Arms engagement are, without exception, among the highest-risk and highest-need veterans in the DVA caseload: veterans with active or recently resolved compensation claims who fear that psychological disclosures to a DVA-funded service could be used against their interests; veterans from special operations or intelligence backgrounds for whom disclosure to any government-proximate service carries perceived security or career implications; veterans with histories of adverse DVA decisions for whom DVA represents not a source of support but a source of harm; and veterans whose experience of institutional culture within the ADF has produced a profound and generalised distrust of government systems that is itself a symptom of the moral injury and institutional betrayal that brought them to treatment in the first place.

These are not peripheral cases. They represent a substantial and clinically well-recognised cohort within the DVA-funded psychological caseload. For this cohort, the policy produces not a safety net but a three-way trap from which there is no clinically acceptable exit: private psychological services capped and inaccessible after the financial limit is exhausted; Open Arms structurally unacceptable on trust and confidentiality grounds; and the override mechanism requiring disclosure of sensitive

clinical information to the very organisation whose trustworthiness is in question. When all three pathways are blocked — financially, structurally, or by confidentiality risk — veterans do not find a fourth option. They disengage from treatment.

8.3 The Clinical Consequence of Total Pathway Closure: Decompensation

The clinical consequence of removing all acceptable treatment pathways for a veteran with active PTSD, complex trauma, or comorbid psychological conditions is not that the veteran stabilises and manages without support. It is decompensation: the progressive breakdown of previously functional coping mechanisms and psychological stability that occurs when the clinical scaffolding sustaining that stability is abruptly withdrawn.

Decompensation in veterans with PTSD and complex trauma is not a slow or gradual process. It can be rapid, severe, and fatal. The clinical literature on treatment disengagement in trauma populations consistently documents increased symptom severity, increased substance use, relationship breakdown, occupational deterioration, and elevated risk of acute crisis in the weeks and months following unplanned treatment withdrawal. These are the predictable sequelae of what the Government's policy — through the combination of the cap, the trust deficit, and the confidentiality risk — will produce for veterans for whom no acceptable treatment pathway remains open.

What makes this particularly serious from a policy accountability perspective is that decompensation of this kind will be functionally invisible to the Government's monitoring systems. DVA's administrative data will record whether a veteran applied for an override and whether it was approved. It will not record that the veteran chose not to apply because the confidentiality cost was too high, or that the veteran declined Open Arms because they could not trust a DVA-funded service. The chain of causation between the policy design and the clinical deterioration that follows will not be captured in any metric the Government currently plans to collect. It will, however, be apparent to every treating clinician who watches a veteran they have worked with for years disengage from care — and to every coroner who records the outcome.

THE ACCOUNTABILITY GAP

The Government has proposed no monitoring framework capable of detecting the clinical harm this policy will produce in veterans who disengage from treatment rather than submit an override or transfer to Open Arms. DVA's administrative data will record financial transactions and override outcomes. It will not record therapeutic disengagement driven by confidentiality fear, trust deficit, or the perception that no acceptable pathway remains. The gap between what DVA's data will show and what is actually happening to veterans in the community is not a measurement problem. It is a foreseeable accountability void — one that will allow the Government to characterise the policy as functioning as intended while veterans whose treatment has ended by policy design deteriorate unseen. The Senate Estimates process, the ANAO, and the Royal Commission Implementation Taskforce should each be asked to address how this accountability gap will be closed before the cap takes effect on 1 July 2027.

9. Recommendations

This white paper makes the following specific, evidence-based recommendations to the Australian Government, the Department of Veterans' Affairs, the relevant Senate and parliamentary oversight committees, and the ACCC.

Recommendation 1: Exclude Psychological and Mental Health Services from the Allied Health Cap

The most clinically sound and administratively defensible resolution is the immediate exclusion of psychology, clinical psychology, psychiatry, and mental health-related occupational therapy from the $5,000 Annual Monetary Limit. Mental health services operate under a fundamentally different treatment logic to physical rehabilitation: sessions are more frequent, treatment duration is longer, the consequences of interruption are more severe, and the population served is at elevated risk of suicide. They should not be captured within a financial instrument designed to reduce overservicing in physical health modalities.

