

Analysis of the Lifecycle Package

Final Report for the DVA Lifecycle Review

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This document is a final report for the Analysis of the Lifecycle Package project undertaken by the Australian Centre for Posttraumatic Mental Health (ACPMH), and submitted to the Department of Veterans' Affairs for consideration.

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Disclaimer

The views and recommendations stated in this report are solely those of the consultants, the Australian Centre for Posttraumatic Mental Health, and do not necessarily reflect those of the Australian Government.

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Executive Summary

Background

The mental health Lifecycle Initiatives were implemented as a 2008-09 budget measure. The goals included enhancing psychological resilience among service personnel, improving mental health surveillance, supporting successful transition from defence to civilian life, and providing effective rehabilitation and support. The purpose of the current analysis was to consider the implications of the project outcomes, as well as to examine the usefulness of the lifecycle concept for future policy and program development. This document is a discussion paper designed to raise issues for consideration. It is not intended to provide specific recommendations.

The Lifecycle Initiative outcomes were reviewed and interviews conducted with the Department of Veterans' Affairs (DVA) and Defence stakeholders. Key themes were identified and used to guide both a literature review and consultation with overseas military and veteran mental health experts. The material was then integrated for consideration by key DVA and Defence personnel.

The Concept of a Military-Veteran Lifecycle

The lifecycle approach assumes that an individual's current mental health is a function of a complex interaction of personal and environmental influences over the course of that person's life. A lifecycle framework facilitates identification of critical points for intervention in the life trajectory. Chapter 2 illustrates the lifecycle approach from prior to military service, through recruitment and training, military service, transition to civilian life, and adjustment as a veteran. Continuity of care is implicit in any lifecycle model, striving for a "seamless service" across the various life stages. The chapter ends by discussing the implications of such a framework for the Departments of Veterans' Affairs and Defence.

The Lifecycle Initiatives

The Lifecycle Initiatives comprised nine separate projects, as well as an additional training initiative. Following consultation with the Departments of Veterans' Affairs and



Defence, five of these projects were selected for inclusion in the current analysis: a) a transition mental health and family collaborative; b) a study into barriers to rehabilitation; c) a trial of options to engage veterans in treatment; d) development and trial of a self care program; and e) the training initiative. Chapter 3 summarises the project reports on each, including key recommendations and activities since project completion.

DVA and Defence Consultations

Consultations were held with key DVA and Defence personnel to explore opinions about the Lifecycle Initiatives, the usefulness of the Lifecycle framework, and the nature of future mental health services. Chapter 4 summarises the many issues raised in this consultation process. These issues were integrated to arrive at four key themes which then guided the literature review and international consultations:

1. Improving the consistency of approaches to mental health across the military-veteran lifecycle, with an emphasis on ensuring continuity of care.
2. Improving the process of transition out of the Defence Force and handover to DVA, aiming for a seamless transfer.
3. Improving the engagement of serving members, veterans, and their families in psychological health and wellbeing initiatives.
4. Optimising the quality of mental health care provided to serving personnel, veterans, and their families.

Literature Review and Overseas Consultations

A review of the “grey” literature, as well as the limited published literature, was conducted. Key Defence and Veterans Affairs personnel in the United States, Canada, United Kingdom, New Zealand, and Europe were consulted about developments in their country. The value of a lifecycle approach was explored – while most countries “implicitly” adopt a lifecycle approach, there was little evidence of consistent application to drive policy and programs. Each of the key themes identified in this review were deemed relevant by those consulted, although substantial variation was evident across countries in the extent to which each was developed.



Integration and Conclusions

Chapter 6 begins with a discussion of the Support for (Wounded) Injured and Ill Program (SWIIP), since that program addresses many issues that have arisen from the Lifecycle Initiatives. The remainder of the chapter integrates material from the early chapters to generate key conclusions:

- Substantial progress has been made in several key areas since these initiatives were conceptualised in 2007. Matrices comparing initiatives in 2007 with current activities are provided, testament to the depth and breadth of work that the Departments of Veterans' Affairs and Defence have accomplished in these areas.
- The lifecycle concept may be a useful strategic framework from which to consider potential mental health initiatives. It serves to inform intervention opportunities at key points of military service and adjustment to civilian life, and sits comfortably alongside more generic healthcare lifecycle models. It is important, however, to see military service in the context of a broader lifecycle and not allow it to completely dominate the picture. Serving members and veterans experience most of the same milestones and challenges throughout their lives as do civilians.
- While much progress has been made in recent years, considerable support was evident for further enhancing consistency across Defence and DVA initiatives in the mental health arena. While each initiative needs to be adapted for the particular point in the lifecycle, increasing consistency of approach where possible was deemed desirable.
- Australia has undergone significant changes in the area of transition and handover in recent years. Many of the recommendations of the recent SIIP review relate to this period in the military-veteran lifecycle and, if implemented, will do much to reduce the chances of vulnerable veterans falling through the gaps and to enhance early engagement in treatment. The advent of electronic health records has great potential to assist this process.
- Engaging serving members and veterans (particularly males) will continue to be a challenge, although initiatives discussed in this report may help. It is also reasonable to assume that progressive reductions in stigma across the broader community will



also impact on serving members. Indeed, there is emerging evidence that veterans from recent conflicts are presenting for treatment earlier than their counterparts from previous deployments.

- There is scope for further initiatives to improve the quality of mental health care provided to serving personnel and veterans by, for example, developing procedures to ensure providers engage in appropriate treatment planning, conduct goal oriented treatment, involve family members where appropriate, and adopt standardised outcome measures.

Much has changed since the Lifecycle Initiatives were conceived in 2007. Several areas for consideration in the design of future mental health initiatives are raised in this discussion paper.



Chapter 1: Background

A number of veteran and military mental health initiatives (referred to as the Lifecycle Initiatives) were implemented by the Government as a 2008-09 budget measure. This chapter provides an overview of the package of initiatives, as well as a description of the aims and process of the current analysis and an outline of this report.

Substantial developments have, of course, occurred in the four years since 2008, and both the Departments of Defence (Defence) and Veterans' Affairs (DVA) have implemented many initiatives in the mental health area. It is not the purpose of this report to cover all those developments. It is, however, important to interpret this review of the Lifecycle Initiatives in the context of those advances. Concerns that were seen as a high priority in 2007, for example, may no longer be an issue or areas of responsibility may have changed. As discussed in the following Chapter, the matrices included in Appendix 1 provide a broad indication of the developments in military and veteran mental health over this four-year period.

1.1: Overview of the Lifecycle Initiatives

The term "Lifecycle Initiatives" is used to describe the specific set of projects that constitute the focus of this report. The term "lifecycle framework" is used to describe a way of assessing and responding to military and veteran mental health more broadly, beyond these specific projects.

The Lifecycle Initiatives were based on the principle that military and veteran mental health is best seen as a continuum, starting from (or before) the point of recruitment, continuing through training and military service, through to transition out of the Defence Force to life as a civilian and veteran. Further details of the "lifecycle framework" are provided in Chapter 2. Briefly, it was argued that a focus on any one of these stages in isolation of the broader context is unlikely to achieve the best result. Rather, a consistent and integrated approach across the military-veteran lifecycle is more likely to result in optimum health and mental health outcomes, as well as functioning and quality of life. These initiatives were designed to pilot interventions and explore strategies that had the



potential to improve psychological wellbeing at each stage of the life of a person who had served in the military.

Each of the initiatives had one or more of the following goals:

- To enhance psychological resilience among service personnel
- To ensure better early intervention and mental health surveillance
- To support successful transition from defence to civilian life for the member and their family
- To provide effective rehabilitation and support, and timely mental health treatment

The mental health Lifecycle Initiatives comprised nine separate projects, which are listed here underneath the relevant goal:

Goal: Enhanced psychological resilience among service personnel:

1. A longitudinal study of psychological resilience in ADF recruits. This project, which was undertaken by Defence in collaboration with ACPMH, is in progress.
2. Pilot study of resilience building initiatives. This project, which was undertaken by Defence with advice from ACPMH via the Scientific Advisory Group, is in progress.

Goal: Better early intervention and mental health surveillance of serving personnel:

3. Routine annual mental health checks for current serving members (now incorporated as part of the periodic health checks).

Goal: Successful transition from defence to civilian life for the member and their family:

4. Family Support Trial (Townsville)
5. Transition Case Management Pilot (Townsville)

These two projects were as intended combined into a single project - the Transition Mental Health and Family Collaborative (Townsville), also referred to as the 'Townsville Collaborative'. This was undertaken by ACPMH and completed. An additional related project was proposed later that was not on the original list of Lifecycle Initiatives.



A Transition Complex Case Management Pilot, later titled 'The At Risk Initiative', was in concept development through extensive discussions between DVA, Defence and ACPMH, but this project did not proceed because it had been overtaken by other initiatives such as the Support for Injured and Ill Project (SIIP), now known as the Support for Wounded, Injured or Ill Program (SWIIP). It was replaced by the current review, titled the Analysis of Lifecycle Package.

Goal: Effective rehabilitation and support, and timely mental health treatment:

6. A study into the barriers to rehabilitation. This project was undertaken by ACPMH and is now completed.
7. Education campaign on social and occupational rehabilitation. This project has now been incorporated as part of core activities of the DVA rehabilitation group.
8. A study to trial a method to improve treatment options for 'hard to engage' veterans. This project was undertaken by ACPMH and is now completed.
9. Self-care trial for 'hard to reach' ex-service members (which developed the Wellbeing Toolbox website). This project was undertaken by ACPMH and the final report has been submitted.

A tenth project, while not initially included as one of the mental health Lifecycle Initiatives and funded separately, was launched at the same time and is best considered as part of the same package:

10. Competency development for community-based mental health practitioners (later referred to as Training for Secondary Mental Health Workers Initiative). This project was undertaken by ACPMH and is now completed.

1.2: Purpose of the Current Analysis

The purpose of the current project was to consider the implications of the key learnings from the completed and, where possible, in progress Lifecycle Initiatives and related projects, as well as to examine the usefulness of the concept of the lifecycle framework and its relevance to future policy and program development.



Following consultation with DVA and Defence, it was agreed that the focus of this analysis would be the five DVA funded projects that were conducted by ACPMH. The education campaign on social and occupational rehabilitation, which has now been adopted by the DVA rehabilitation group, was part of the original project plan but has since been removed following a decision by the Lifecycle Working Group in November 2011. The three projects conducted by Defence and the project that did not proceed are not included in this analysis. It is understood, however, that Defence will be informed of any implications for Defence processes or practices that emerge from the analysis. Therefore, the following five projects are included in the current analysis:

1. Transition mental health and family collaborative (Townsville)
2. A study into the barriers to rehabilitation
3. A study to trial a method to improve treatment options for 'hard to engage' clients
4. Self-care trial for 'hard to reach' ex-service members (Wellbeing Toolbox)
5. Competency development for community-based mental health practitioners (later referred to as the Training for Secondary Mental Health Workers Initiative)

1.3: Methodology and Governance

The current analysis has relied on a close collaborative relationship between ACPMH personnel working on the project and key DVA and Defence personnel involved in various aspects of mental health policy and service delivery. Thus, throughout the project there were multiple opportunities for formal and informal consultation and feedback. During the course of this project, ACPMH personnel reported to, and liaised with, the Lifecycle Working Group (LWG). The LWG included representatives of DVA, Defence and ACPMH. The first meeting was held at DVA on 7th September 2011, with subsequent meetings being held the 30th November 2011 and 1st May 2012.

The first phase of the project involved convening the above-mentioned LWG and establishing the consultative processes to be used. The next phase comprised conducting extensive interviews with key stakeholders in DVA and Defence, and reviewing each of the Lifecycle Initiatives' project outcomes. From these consultations



and reviews, key themes were drawn out that were relevant to achieving an optimum approach to mental health. Next, a rapid review of the published and “grey” literature was conducted, alongside consultations with international military and veteran mental health experts, in order to explore the previously identified themes. This allowed integration of all the material for consideration by key DVA and Defence personnel.

1.4: Structure of this Report

The next chapter discusses a framework for representing the projects within the concept of the military-veteran “lifecycle”.

Chapter 3 provides a summary of each of the Lifecycle Initiatives, including key outcomes and recent developments.

Chapter 4 summarises feedback received in the consultations with DVA and Defence staff, starting with project specific feedback and moving on to the key themes and focus points for future directions identified by those personnel.

Chapter 5 provides a summary of findings from a rapid (published and “grey”) literature review, which included consultations with relevant military and veteran mental health experts from overseas, designed to explore the key themes identified in Chapters 3 and 4.

Chapter 6 integrates information from the various sources and goes on to discuss the utility of adopting a lifecycle framework.

It is important to emphasise that this document is intended as a discussion paper designed to raise issues for consideration. It does not attempt to provide specific recommendations.



Chapter 2: The Military-Veteran Lifecycle

The purpose of this chapter is to provide a context in which to understand the Lifecycle Initiatives. The chapter discusses the concept of the military-veteran "lifecycle framework", providing an opportunity to explore how the projects fitted into a coherent approach to veteran and military mental health. It goes on to look more generally at how such a framework has the potential to guide policy and program development, highlighting gaps and opportunities. This approach is consistent with the program logic map that underpinned the recent Evaluation of the Department of Veterans' Affairs Mental Health Initiatives 2007-2010 completed by ACPMH in 2010 [1], although that map focuses only on the veteran end of the lifecycle. (A copy of that logic map is included in Appendix 2).

2.1: Understanding the Lifecycle Framework

The concept of viewing military mental health from a lifecycle perspective – from recruitment, through military service, transition out of the Defence Force, to life as a veteran in the civilian world – has a long history in Australia. Both formal and informal discussions along these lines have been held for many years, in the recognition that mental health problems in later life routinely have their genesis in earlier life experiences. In March 2003, for example, a DVA/ Defence/ ACPMH two-day workshop was held for key senior personnel from each organisation with the aim of building *“stronger links at a working level in Defence and DVA with a focus on mental health issues in deployment, transition management and mental health, and vocational and social rehabilitation”*. In 2007, this concept was formally spelt out in Government policy initiatives that became the launching pad for the Lifecycle Initiatives, which are the focus of this report. The lifecycle framework highlights the fact that just as with a person's physical health, their mental health warrants attention from both a monitoring and intervention perspective continuously across their military-veteran life, but especially at key time points that are known to place the person at a higher risk for developing problems.

At the root of this approach is the understanding that an individual's mental health at a given age – be it 30 or 50 or 70 – is a function of a complex interaction of personal and environmental influences over the course of that person's life. The genetic code that he



or she inherits carries with it certain vulnerability and protective factors, making it more or less likely that the person will develop problems such as anxiety and depression later in life [2].

2.1.1: Prior to military service

What is becoming increasingly clear through a mounting body of research is that environmental influences and a person's genetic code are potential influences only. Whether these vulnerability and protective factors become activated, and how strong their influence will be, depends on their interaction with a broad range of environmental factors, particularly during childhood and adolescence [3].

Entry: It is during late adolescence or early adulthood that most new recruits enter the Australian Defence Force (ADF). While it is not possible to change their genetic or environmental history, it may be possible to identify “at risk” or “resilient” individuals through the selection process and, potentially, to enhance their psychological resilience through targeted training. The first two Lifecycle Initiatives – “*A longitudinal study of psychological resilience in ADF recruits*” and “*A pilot study of resilience building initiatives*” – were targeted at this part of the military-veteran lifecycle.

2.1.2: Military service and transition

Service: The impact of environment on mental health continues through adulthood. There is now a large body of research data supporting a link between stressful life events and high prevalence mental health conditions such as anxiety and depression [2]. Military service carries with it frequent exposure to potentially stressful events, not only through deployments but also through other postings and training experiences. Thus, it is important that the mental health of all service men and women be regularly monitored in order to identify as early as possible any adverse impact of military service (or, indeed, other stressors in their lives through this period). The third Lifecycle Initiative – “*Routine annual mental health checks for current serving members*” – was designed to achieve this goal.

Transition: Military service is not necessarily the long career it routinely once was, with many people signing up for short periods with a view to moving on to other job opportunities while still relatively young. The average length of service is currently 6.8



years. Service men and women, therefore, will move out of the Defence Force and into civilian life at many different ages and life stages. They will also leave the military for different reasons. For some, it may be part of a planned career trajectory. For others, however, their future in the armed forces may have been cut short for medical reasons, administrative discharges or “unsuitability for service”, or simply disillusionment.

For all those leaving the Defence Force, but particularly for those who are leaving earlier than planned, expert opinion (i.e., the local and overseas experts and stakeholders consulted as part of the review, as well as members of the ACPMH review team) suggests that the process of *transition* is a major turning point in their lives and, potentially, a highly stressful time. For many, they have to quickly learn to navigate new and unfamiliar systems in the civilian world, whilst for a minority of people, particularly single younger members, this may be the first time they have had to manage all aspects of their life themselves – housing, employment, healthcare, and so on. The challenges involved in doing this, even for those that are healthy, let alone for those with physical or mental health problems and their families should not be underestimated. It is reasonable to assume that, managed well, this period can establish a healthy life trajectory that takes the person to a future characterised by healthy relationships, optimum functioning, and good psychological health and wellbeing.

When things go wrong, however, clinical experience (i.e., the experience of clinicians on the ACPMH review team and their colleagues working in veteran mental health) suggests that there is great potential for the life trajectory to take a different course. Perceived rejections and failures, combined with difficulty meeting the new challenges of life outside the military, can build upon one another to precipitate a downward spiral into poor mental health and impaired functioning.

Many of those consulted in the course of this review suggested that any gap in availability of services for veterans as they move out of defence and wait ‘in limbo’ for the administrative aspects of handover to be completed can be particularly frustrating. For many the shock of being in a new system that requires them to be proactive in seeking care, rather than passively be provided with it, can be overwhelming and confusing. For others, the whole issue of needing to seek ‘entitlement’ for services is an emotionally charged one that can become a major source of frustration, anger and disillusionment.



It was this point in the military-veteran lifecycle that the fourth and fifth projects – the “*Family support trial (Townsville)*” and the “*Transition case management pilot (Townsville)*” – were designed to address, conducted jointly as the Transition Mental Health and Family Collaborative (Townsville). Recognition of the vital role of the family in the process of transition was an inherent component of the project. The need for special initiatives to be in place for those people exiting the Defence Force with significant physical, mental, and/or social/behavioural problems was subsequently addressed more comprehensively through the Support for Wounded, Injured or Ill Program (SWIIP).

2.1.3: Post military service

For the majority of people, the move to civilian life is a positive one and they are able to adjust and adapt to the new challenges, functioning well in social, occupational, and psychological health domains. For others, however, the path is less easy, particularly those who are struggling to pick up their lives after significant mental or physical injuries. Many programs and opportunities exist both within and outside the veteran-specific sector, yet a substantial number of people fall through the gaps and are not able to achieve their optimum level of wellbeing or functioning. The next two Lifecycle Initiatives – “*A study into the barriers to rehabilitation*” and “*An education campaign on social and occupational rehabilitation*” were designed to address this issue. There is ample evidence that return to work following injury is generally associated with improved mental health and functional outcomes [4]. Even where return to paid employment is not possible, engagement in meaningful activities (including voluntary work), as well as social re-engagement, will contribute to improved psychological health and wellbeing.

Even the best systems and attention to barriers to care will not be successful in engaging all those with identifiable problems. As the military-veteran lifecycle continues, those with significant mental or physical health problems may find themselves becoming increasingly isolated from the rest of the community and from those individuals and agencies who are in the best position to provide assistance. Thus, it was recognised that more assertive and flexible approaches might be needed to assist that group of veterans – and their families – in addressing their problems. The “*Study to trial a method to improve treatment options for ‘hard to engage’ clients*” was designed to trial more assertive outreach approaches to engaging this hard to reach group of veterans and their families. Such initiatives are by no means limited to those veterans in later life. On



the contrary, the opportunity to engage contemporary veterans with an assertive outreach approach has great potential to reset their life trajectory towards a more positive path before mental health problems and maladaptive behaviours become too entrenched.

The difficulty for individuals of acknowledging mental health problems, let alone seeking mental health treatment, should not be underestimated. Even with effective assertive outreach and the best pathways to care, some will not be willing or able to avail themselves of treatment in its traditional forms [5]. Thus, the idea of improving the ability of these veterans (and their partners) to help themselves was pursued in the form of the “*Self-care trial for ‘hard to reach’ ex-service members (Wellbeing Toolbox)*”. Comprising a web-based, evidence informed approach, this initiative was designed to teach simple coping skills in an accessible, interactive format. The strength of this approach is its applicability right across the military-veteran lifecycle.