Recommendation 2: Establish a Defined Clinical Override Protocol with Published Processing Standards

DVA must immediately publish a full clinical override protocol including: the clinical criteria for override eligibility; the qualifications required of the decision-maker; a maximum processing timeframe of no greater than five business days for urgent mental health presentations; a duty of care provision ensuring treatment continuity during the override assessment period; and a publicly accessible appeals pathway where override is refused. Any override protocol must be authored and peer-reviewed by registered mental health clinicians with demonstrated expertise in the veteran population.

Recommendation 3: Implement a Moratorium Pending Independent Clinical Impact Assessment

The Government must commission, and publicly release in full, an independent clinical impact assessment of the proposed cap's effect on mental health treatment continuity for veterans with active PTSD, complex trauma, suicidal ideation, and co-occurring conditions. This assessment should be conducted by clinical experts independent of DVA and Treasury, should include consultation with treating practitioners, and must be released before the measure takes effect on 1 July 2027.

Recommendation 4: Commission a Suicide Risk Impact Assessment

Given the well-established relationship between rationed mental health treatment and elevated suicidality in the veteran population, the Government must require DVA to conduct and publish a suicide risk impact assessment of the proposed cap. This assessment should be distinct from the clinical impact assessment above and conducted in accordance with the suicide prevention obligations established by the Royal Commission's final report.

Recommendation 5: Refer the Open Arms Exemption to the ACCC for Independent Review

The structural asymmetry created by the Open Arms exemption — whereby the Commonwealth's own psychological services provider operates in the same market as private registered psychologists, free from the financial cap imposed on those private competitors — should be referred to the ACCC for formal examination under the Commonwealth's competitive neutrality framework and the Competition and Consumer Act 2010 (Cth). This referral should occur before the measure takes effect. The findings should be made public and tabled in Parliament.

Recommendation 6: Protect Existing Treatment Relationships

Veterans who are currently in active, ongoing therapeutic relationships with DVA-funded psychologists must not have that treatment interrupted by the introduction of the cap. A grandfather provision should be enacted to protect existing treatment plans from financial disruption upon the cap's introduction. Forcing a veteran who has spent years building a therapeutic alliance with a treating psychologist to justify ongoing treatment to an administrative override committee is both clinically damaging and ethically indefensible.

Recommendation 7: Separate the Savings Measure from the Fee Increase

The Government's framing of this measure as a net benefit to veterans — because the savings fund a fee increase — is misleading. The fee increase and the cap are structurally separable. The Government should fund the long-overdue fee increase

directly through the Budget, without requiring veterans to surrender open-ended access to psychological treatment as the mechanism of funding it. The message that 'we will pay your psychologist more but limit how often you can see them' is not a positive outcome for veterans in acute mental health need.

10. Conclusion

Australia's veterans did not choose to develop PTSD. They did not choose the chronic pain that follows operational injuries. They did not choose the moral injury that comes from service in environments of extraordinary stress. What they were promised — by successive governments, by the covenant of service, and by the findings of a Royal Commission convened specifically to address the tragedy of veteran suicide — is that their country would care for them.

> *The $5,000 cap does not reflect the clinical reality of veteran mental health. It reflects the arithmetic of budget consolidation — and that arithmetic, applied to this population, carries a foreseeable human cost.*

The $5,000 Annual Monetary Limit, as currently designed, does not honour that promise. It consolidates the physical and psychological treatment needs of profoundly complex patients into a single financial envelope calibrated for administrative tidiness, not clinical adequacy. It increases the per-session cost of psychological treatment while reducing the number of sessions the envelope will fund. It exempts the Government's own provider from the very constraint it imposes on every private practitioner in the same market. And it does all of this in the name of a cohort — Australia's veterans — who deserve better.

The Government has the opportunity, before 1 July 2027, to correct the design of this measure: to exempt psychological and mental health services from the cap's scope; to refer the Open Arms competitive neutrality question to the ACCC; and to demonstrate that the Royal Commission's work was not merely a rhetorical exercise. That opportunity must be taken.

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Disclosure

The author provides psychological services to veterans and ADF personnel through D.G. Broadbent & Associates and has a direct professional and ethical interest in the matters addressed in this paper. This white paper represents the author's professional and clinical opinion and does not constitute legal advice. It is prepared for distribution to policymakers, parliamentary committees, veteran organisations, allied health peak bodies, the media, the Australian Competition and Consumer Commission (ACCC) – and everybody else in the community who shares an interest in the healthcare of those who run toward the bullets – not away from them…….