Underpinning any approach to improving mental health is the assumption that, if people can be assisted and encouraged to access professional treatment, they will receive high quality evidence-based care. Regrettably, that assumption is not always borne out in reality for either serving members, veterans or the general community. The quality of services provided by mental health service professionals is variable, as is the level of understanding of the particular needs of past and present members of the Defence Force. The final Lifecycle Initiative, “*Competency development for community-based mental health practitioners*” was designed to address this concern. It comprised extensive training, supervision, and peer support initiatives across Australia with a view to improving the competence of community providers in recognising and managing veterans’ mental health issues. As such, it was an attempt to improve access to mainstream services, as targeted providers were private practitioners based in the community for whom veterans and serving personnel were only a part of their clinical caseload. Interventions that target mental health providers are also an important aspect in addressing continuity of care (see below). Many of the targeted providers treat both serving personnel and veterans, so initiatives such as these may enhance the quality and consistency of mental health services provided across the military-veteran lifecycle.



2.1.4: Continuity of Care

Continuity of care (or “continuum of care”) is an important and related construct in the context of a lifecycle framework since it, too, is concerned with the quality of care over time [6]. From the patient’s perspective, the ideal scenario would be to have an unbroken caring relationship with their health care provider(s) over time. This, of course, is embodied to a degree in the traditional “family doctor” model of care. It is increasingly hard to achieve in the present day, partly because patient needs can rarely be met by a single provider and partly due to greater mobility among both providers and patients (especially serving members and veterans).

Continuity of care is best addressed from the provider perspective by striving for a “seamless service” through integration, coordination and effective sharing of information between different providers involved in the patient’s care. This is achieved with reference to related constructs such as case (or care) management, multidisciplinary team approaches to care, and effective record keeping. Proponents of continuity of care models argue that this approach results in higher levels of patient satisfaction as well as improved healthcare outcomes [7]. A lifecycle approach sets the framework within which to implement continuity of care, but the challenges are considerable. Given the significant transitions from civilian to military life, through deployments and postings, through discharge and resettlement back into civilian life, the difficulties of achieving a seamless service across every stage are significant.

2.2: Using the Lifecycle Framework

Conceptualising veteran and military mental health along a temporal continuum provides the opportunity to identify gaps in and opportunities for interventions to promote mental health. An example of this is provided in Appendix 1, which presents matrices that combine stages of the lifecycle with the potential “target” audiences. Two matrices are provided which show examples of the initiatives underway in 2007 when the Lifecycle Initiatives commenced, as well as examples of those currently underway in 2012. Adopting a lifecycle matrix framework such as this can facilitate questioning along the following lines, ensuring that all the relevant “boxes” are addressed:

- What can be done to ensure that young people entering the Defence Force have the right attributes and psychological resilience profiles?



- Is it possible to identify and mitigate (where possible) the psychosocial risk factors that arise during military training? Is it possible to enhance the resilience of recruits at that point? What training do health and other personnel require to support this?
- What can be done during general military service to identify and mitigate psychosocial risk factors? What training is required for leaders and peers?
- Is it possible to identify the early warning signs of mental health problems? If so, is it possible to intervene effectively? What training and/or programs are required?
- What can be done to improve the process of transition and handover for discharging ADF members?
- What is the role of areas within Defence, DVA, and the community in this process? What new training, policy, or procedures are required?
- Is it possible to identify, during or immediately after discharge, who is not functioning well and/or who may be at risk for future problems? How should organisations do this and who should be responsible? What strategies need to be in place to assist these people?
- How can families be engaged effectively, not only for the benefit of the serving member or veteran, but also for the benefit of their own mental health?
- What is the best process for ensuring easy access to high quality care for any veteran with mental health problems? What training, policy, funding options should be explored?
- What is the best way to assist veterans and their families in seeking support? Does it require better information, reduced stigma, better integration with mainstream services, alternative funding models, etc.?
- What training, support, and accountability measures are required?

This is clearly not an exhaustive list. Rather, the goal is simply to illustrate the potential benefit of taking a longitudinal, lifecycle framework as a means for identifying gaps and generating appropriate initiatives. For each stage, it is reasonable to ask what Defence can do, what DVA can do, and – perhaps most importantly – what can they do in collaboration. One point that emerges from consideration of the lifecycle framework is the danger of a gap in accessing services occurring between an “unwell” member of the Defence Force being discharged and the point at which they first claim services from DVA. This point is taken up again later.



Chapter 3: Project Summaries

The following pages provide summaries for each of the five Lifecycle Initiatives covered by this review. These initiatives, as well as their findings and implications for DVA, are described in detail in the individual project reports previously submitted to DVA. The projects are:

- Transition Mental Health and Family Collaborative (Townsville) – combining the Transition Case Management Pilot and the Family Support Trial.
- A study into the barriers to rehabilitation
- A study to trial a method to improve treatment options for ‘hard to engage’ clients
- Self-care trial for ‘hard to reach’ ex-service members (“Wellbeing Toolbox”)
- Competency development for community-based mental health practitioners (later referred to as the Training for Secondary Mental Health Workers Initiative)

The summary for each project begins with a brief introduction to set the context for the project. The summary is then structured under the following headings:

- Project aims
- Project activities (a brief overview of the project work)
- Findings and outcomes (a brief summary of key findings and outcomes)
- Recommendations (a summary of recommendations provided in the final reports)
- Activity since completion (any known recent developments)

Refer to Appendix 3 for an overview of each project’s lead personnel, their position and other involved parties. Refer to each project’s final report for detailed information on project background, findings and implications for DVA.



3.1: Transition Mental Health and Family Collaborative (Townsville)

Transition from service to civilian life has the potential to be a crucial turning point in the military-veteran lifecycle. Clinical experience suggests that, if handled well, there is great potential to set a positive trajectory for subsequent health and wellbeing as a civilian. On the other hand, the reverse can also be true, so that veterans who perceive their transition or handover has been unsatisfactory may be placed at higher risk for developing subsequent health and wellbeing problems as a civilian. This may be especially true for those undergoing medical or administrative discharge. The Transition Mental Health and Family Collaborative (Townsville) was designed to explore opportunities for optimising psychosocial aspects of transition, with the anticipated outcome of improved health and wellbeing in subsequent years in life as a veteran.

It is important to note that significant changes to the process of transition, including a focus away from transition as the time to address health issues, have occurred since this project was initiated in 2007. These changes are discussed briefly below in Section 3.1.5.

3.1.1: Project aims

The aim of this initiative was to enhance transition related to mental health and family support services for medically discharging ADF members and their families in Townsville. Some confusion has resulted from wording in the original aim of this project, suggesting a much broader remit to review the general nature and extent of transition services. In practice, this meant that the scoping study led to the inclusion of a wide range of agencies and functions that had direct contact with transitioning members. In terms of the intervention that followed, the project focussed on generic issues of staff practice and knowledge in interaction with clients, especially in relation to family and mental health issues. It also focussed on communications between staff within and across agencies. It did not address structural or policy issues of service provision.

Defence, DVA and their funded health providers participated in an intensive nine-month quality improvement collaborative focussing on the following five change priorities to improve their transition mental health and family support practices:



- Improved inter-agency collaboration
- Effective engagement and communication practices
- Better recognition of mental health problems and related issues
- Improved family sensitive and inclusive practices
- More effective advice, support and treatment

These practices were chosen because stakeholders identified them during the scoping phase of the initiative, and they are consistent with the research literature on improved mental health and family outcomes.

3.1.2: Project activities

Ten teams representing 14 services in Townsville participated in the Collaborative. Five of these teams were from local Defence Health and/or Rehabilitation Services, two were from civilian rehabilitation providers, and one each came from the DVA State Office, VVCS, and community/hospital providers. A “pre-work” phase was followed by three “learning and action” phases, with the final step being a collaborative conference.

The pre-work phase required each team to define member responsibilities and expectations, complete an organisational readiness measure, and draft a statement of aims that operationalised the application of the change priorities specifically for their team – what did they, as a team, want to achieve?

All teams attended three, two-day learning sessions at which experts in the field provided information. Each team reported on progress to date and received feedback and suggestions from other teams. They also set goals for the next action period. During the action periods between learning sessions, teams implemented changes in their local service settings and collected data to measure the impact of these changes.

The final conference brought the teams together along with people from around Australia with an interest in ADF transition. The conference provided a forum to report back on the project and to discuss issues such as sustainability and generalisability across the country. Throughout the project, each team submitted monthly progress reports and



received support from the faculty and other teams via teleconferences, meetings, email, telephone and the website.

3.1.3: Findings and outcomes

Standardised self-report measures assessed participants' perceptions of change. Baseline measures revealed little emphasis on the key areas of concern (especially inter-agency collaboration, attention to mental health issues, and family involvement). There was an increase in most of the knowledge and skills domains from Learning Session 1 to Learning Session 3. The most notable improvements were increased confidence in their ability to recognise and address mental health needs, and knowledge about effective collaborative care arrangements for ADF members.

Teams used a 'Practice information checklist' to record whether staff implemented practices across the five change priorities with a client. Over 300 MEC3 and MEC4¹ clients were recipients of the improved practices used by teams during the initiative. Findings indicated a five-fold increase in the number of clients receiving services that involved collaboration with other services, improved engagement strategies, questions about common mental health and family problems, a request for permission to contact family, and provision of feedback, advice and information about mental health issues and related services.

Feedback from clients, team leaders, and other stakeholders was also generally positive, although some negatives were noted including concerns about transferability to other locations, what was seen to be a high investment for a relatively small number of people, and a 30% team dropout rate. Perceptions of sustainability were variable; while only 45% of stakeholders (many of whom were not located in Townsville) believed changes would be sustained, 86% of team leaders in Townsville believed they would.

¹ These terms refer to the Medical Employment Classification (MEC). MEC3 refers to clients classified as medically unfit for deployment or seagoing service for 2-12 months. MEC4 refers to clients classified as medically unfit for deployment of seagoing service for 12+ months.



3.1.4: Recommendations

The following are abbreviated versions of the recommendations made in the 2010 final report for the Transition Mental Health and Family Collaborative (Townsville):

Recommendation 1: *Implement the five transition change priorities.* It was recommended that the five change priorities for mental health and family practice improvement be implemented across all Defence and DVA transition services.

Recommendation 2: *Implement affordable practice improvements.* It was recommended that less resource intensive practice improvement methods be implemented nationally by:

- Identifying local internal leaders with authority and support to implement
- Reducing the amount of face to face training, increasing the emphasis on a package of simple written guidelines and video modelling of core skills
- Reducing face to face communication between teams in favour of virtual communication (phone, email, teleconference)
- Maintaining the requirement for demonstrating practice changes over time

Recommendation 3: *Use objective measures of practice change.* It was recommended that the main practice priorities be monitored using common objective measures across sites.

Recommendation 4: *Joint Defence and DVA leadership of transition improvement efforts.*

It was recommended that the full range of Defence and DVA funded transition services be included in the implementation of these practice improvements (e.g., health, chaplaincy, rehabilitation, transition, compensation, Defence Community Organisation, VVCS). This was designed to build their identity as a seamless system of transition support services. It was recommended that implementation of these recommendations be led jointly by Defence and DVA.



3.1.5: Activity since project completion

Although this initiative was not continued in a formal way, reports from personnel in Townsville suggest that many attitudinal and procedural changes have persisted. The final report and recommendations were provided to Defence as part of the SIIP review, and are reflected in the SWIIP program currently being implemented. In terms of the methodology, the collaborative model developed for this project was not considered feasible for a national rollout by DVA or Defence due to its high resource requirements. Along with the Training for Secondary Mental Health Workers Initiative (formerly Competency Development for Community-based Mental Health Practitioners), which used a similar model, this project provided a broader picture for DVA on the use and effectiveness of collaborative models in general.

Since this project, important changes have taken place in the way in which transition is managed and the focus for identifying health issues is now during service. While DVA had a role in the transition process at that time, since 1 October 2011 DVA's main service provision role is the On-Base Advisory Service which extends beyond transition to the whole period of service. The On-Base Advisory Service is involved in early intervention in relation to DVA's role in administering the Military Rehabilitation and Compensation Act for members while serving, and determining liability under all compensation arrangements.

All transition services are now the responsibility of Defence. The new term "handover" is more commonly used from a DVA perspective in relation to the negotiated transfer of responsibility for care. However, SWIIP also involves the notification or engagement of DVA as necessary in relation to its areas of responsibility during service and prior to discharge. The change priorities and recommendations from the Townsville report were made available to inform the development of the SWIIP program, including the implementation of the On-Base Advisory Service. The major part of the SWIIP program, however, is aimed at enhancing the processes within Defence itself for addressing the needs of wounded, injured or ill in treatment or rehabilitation while serving, and includes transition only as part of a similarly broad 'lifecycle' focus.



3.2: A Study into the Barriers to Rehabilitation

With the introduction of the Military Rehabilitation and Compensation Act 2004 (MRCA), increasing attention and emphasis has been placed on rehabilitation. The goal is to ensure that all veterans return to an optimum level of social and occupational functioning following injury. Analysis of existing DVA data, as well as results from DVA funded research such as the Pathways to Care study, reveal that over 40% of veterans with an accepted mental health disability do not access specialist treatment following acceptance of their claim [8]. This is despite the availability of free treatment and the introduction of several vocational rehabilitation initiatives designed to assist veterans in returning to full or part time employment. These findings raise the question of whether it is possible to identify and address barriers – what is preventing injured veterans from achieving optimum psychosocial and vocational rehabilitation?

3.2.1: Project aims

With the objective of determining whether there were systematic barriers to successful rehabilitation for DVA clients, this two-year project evolved over time in response to emerging information about needs, processes, and procedures. A preliminary review suggested that systems and processes around initial assessment, treatment planning, and outcome measurement were inconsistent and often less than ideal. Phase One, therefore, involved data collection from a range of sources with the aim of increasing understanding about how rehabilitation outcomes were being measured, how ‘success’ in rehabilitation was conceptualised by different stakeholders, and identification of perceived barriers to achieving successful rehabilitation outcomes.

The objective of Phase Two was to evaluate the introduction of trial procedures designed to overcome some of the barriers identified in Phase One. There were two parts to Phase Two:

- Study 1: to evaluate the introduction by DVA of a DVA-developed on-line Needs Assessment (NA) tool including assessing the comprehensiveness and quality of completion, and the factors that act as barriers or enablers to the introduction of the tool.



- Study 2: to trial the introduction of an appropriate, sustainable outcome measure to be added to modified forms to be used by DVA-contracted rehabilitation providers. The aim was to assess the usefulness to DVA of Goal Attainment Scaling (GAS) and a life satisfaction questionnaire (LSQ) as routine outcome measures that recognise the broader psychosocial rehabilitation philosophy reflected in the MRCA and Safety, Rehabilitation and Compensation Act 1988 (SRCA).

3.2.2: Project activities

This project focussed on veterans in the MRCA and SRCA schemes. Phase One involved collecting data through the following means: a) interviews with DVA clients; b) focus groups with DVA staff; c) an online survey of rehabilitation service providers; d) interviews with key stakeholders; and e) a review of a sample of DVA case files. For each group, the kinds of areas covered included: a) expectations regarding rehabilitation and its outcomes; b) the process, experience, and key components of rehabilitation; c) measures at different points, including perceptions and measures of success; d) perceived facilitators and barriers to rehabilitation; and e) suggested areas for improvement. These data were collated and combined with a literature review of best practice in psychosocial rehabilitation (since published as a journal article) to generate initial recommendations and guide Phase Two.

The first part of Phase Two involved assessing an electronic Needs Assessment (NA) form designed and trialled by DVA in three DVA offices. A total of 346 electronic NA forms were collected throughout the 9-month trial period. Forms and related documentation were reviewed to assess consistency and quality, and information was sought from DVA staff and key stakeholders about the strengths and weaknesses of the new system.

The second part of Phase Two comprised a feasibility trial of standardised outcome measures (GAS or LSQ) among rehabilitation providers in Victoria, South Australia, and Queensland. A manual was developed for providers and training offered in each state. A total of 84 rehabilitation plans were submitted and analysed to determine the use of GAS and LSQ measures. Feedback about the process was sought from providers and DVA staff.



3.2.3: Findings and outcomes

There were a number of reports arising from this program of research. The Final Phase One report identified several important themes that emerged from the Phase One data collection and review. There was a consistent view that communication (between and among staff, clients, and rehabilitation providers) was not as effective as it could be, and that veterans often knew little about the process of rehabilitation or what services were available. The second key theme highlighted the importance of holistic and flexible approaches to rehabilitation, rather than a generic “one size fits all” approach. The third major theme revolved around the need to improve DVA administrative processes, which were seen to delay liability determination, assessment, and the provision of rehabilitation services.

The report on the DVA electronic NA form trial highlighted several concerns, including issues with compliance by delegates, complaints regarding the “usability” of that version, and poor integration of the form with other systems. Despite those concerns there was overall support for the concept of a standardised electronic needs assessment form, provided the problems could be resolved. The Report provided DVA with material to guide their future decision-making.

The report on the feasibility study of the use of GAS and LSQ as routine outcome measures for DVA rehabilitation cases generally supported their feasibility and potential usefulness. The approach was seen to support a client-focussed approach to rehabilitation, with the data useful for providers, DVA rehabilitation coordinators, and DVA executives in reporting rehabilitation outcomes. More importantly, introduction of these measures was seen to improve the quality of rehabilitation services being provided to veterans.

3.2.4: Recommendations

Specific recommendations were not generated from Phase One. Rather, the findings were used to drive Phase Two of this project. The following are abbreviated versions of the recommendations made in the 2010 final report:

Study 1: Needs Assessments:



Recommendation 1: It was recommended that DVA further support staff conducting needs assessments (NA) by providing pre-written, template style paragraphs to use in client letters.

Recommendation 2: It was recommended that DVA investigate a more appropriate platform to support more efficient and effective delivery of NAs.

Recommendation 3: It was recommended that expectations regarding depth of information to be sought in the NA be made clearer to staff.

Recommendation 4: It was recommended that DVA investigate the potential impact of the time taken to process key performance indicators (KPI) for liability assessment on early intervention for rehabilitation. DVA may wish to review KPIs around time taken to *commence* (but not complete) a NA, quality of the NA process, and resulting letters to clients. It was suggested that an audit of NA forms and quality of letters should be routine.

Study 2: Outcome Measures:

Recommendation 1: It was recommended that DVA adopt the Goal Attainment Scaling (GAS) approach as a routine outcome measure for rehabilitation, and the optional use of the Life Satisfaction Questionnaire (LSQ) was also recommended.

Recommendation 2: It was recommended that DVA give further consideration to using a brief form of GAS for services provided without assessment or a rehabilitation plan.

Recommendation 3: It was recommended that DVA provide training to providers in the use of the GAS and LSQ, and that this be provided in a format that can be accessed easily by providers (e.g., on-line or compact disc) when they have changes in personnel.

Recommendation 4: It was recommended that DVA provide basic training to DVA staff in the background, intent, and practicalities of the GAS and LSQ, and that this be provided in a format that can be accessed easily by offices when they have changes in personnel (e.g., online, self-directed learning modules).

Recommendation 5: It was recommended that DVA consider ways to incorporate the use of the GAS and LSQ data into existing or future systems.



3.2.5: Activity since project completion

Needs assessment: Processes have commenced around achieving national consistency. Work is still to be done on developing an electronic NA form, but all states are now using the same process (pen and paper). DVA is addressing the process of communication with clients (i.e. the letters that arise from assessment) and reviewing the key performance indicators that relate to timeliness (recommendation 4).

Outcome measures: The Repatriation Commission has endorsed the recommendation for a national roll out of the GAS as a routine outcome measure and agreed to proceed. DVA is now in the process of developing an implementation plan. Policy and procedure manuals designed for the study will be updated and a provider information pack developed. It is worth noting that there is broad industry acceptance of the GAS, beyond DVA (e.g. Transport Accident Commission of Victoria, and interest from Defence).

3.3: A Study to Trial a Method to Improve Treatment Options for 'Hard to Engage' Clients

Analysis of existing DVA data, as well as results from DVA funded research such as the Pathways to Care study, reveal that over 40% of veterans with an accepted mental health disability do not access specialist treatment following acceptance of their claim [8]. There is no doubt that seeking psychiatric care is a decision that many people find frightening and difficult – nearly two-thirds of those with a mental health problem in the general community do not seek treatment from a mental health specialist, indicating that mental health service use is far higher among veterans than among the general population [9]. It could be argued, however, that DVA has a particular duty of care to these veterans and that more assertive outreach approaches designed to encourage them to seek specialist care would be justified. This study was designed to explore this issue. As such, it is closely linked with several other recent policy initiatives both within the Lifecycle program (e.g., barriers to rehabilitation, self-care options) and more broadly within DVA's mental health policy initiatives (e.g., At Ease program).



3.3.1: Project aims

For pragmatic and feasibility reasons, this project was limited to a single geographical area in Victoria, the Barwon South-Western Region, with a population of 350,000. On a simple proportional basis it was estimated that there were about 750 past Defence Force members residing in the region. The aim was to significantly increase the numbers of veterans and former ADF members in that region who engage in mental health treatment for the first time. The issue of sustainability and generalisability was considered from the outset. Thus, the aim was to achieve this increase in engagement with treatment using only low cost methods and an emphasis on existing resources and services.

3.3.2: Project activities

The first step involved establishing a partnership with key service providers in the region, including VVCS, Geelong Clinic, St John of God Healthcare in Warrnambool, and Austin Health Veterans Psychiatry Unit. A steering group was formed comprising these service providers, as well as DVA staff from the Geelong and Warrnambool Veterans Affairs Network Office and the Location Manager Community Mental Health. Efforts were made to engage Ex-Service Organisations in the region at every stage. A suite of promotional materials under the theme of “How are you travelling?” was developed.

Three interventions were evaluated. First, over 3000 letters signed by the DVA Principal Medical Adviser were distributed to inform all veterans in the region about the initiative. Second, information and campaign materials were distributed through general practitioners and Ex-Service Organisations (13,000 brochures, 10,000 postcards), media (9 newspaper articles, 3 radio interviews, 2 television interviews), and the establishment of a website dedicated to the initiative (www.howareyoutravelling.org.au). Third, community meetings were planned to provide the opportunity for the target group to: a) hear from other veterans, partners and services providers about their experience of mental health issues and options for care, and b) have a consultation with a mental health practitioner if they chose to do so. Four meetings were held across the region.

Assertive outreach involved up to three attempts at follow-up being made to any member of the target group following an expression of need on their part or an expression of concern on the part of a family member or friend.



3.3.3: Findings and outcomes

Prior to commencement, it was estimated that if 50 new people were recruited to mental health care in this trial, the average cost would be \$3000 per person.

Nearly 100 people, including veterans, family members and friends, attended the community meetings. Of those who attended community meetings, 26 requested help and 14 took the opportunity for a brief consultation with a mental health practitioner on the night. The remaining 12 requested follow-up in the few days following. Ultimately, 14 new client registrations came out of the community meetings.

In this period 88 people from the target geographical area made direct contact for the first time with the service providers who were partners to the initiative. Of those who contacted a service provider directly, 60 requested help and were registered as new clients. The total number of new client registrations over the period of the initiative was 74. This compares to 48 for the same period in the previous year – a 54% increase. Of the new registrations, 26 clients indicated that they had sought help for mental health problems the first time solely because of the initiative. These figures, of course, relate solely to the duration of the project. There is no way of knowing how many more veterans were prompted by these initiatives to engage in treatment sometime following the evaluation period.

Eighty-five per cent of the new client registrations arising from the initiative were aged over 54. The initiative was less successful in engaging the younger cohort of veterans and former serving members, that is, those who served post 1975. This may not be surprising given their relatively low numbers in the region, but consideration is given to effective strategies to reach this group. The evaluation suggested that the most valuable activities undertaken to increase awareness were the signed letter from DVA Principal Medical Adviser and the media campaign.

3.3.4: Recommendations

The following are abbreviated versions of the recommendations made in the 2009 final report:



Recommendation 1: It was recommended that a strategy of regular (e.g., 2-3 yearly) regional mail-outs be developed, including a letter signed by the Principal Medical Adviser together with relevant brochures.

Recommendation 2: Assertive outreach practices by VVCS, contractors and other DVA funded providers were encouraged, rather than requiring the veteran to make first contact with the service.

Recommendation 3: It was noted that engaging Defence Force members less than 50 years old would require more intensive or different means for engagement such as social networking technologies and efforts to engage them closer to their discharge from the defence services.

3.3.5: Activity since project completion

Since completion of this project, the intent of these recommendations has been incorporated into the broader DVA mental health policy framework and is consistent with emerging directions such as the use of technology and other efforts to engage younger veterans early following discharge. These efforts include the continued development of web-based resources and emerging use of smartphone applications. The community meeting model has not been adopted, although it remains an option for selected areas should a specific need arise in the future.

The project assisted in informing other activities such as the mental health literacy project, the “Wellbeing Toolbox” (self-care initiative), and the Training for Secondary Mental Health Workers Initiative (formerly known as Competency Development for Community-based Mental Health Practitioners). A mail out to veterans was used as part of the marketing strategy for the “Wellbeing Toolbox”.

3.4: Self-care Trial for ‘Hard to Reach’ Ex-service Members (“Wellbeing Toolbox”)

Despite the best efforts of Defence, DVA and service providers, the fact is that many veterans will not seek assistance for mental health problems [8]. Lower than desired levels of help seeking is not unique just to veterans, but is an issues faced by community health services more broadly. In some cases, this is because the symptoms are still



relatively mild and/or because people are not always prepared to acknowledge that they have a problem. Even among those whose symptoms have worsened, many continue to bear the psychological distress, as well as the associated functional impairment, rather than confront the personal or systemic barriers to care. If these people do end up seeking treatment, it is often because they or their families have reached crisis point.

One potential avenue to assist this population is to provide an intervention that is not explicitly labelled as “psychiatric” or “mental health”, but which nevertheless addresses the problems that these men and women are experiencing. There is a mounting body of research evidence to suggest that internet based self-help interventions, while not appropriate for everybody, do perform a very valuable function for a proportion of the population. This is likely to be particularly relevant for younger people who have grown up using the internet. The purpose of this project was to provide some simple, evidence informed, self-help strategies targeted specifically at sub-clinical levels of high prevalence disorders such as anxiety and depression. The goal was not to treat established psychiatric disorders, although the interventions may well be of some assistance to that group also. Rather, the goal was to provide an accessible, low-key, non-intrusive intervention package that may change the person’s future trajectory from a slide into deteriorating mental health and disability, to improved coping and, if required, a pathway into more specialist care.

3.4.1: Project Aims

The aim of this project was to provide a web-based tool for veterans, other ex-serving members, and their families to explore a range of mental health and wellbeing issues. The site was designed to appeal particularly to the needs of younger veterans in the transition phase from military to civilian life, whilst maintaining relevance for the full range of past and present Defence Force members and their families.

The goal was to assist users in managing their own problems through psycho-education, identifying areas for change, goal setting, and review. The site provides users with an opportunity for self-assessment and tailored self-care strategies, along with information that allows them to make informed choices about whether and how to seek additional support or treatment.



This Wellbeing Toolbox builds on the “*How are you travelling?*” ethos developed in the “Hard to Engage” Lifecycle Initiative. It is linked to the Touchbase website, which was developed around the same time, as well as sites such as The Right Mix (alcohol), At Ease (mental health information) and the DVA mental health and wellbeing pages. It is available in addition to other treatment options such as VVCS, and services provided by DVA funded allied health providers.

3.4.2: Project activities

The content of the Toolbox was developed throughout 2010 by ACPMH, with technological aspects undertaken by SMS Management Technology. The site was launched in March 2011 and marketing of the site has been undertaken by DVA.

The site contains the following parts:

- *Modules* on six key topic areas (see below)
- *A Self-Management Plan* for saving and reviewing personal goals
- *An Optional Questionnaire* to assess psychological distress on multiple occasions
- *Helpful Resources*, with links to other DVA websites, factsheets, VVCS, etc.
- *Privacy information* including assurances about privacy and confidentiality
- *Feedback page* with a focus on evaluation of the site
- *Interactive worksheets* and activities for every module

The six modules were based on the evidence informed 'Skills for Psychological Recovery' resource kit developed by the United States National Center for Posttraumatic Stress Disorder and National Child Traumatic Stress Network, with substantial input from ACPMH. The materials were modified to suit the population and the web format.

Modules comprised:

- *Solving Problems* – become better at overcoming challenges and problems
- *Building Support* – get the support you need from family and friends
- *Helpful Thinking* – feel better through realistic, helpful thinking



- *Getting Active* – find the motivation for regular and fun activities in your life
- *Keeping Calm* – learn how to cope with distressing reminders of trauma, to handle anger well, to relax and avoid using non-prescribed drugs or alcohol excessively
- *Sleeping Better* – learn new strategies for establishing good sleep habits.

Data for the evaluation was drawn from Google Analytics, website feedback, a brief on-site survey, and interviews with a small number of veterans. Key stakeholders were also interviewed. The Wellbeing Toolbox can be located at www.wellbeingtoolbox.net.au.

3.4.3: Findings and outcomes

Information about the Toolbox was sent to 65,536 DVA beneficiaries and the site received 7,477 unique visitors in its first year of operation. According to the site survey, approximately 86% of visitors are veterans. Taken together, these figures suggest that approximately 6400 veterans (86% of 7,477) visited the site, representing almost 10% of those who received the letter (6400 of 65,536). Although only 20% of these completed the distress measure (K10), of those who did, the average score indicated moderate to severe psychological distress, suggesting that the site is attracting those in high need.

The Wellbeing Toolbox was well received during the trial period and fulfilled the main aims of the site: to provide an accessible structure for exploring wellbeing issues, self-assessment, self-management options, and direction to additional support or treatment when appropriate. Site visitors perceived the topics as relevant to their needs.

The rate of use amongst contemporary veterans was comparable across age groups but, importantly, satisfaction was highest among the younger 30-39 and 40-49 age groups. There was some evidence that the Toolbox was reaching the hard to engage group: half the users interviewed were not currently connected to other psychological services.

3.4.4: Recommendations

The following “considerations” (rather than recommendations) were generated in consultation with the DVA Mental Health Policy Unit. The following are abbreviated versions of those made in the 2012 final report:



- Consider a strategy for updating the site to keep it current and ‘fresh’, and for monitoring accessibility
- Consider ways that website users might be supported or encouraged in use of the site
- Consider how best to integrate the Toolbox within DVA services and with other mainstream online resources
- Consider how to target transitioning veterans to raise awareness of the site at a time when they are most vulnerable to adjustment challenges
- Consider tailoring the site to specific demographics e.g. much younger veterans or families of veterans
- Consider how lessons learned from this first DVA self-help website can be effectively disseminated to inform future initiatives for veterans
- Consider further edits to the site which might improve the user experience

3.4.5: Activity since project completion

The initial contract for the delivery of this project ended 31 May 2012 - DVA indicated they intend to continue to offer the website. A contract variation was signed in June 2012 to extend the monitoring period for a further six months to allow ACPMH and DVA to engage in discussions to ensure appropriate handover for future essential site monitoring tasks.

Although this website will continue to function as a potentially useful tool for veterans, some resource allocation will be required to maintain it and options around the sustainability of this tool will need to be considered. As noted above, this site fits well with several other DVA on-line initiatives (such as The Right Mix and At Ease), and e-health continues to be a central plank within DVA’s broader health policy. DVA has funded further investigation into the Wellbeing Toolbox through the Applied Research Grant funding scheme.



3.5: Training for Secondary Mental Health Workers Initiative (formerly Competency Development for Community-based Mental Health Practitioners)

Although not initially part of the Lifecycle Initiatives, this project was part of the original policy proposal and was initiated alongside the other projects by DVA. Thus, to all intents and purposes it was a Lifecycle Initiative and is considered here along with the others.

Veterans seeking treatment for mental health problems in the community are likely to end up seeing psychologists or mental health social workers for therapy. The competence of these providers varies considerably and, in rural and remote areas in particular, it is often difficult to find a provider with both expertise in evidence-based treatment and a good understanding of veteran issues. To maximise the chances of veterans across Australia receiving the best possible care from community-based (private) providers, this project was designed to improve the specific skills required to treat complex veteran cases. Similar approaches have been adopted by third party insurers and related organisations (such as the Transport Accident Commission in Victoria).

3.5.1: Project aims

This initiative was designed to increase the chances of veterans being able to access best practice mental health treatment in the community. The first aim was to identify competency gaps amongst providers required to deliver evidence-based best practice interventions for common mental health problems in veterans.

The second aim was to design and deliver training to address the gaps identified in Phase One. As a result of the training, it was intended that participants would: a) use evidence-based screening and assessment practices; b) improve their identification and management of high-risk cases; c) improve treatment sequencing and planning for complex cases; d) include evidence-based practices in treatment plans for common veteran mental health problems; and e) improve communication with other service providers.



3.5.2: Project activities

Phase One, the competency assessment phase, included focus groups, on-line responses to case studies, an on-line survey, and follow-up interviews with a sub-sample of the survey respondents by telephone. There was a very close concordance of results from all methods of inquiry. Competency gaps included the ability to conceptualise complex cases, to manage risk, and to plan and deliver evidence-based treatments. Providers reported low levels of skills and confidence when managing co-morbid disorders and understanding the context of recent military experiences. Many providers also felt isolated and lacked professional support.

In order to deliver the training, a learning collaborative model was developed. Participants (mental health providers who routinely treated veterans in their clinical practice) were allocated to groups within their geographical areas. A total of 66 learning collaborative groups were formed, with 7 – 10 participants in each. These learning groups stayed together through the training and follow up period, providing peer supervision and support to each other. Many of these groups continued after the end of the project.

Participants were provided with extensive pre-reading and then attended a 2-day workshop with an emphasis on case formulation for complex presentations. During the subsequent six months (Support Phase), the groups met on a monthly basis with telephone supervision from an ACPMH clinician. A 1-day workshop was then held to review progress, followed by another 3-month support phase. A website containing a wide range of downloadable clinical resources was made available to participants.

3.5.3: Findings and outcomes

Training was provided at 14 sites nationwide. In total, 792 providers applied to attend the training, with 442 being allocated a place. Findings nine months after training indicate the success of the program in the longer term.

The case formulation approach was integrated into participants' clinical practice in 92% of cases, with most reporting that it resulted in better outcomes. The retention rate throughout this long project was high (87%) and nearly half the providers were still meeting with their learning collaborative group at 9-month follow up for peer supervision



and support. Standardised approaches to assessment had been adopted by up to 90% of participants, and most were using case formulation effectively to assist in treatment planning and sequencing. Although the training did not include skills training in specific evidence-based interventions, most (83%) had identified and pursued further training in these areas. Participants reported improved collaboration with other providers.

3.5.4: Recommendations

The following are abbreviated versions of the many detailed recommendations that were made in four key areas in the 2011 final report:

Recommendation 1: It was recommended that priority topics for skills and knowledge development be identified to ensure veteran and serving members' needs are met. It was suggested that key priorities should be: a) case formulation to help manage complex cases; b) trauma-focussed cognitive behavioural therapies (e.g., prolonged exposure, cognitive processing therapy); and c) contextual information for providing treatment to military and veteran populations.

Recommendation 2: It was recommended that effective strategies for disseminating resources about the treatment of veterans be developed to ensure that they are acceptable and accessible to providers. It was suggested that the emphasis should be on: a) using existing professional networks and groups; b) collaboration with professional associations; and c) easy to access information gateways for providers.

Recommendations 3: It was recommended that strategies be developed to ensure that changes made in practitioners' clinical practice as required by DVA are sustainable, and that the reach of and influence of educational materials is maintained over time.

Recommendations 4: It was recommended that VVCS, in addition to the above recommendations, continue to build organisational support for the use of case formulation, consider strategies to induct new counsellors and staff who have not received training in the use of case formulation, and consider defining or recommending 'appropriate training' for psychologists delivering trauma-focussed therapy.



3.5.5: Activity since project completion

Several new training initiatives targeted at mental health workers have been initiated since the completion of this project, including an update of the Mental Health Advice Book and training in cognitive processing therapy funded and rolled out for VVCS. Projects planned include training in case formulation, understanding the military experience, and conducting trauma based therapies, in addition to the development of a mental health online clearinghouse.



Chapter 4: Consultation Findings

This chapter briefly describes the consultation process with DVA and Defence staff, before outlining their feedback relating to each of the specific Lifecycle Initiatives. It then goes on to summarise the key themes that emerged from participants in the consultations. In reporting the feedback from the consultation process, the goal is simply to report what was said by the participants, categorised under commonly recurring themes. All comments are de-identified.

4.1: Consultation Methodology

During the consultation process, ACPMH conducted a series of semi-structured group and individual interviews with nominated key personnel from Defence, DVA and ACPMH. Prior to the commencement of the consultation process, the Lifecycle Working Group (LWG) approved the interviews' structure and content, and nominated staff members to be invited to participate. The consultation aimed to:

- Gather information for summaries and updates related to each of the Lifecycle Initiatives (summarised in Chapter 3 of this report)
- Discuss learnings and feedback related to the individual Lifecycle Initiatives, and understand how they may have impacted upon and influenced current and future mental health policy and organisational priorities
- Use the Lifecycle concept to facilitate a broad based discussion around priorities for future mental health planning and programming within both Defence and DVA.

The consultation interviews occurred during February and March 2012. In total 36 key staff members participated in the consultation process. Seven group interviews and 15 individual interviews were conducted. Each interview was facilitated by ACPMH senior staff, Jane Nursey and/or Andrea Phelps, and was conducted face-to-face in Melbourne and Canberra, by phone or via video conference.

Refer to Appendix 4 for the consultation document distributed to participants prior to the interview. It provides project background and information on the questions discussed during the consultation. The semi-structured interview approach allowed for some



flexibility in the specific questions asked to each participant. Questions could be tailored to the position and role of the staff member within DVA and Defence, and their knowledge of the Lifecycle package. Appendix 4 also includes a list of the Defence, DVA, VVCS and ACPMH staff who participated in the consultation process.

4.2: Consultation Feedback about Specific Projects

4.2.1: Transition mental health and family collaborative (Townsville)

Several DVA and Defence stakeholders provided feedback on this project in the consultation process, with many noting the extent to which processes and responsibilities had changed over the last five years since this project began.

Most respondents felt the project had increased family sensitive practice, with family involvement by health and mental health providers now much more routine, and that this philosophy had gone on to influence other initiatives such as Touchbase and the Wellbeing Toolbox. There was recognition that it promoted collaborative work between professionals, fitting well with existing aims to achieve consistency in treatment delivery and enhance multidisciplinary team practice. The notion of co-location of DVA for the On-Base Advisory Service (OBAS) was supported by this project. The general principles were seen as useful for improving outcomes and have been considered in the development of several subsequent projects including SWIIP.

On the other hand, several respondents saw the initiative as being too resource intensive, arguing that this adversely affected its sustainability in Townsville, as well as the likelihood of it being rolled out across the country (in particular, the learning collaborative – while useful for this project – makes the model difficult to roll out to other locations because of its labour intensive structure). Others suggested that there was something specific about Townsville (particularly in the cross-agency relationships) that made the project work here in a way that it would not elsewhere. There was concern that expectations did not match outcomes; senior DVA staff did not get what they wanted from the project. There was a suggestion that it had made little difference to the process of transition in the long term. Townsville based consultants however, report that the project had significant impact on local providers and consultants and has resulted in lasting changes in their practice in five priority areas of change.



4.2.2: A study into the barriers to rehabilitation

There were three phases to this project, and not all of those consulted were able to comment in detail on all phases. There was a consensus that the project as a whole had been successful and that the outcomes had been valuable for the organisation, front line staff dealing with rehabilitation issues, providers, and veterans. Informants noted there was ongoing work to improve consistent practice around needs assessment nationally, and to support staff in their role of identifying all needs. They further identified that the Goal Attainment Scaling (GAS) has been very well received, with high level support.

DVA Rehabilitation informants reported that whilst there were some positive outcomes from the study, both in terms of the trial to improve needs assessment processes and the trial of outcome measures, 'barriers' to rehabilitation service delivery remain. They see a lack of information for transitioning members about the DVA Rehabilitation system as a major impediment to engaging veterans in Rehabilitation programs. Staff said that veterans can sometimes be angry that they go from a system in the ADF that "does everything for them" to a DVA system that requires them to self-initiate and actively work with the system to get what they want. Rehabilitation informants felt that this could leave veterans with "feelings of being abandoned" and generate an "us and them" mentality, with DVA as the "other". Other factors affecting veterans' engagement in rehabilitation were the perceived difficulties in getting mental health issues accepted as a disability and the situations where 'Permanent Impairment System' serves as a disincentive for recovery. The consultation with DVA Rehabilitation staff also highlighted that some inconsistencies between states in terms of the interpretation and implementation of DVA Rehabilitation policy and procedures remain. They identified four key priority areas for action as follows:

- Effective education of transitioning personnel about DVA procedures prior to them leaving the ADF
- The development and implementation of nationally consistent rehabilitation procedures
- Further education for DVA staff in mental health awareness and Psychosocial Rehabilitation issues
- Improved provider education and vetting



4.2.3: A study to trial a method to improve treatment options for ‘hard to engage’ clients

Limited feedback was received about this initiative in the recent consultation process. It was noted that the results were interesting and positive with regard to older veterans, but disappointing in attracting younger veterans into treatment. It was suggested that this might be, in part, a “stage of life” issue and that this cohort will potentially engage more – both in treatment and with each other – as they get older. In the meantime, interviewees thought that better use of e-health and social networking technologies to engage this younger group may be critical. A key issue going forward will be to identify which aspects may be sustainable in the longer term. It was noted that the letter from the Principal Medical Adviser (one of the simplest yet most effective strategies) only went to existing DVA clients; younger veterans may not have lodged a claim with DVA yet and would not receive the letter.

4.2.4: Self-care trial for ‘hard to reach’ ex-service members (“Wellbeing Toolbox”)

Feedback relating to the Wellbeing Toolbox was generally positive and there was a recognition that e-health is clearly a high priority for future development. The Toolbox was seen as timely, sustainable, and relatively low cost to develop and maintain. It was suggested that the project had influenced thinking on interactive web-based resources and prompted consideration of other interactive web-based platforms. There was, however, a perception that web resources are poorly integrated and “come across as piece meal”. Informants identified a need for better promotion of Toolbox and other key sites, especially to people who are transitioning out of the Defence Force. It was felt that more involvement from Defence would have been beneficial, with a view to developing a “common language” in web-based resources that speaks to both currently serving and past Defence Force members. There was also a concern that insufficient thought had been given to what would happen with the tool-box post-pilot. A further comment was - when beginning new projects, not enough time is devoted to planning for longer term sustainability after the termination of the specific project. There was some concern that many veterans were unable to access the program on-line and wanted a hard copy. The relatively low proportion of younger to older veterans using the toolbox was surprising. It was suggested that decisions need to be made about where the Wellbeing Toolbox “fits” (e.g., with At Ease and other mental health initiatives).



4.2.5: Training for secondary mental health workers initiative (formerly Competency Development for Community-based Mental Health Practitioners)

This project did not receive detailed feedback in the recent consultations. There was, however, a suggestion that there is now a need to increase the emphasis on brief focussed interventions (e.g., cognitive processing therapy) that lend themselves to discrete episodes of care. Where possible, there should be a move away from long term support with no clear treatment goals or end date. There was a suggestion that this initiative was too resource intensive – not many were trained for the amount of money allocated – and that e-learning models may be a cheaper alternative. Concern was expressed that maintaining these skills – especially in the context of a changing workforce – will be difficult. Specific comments were made about the training for VVCS staff, and were generally very positive which suggests that the concepts were still very much in routine use. It was noted, however, that a combination of VVCS staff turnover and multiple other initiatives might inhibit a more comprehensive adoption of the principles.

4.3: General Feedback on Lifecycle Framework and Initiatives

4.3.1: The Lifecycle Initiatives

Several broader comments were made about the Lifecycle Initiatives more generally.

Much of the feedback about the initiatives and the lifecycle framework was generally positive. However, there was some concern expressed that the projects were initiated and implemented hastily and that this impeded optimising stakeholder ownership and integration across projects. There was also some concern expressed regarding how best to learn from these projects and effectively feed those learnings into future planning and policy development. Those comments led on to discussions regarding the current review and the importance of using this opportunity to take stock of what has been learnt.

4.3.2: The Lifecycle framework

The value of the Lifecycle framework was noted and generally well accepted, with a consensus that it enhanced continuity of care. A focus on the Lifecycle framework as a



continuum, rather than a set of individual initiatives targeting different life stages, was considered a potential tool for highlighting service gaps, process and systems issues. It was also felt that it keeps the focus on seamlessness of care. It was even suggested that it could be a requirement for any new mental health initiative in either DVA or Defence to explicitly state how it would be consistent with the overall military-veteran lifecycle framework.

Nevertheless, some difficulties with this framework approach were noted. The importance of ensuring that the concept was understood by all key stakeholders – "that we are all talking the same language" – was emphasised. This was particularly because many felt that the framework was not universally understood when the Lifecycle Initiatives were implemented. The potential benefits for Defence members and DVA clients were noted – the idea that their care could be seen as seamless from their perspective – but the challenges that posed were also widely recognised.

4.3.3: General comments

Several informants went beyond the Lifecycle Initiatives to comment on the way in which mental health policy and practices are developed and implemented in both organisations. For example, concern was expressed by a few participants about a general tendency (including the Lifecycle Initiatives) for good work to be done in isolation, with the result that gains do not generalise in a coherent and consistent manner. New policies, procedures and clinical practice skills do not get effectively embedded because the organisation moves on to the next project too quickly, with inadequate time for reflection and consolidation.

It was suggested that better systemic planning is required to ensure that projects are embedded within a clear policy framework such as the Lifecycle. Consideration needs to be given to sustainability (including cost and human resource perspectives). DVA staff turnover was also noted as an impediment to consistent and coherent development of policy and procedures. Finally, it was suggested that there is often a disconnect between strategy and implementation.

As noted at the end of Chapter 3, specific concerns were also raised, for example: the risks of "unwell" veterans falling through the gap when they are discharged before they submit a claim to DVA. Under the present system, it is hard to identify these veterans



early enough to enable interventions to be offered before a significant deterioration takes place and unhelpful behaviours become entrenched. One possible solution to this may be by means of screening those who are transitioning or post-discharge (see Section 4.3.8).

4.3.4: Priority areas

Several areas were identified in the consultation process as being high priority. Although participants were not asked to rank their priorities, the order of the following list broadly reflects the level of endorsements for each:

- Improved collaboration and consistency across Defence and DVA (e.g., language, policy, shared initiatives, etc.)
- Effective engagement of veterans with mental health problems (especially younger veterans)
- Improved transition processes
- Early recognition and intervention
- Best practice treatment, with effective accountability and governance
- Reviewing DVA processes to facilitate clients' progress through the system
- Use of mainstream services by veterans to improve help-seeking and health outcomes
- E-health initiatives

Also mentioned, but without further comment, were the following:

- Prevention of mental health problems
- Promotion of resilience and wellbeing initiatives
- Increased awareness among military commanders and peers regarding mental health.



The following provides a summary of the key comments recorded during the consultation process under each of the priority areas noted above.

4.3.5: Consistent approaches across the military-veteran lifecycle

There was widespread recognition of significantly increased collaboration between DVA and Defence on mental health initiatives, with an acknowledgement that this is still an important area for continued improvement. There was a view expressed that although legislation and ministerial responsibility is shared, each organisation often (by necessity) works independently of the other.

Some general themes included:

- **Congruence of mental health policies:** It was recognised that the two organisations have slightly different aims for their mental health policies, although the differences may not be as great as some believe. For example, the philosophy of “capability through mental fitness” need not be restricted to serving personnel. It was suggested that the mental health policies of the two organisations would benefit from being consistent and, where appropriate, interlocking around areas of mutual interest, in order to develop integrated models for mental health care into the future.
- **A shared language around mental health:** Feedback preferred the use of the same terms and consistent messages throughout the military-veteran lifecycle, tailored to maximise relevance at each stage. Example of consistent messages included expectations of healthy adaptation and recovery, the benefits of early recognition and intervention, and key aspects of psychological resilience.
- **Increased adoption of shared programs and initiatives:** It was recognised that this is already occurring (e.g., Support for Wounded, Injured and Ill Project, including the On-Base Advisory Service), but that there is further potential across areas such as educational and awareness initiatives, e-health, and resilience programs. It was suggested that where possible joint funding of projects would facilitate engagement and a sense of “ownership” from both organisations. Simple examples of current project possibilities included adapting the At Ease site for serving members (perhaps with different entry points for members, veterans, partners, children, etc.), improved



marketing of the Wellbeing Toolbox and Right Mix to serving members, and adapting programs such as BattleSMART for veterans.

- **Increased consistency across clinical approaches:** Which may include, for example, intake and referral processes, comparable clinical measures and assessment tools, use of the same (preferred) mental health providers, the same (or, at least, congruent) accountability processes and documentation, etc. It was felt by stakeholders that there is greater scope for more collaboration around VVCS services, including their contract counsellor network.
- **Improved (“seamless”) sharing of information:** A number of stakeholders commented that the information flow between DVA and Defence could be improved. This included sharing of client healthcare information (notwithstanding issues of confidentiality), for example among Garrison Health, VVCS, and DVA-auspiced rehabilitation and healthcare providers. Stakeholders noted that the new electronic records initiative currently in development (i.e., the Joint e-Health Data and Information System (JeHDI)) should go some way towards ameliorating this problem although may take some time to be realised. There was a view expressed that the quality assurance and contractual arrangements of the respective organisations in the mental health arena would benefit from increased transparency and accessibility. It was suggested that improved information about DVA and its services should be available to all serving members. The On Base Advisory Service program should go some way to addressing this.

The difficulties of achieving greater collaboration and consistency across the military-veteran lifecycle were also noted, with recognition that the two organisations at times have different goals, different systems, different cultures, and different clients. It was acknowledged that mental health is one component in a complex set of health and career management relationships.

4.3.6: Engagement

The challenge of engaging serving members and veterans in psychological health and wellbeing initiatives, let alone in formal mental health care, was an issue raised by many participants in the consultations. There was a recognition that the best services in the world are of little benefit unless people are willing to use them. The possibility that there



is something inherent in military culture that acts as a barrier to accessing these services, or even using effective self-care strategies, was raised. Indeed, the issue of stigma as a barrier to mental health care – both within and outside the Defence Force – was a common theme.

- **Engaging veterans while still serving:** There was a strong view expressed by many stakeholders that more should be done to engage members while they are still serving – as once they are discharged, it is too easy to lose contact and to allow people to slip through the net. Some suggested that having a clear DVA presence on every military base, integrated with Garrison Health, would be a good start. Others noted that clear information on DVA benefits and services should be made available to all serving members, but particularly to those who are injured (without waiting until the point of discharge). Once again it is noted that the On Base Advisory Service and SWIIP are already beginning to address these suggestions.
- **Engaging veterans in the period post-discharge:** Stakeholders were concerned with how difficult it was to identify and engage veterans following discharge unless, and until, the veteran lodged a DVA claim. The benefits of engaging them prior to that point were noted by many, along with the fact that warning signs of future incapacity are likely to emerge within the first 12 months. The possibility of DVA contacting every discharging ADF member (perhaps along the lines of the Hard to Engage project letter) was raised, although the difficulty of getting accurate information on who is being discharged was noted. It was suggested that not enough use is made of routine interpersonal contacts (e.g., yearly general practitioner check-ups) and opportunistic identification (e.g., the physiotherapists in the Transition Case Management Pilot Project (Townsville) identified many mental health issues).
- **Reducing stigma:** Although this was noted as a key challenge by many participants in the consultations, few clear suggestions were made to address the issue. It was noted that strategies to reduce stigma need to walk a thin line – it is important not to generate expectations of ill-health and potentially precipitate a “contagion” effect. In this context, it was suggested that messages should talk about psychological health and wellbeing on a continuum and not take a categorical diagnostic approach – mental health is everyone’s business, it is not just for the “sick”. Nevertheless, it was



generally believed that continuing attempts to improve mental health literacy and other strategies to reduce stigma were worthwhile.

- **Engaging younger veterans:** While it was recognised that specific strategies (e.g., social media) might be needed to effectively engage younger veterans, it was also noted that the difficulty engaging this group might be a function of their age. Some commented that previous cohorts of veterans have not tended to group together or to access services while they are still young and busy with family and other responsibilities. As they age, they are more likely to join groups and to seek out care and support options. It was suggested that contemporary veterans are a more diverse group (e.g., gender, ethnicity, age range, deployment experiences) than previous veteran cohorts. It is important to be careful to recognise these differences and provide multiple pathways to information and care. A note of caution was also sounded by some participants: engaging younger veterans is very important, but should not be at the expense of care for older veterans, their partners, and war widows.

Finally, it was recognised that there is still little known about why individuals do, or do not, engage in mental health treatment – what are the triggers and drivers for engagement in effective self-help or formal treatment? Is there something special about veterans that make it harder for them to engage?

4.3.7: Transition

In addition to feedback made in the context of the Transition Mental Health and Family Collaborative (Townsville), several stakeholders took the opportunity to make more general comments about transition out of the Defence Force and into civilian life. It is clear that many saw this as a crucial point in the military-veteran lifecycle trajectory and one which, if managed well, had the potential to set up healthy pathways into the future. This section covers comments made during the consultation process. It is noted, however, that DVA's provision for involvement in the transition process is currently limited and that the term "handover" may prove to be more accurate when addressing this issue in the context of future DVA initiatives.

Many stakeholders made comments to the effect that the move from Defence to DVA should be seamless from the client's point of view, with a strong emphasis on continuity



of care. Concern was expressed by some that this is not often the case and that the process of transition can represent a significant disjunction in care, with the potential for deteriorating mental health and compounding feelings of anger towards, and betrayal by, the system. Primary suggestions for improvement revolved around clarity of responsibility and sharing of information.

- **Transition responsibilities:** Several stakeholders felt that responsibilities around the transition process were not clearly defined, with perceived overlap in some parts (Stepping Out and the Transition Seminars were suggested as possible examples) and gaps in other parts. It was suggested that transition would benefit from a joint review to identify the key stages and processes, followed by clear documentation and allocation of responsibility for each. (Others noted however, that the Support for Wounded, Injured or Ill Program (SWIIP) is designed to address this). It has been noted by ACPMH that the recent phasing out of the DVA Transition Management Service and the commencement of the DVA On Base Advisory Service as part of the SWIIP program may help to address some of the perceived areas of overlap and gaps identified).
- **Sharing of information:** Following the discussion above (see 4.2.3), it was felt that transition is the most important phase of the military-veteran lifecycle where a close collaboration and integration between DVA and Defence could occur. Concern was expressed that there was little in the way of systematic procedures for sharing information around transition, and that the extent to which information was shared varied enormously across sites and the individuals involved. (Once again ACPMH acknowledge that whilst these were concerns raised by stakeholders, programs such as SWIIP and Touchbase go some way to addressing these concerns).

It was suggested by some stakeholders that DVA has considerable potential to facilitate the process of transition to civilian life, with help not only around healthcare and benefits, but also practical issues (such as family adjustment, employment and housing) that are major contributors to psychological health and wellbeing. DVA can only do this, however, if they are able to effectively identify and work with members transitioning out of Defence, and if they are given the mandate to operate in this space as early as possible.



4.3.8: Early recognition and intervention

Several participants commented on the need to identify those with mental health problems, and offer appropriate intervention, as early as possible. Hope was expressed that the culture has improved since the Vietnam era, with greater mental health literacy, such that there should be less delay in seeking treatment. Equally, the danger of veterans falling through the gap between discharge and engagement with DVA was noted. The majority of comments regarding early recognition revolved around screening models.

- **Screening for mental health issues:** Many stakeholders believed that it was appropriate to screen for mental health issues (and rehabilitation needs) regularly while the member is still serving, although the possibility that people will not answer truthfully for fear of an adverse impact on their career was noted. It was suggested that DVA could routinely screen their clients post-discharge if the veteran had any history of mental health issues while in Defence, although concerns were expressed about both the cost and privacy implications. However if it is achieved, monitoring veterans following discharge was viewed as critical, especially with regard to mental health, in order to minimise the danger of them failing to access supports and services. There are also benefits to screening and early intervention following discharge for Defence, since return to service is potentially possible for many who have left. This is likely to be in the form of reserve service, but it is also not uncommon for individuals to sign up for further full time service after a period as a civilian.

4.3.9: Other Issues raised in the consultation

Several additional issues were raised by stakeholders but, since the level of endorsement was limited, they will be covered only briefly here.

- **Treatment quality and accountability:** It was noted that governance and quality assurance of treatment providers/programs was of great importance, but that no formal processes exist to check quality of providers or their services within the current funding model. It was noted that there are pros and cons to having contract counselling arrangements with specific providers versus the recent shift to using mainstream services. Finally, it was suggested that Defence and DVA could improve



their links with the professional bodies and that stronger relationships with groups such as the Australian Psychological Society, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australian College of General Practitioners, and the Australian Association of Social Workers may allow DVA to influence and support initiatives designed to improve quality assurance and accountability so that they more clearly address the needs of veterans.

- **DVA systems:** Some informants expressed concerns about the potential impact of some DVA processes can have on individuals. The complexity of the claims system was noted. It was suggested in one consultation group that “some clients feel like they are on the scrap heap post-discharge” as they transition into civilian life. There was a concern that veterans’ expectations of being cared for were not always met. The implication was that the more difficult veterans find it to navigate the system, the more stressful it will be for them and the more likely their mental health will deteriorate during the process. One participant suggested people who are not progressing in the system could be identified, with the potential to use a panel of experts to review the case and make recommendations. Another participant thought a formal category to indicate “provisional liability status” could be used to allow for provision of services until liability status is formally determined.
- **Use of mainstream services:** It was noted that moves towards a more consistent approach across the lifecycle were in line with recent initiatives in mainstream health services, where continuity of care is now a high priority. DVA is, of course, a major purchaser of mainstream health and mental health services from both hospitals and community providers. Since the phasing out of the Repatriation Hospital system, increasing numbers of veterans routinely receive treatment from mainstream providers.

Despite the current policy to promote care through mainstream services, whether veterans prefer, or respond better, to services oriented towards their specific needs and delivered through targeted settings (e.g., VVCS, psychiatry departments in the old Repatriation Hospitals) has not been established. Indeed, in the consultations there was lack of consensus amongst informants about the extent to which past and current members of the Defence Force should, or can, access mainstream services. It was noted by some informants, for example, that many ADF members do not



access Medicare services whilst they are a serving member, and may find it difficult to navigate the system following discharge. Some argued that not encouraging veterans into mainstream services – allowing them to seek care exclusively from veteran-specific agencies – prevents them from reintegrating into the general community. While some veteran groups emphasise that they are a unique population with unique needs, some informants felt that veterans are not so different that they should not be encouraged into mainstream services. On the other hand, others expressed concern that mainstream health services are not meeting the needs of veterans adequately there needs to be improved understanding of the reasons for this.

- **E-health initiatives:** Although several stakeholders discussed e-health initiatives, and this is clearly a high priority area for many, most comments were descriptions of current e-health initiatives and will not be presented here. Nevertheless, there is considerable potential strengthen delivery of mental health services and support through activities such as electronic records (e.g., the Joint e-Health Data and Information System (JeHDI) and the Personally Controlled Electronic Health Record (PCEHR)); training for providers and staff (e.g., using webinars which are seminars or presentations that take place through the internet, allowing people in different locations to participate); engaging serving members, veterans, and families (e.g., social networking sites); and low key interventions for clients (e.g., Wellbeing Toolbox). The opportunity to connect with other systems (e.g., in primary care) has great synergistic potential.

4.4: Contextual Issues

Several participants in the consultation process felt that it was important to understand the current context for delivery of mental health services to current and former serving members, especially current and proposed initiatives. The following is not intended to be a comprehensive list of current initiatives; rather, it simply represents those that were referred to by stakeholders during the consultations.

- A review of Defence mental health policy has recently been completed, and Defence is working to improve consistency and standardisation in service delivery



- DVA is also currently updating its (10 year old) mental health policy, with the potential to integrate more with new Defence mental health policy directions and broader policy directions in mental health
- DVA is updating the Mental Health Advice Book for practitioners, developing an algorithm based on the book (online and paper based), and establishing a “clearing house”
- There is a shift from a primary focus on general practitioners to a broader focus that includes allied health providers also
- DVA has provided funding to VVCS to roll out training in cognitive processing therapy for their staff
- Defence, with some involvement from DVA are currently implementing the Support for Wounded, Injured or Ill Program (SWIIP) recommendations.
- Other programs, such as various e-health initiatives were also mentioned, as well as a YouTube project.

4.5: Conclusions and Key Themes

The consultation process provided valuable insights into the concerns and priorities of key Defence and DVA personnel in the mental health area. Many of the priorities were consistent with themes identified in the individual Lifecycle Initiatives. Integration of the various comments resulted in the emergence of the four key themes that are briefly introduced below. These themes were then used to drive the next stage of the project and are discussed in detail in Chapters 5 and 6.

Theme 1: Improving the consistency of approaches to mental health across the military-veteran lifecycle, with an emphasis on ensuring continuity of care.

This issue was raised by many participants in the consultation as a theme that has potential relevance across all areas of mental health policy and practice. It is clearly a complex and sensitive issue, but one that is fundamental to the whole concept of a military-veteran lifecycle. Since it is an issue that will influence the remaining three themes (to varying degrees), it is included as Theme 1.



Theme 2: Improving the process of transition out of the Defence Force and handover to DVA, aiming for a seamless transfer.

Transition and handover were noted as a pivotal point in the military-veteran lifecycle, a time of both threat and opportunity. If handled well, with appropriate assessment of needs and linking to services, it has the potential to set the veteran on a healthy and productive life course as a civilian. If handled badly, it has the potential to contribute to a trajectory of deteriorating mental health and impaired social and occupational functioning in vulnerable individuals.

Theme 3: Improving the engagement of serving members, veterans, and their families in psychological health and wellbeing initiatives.

The engagement of serving members, contemporary veterans, and more mature veterans in psychological health and wellbeing initiatives is a challenge throughout the military-veteran lifecycle. Too often, help seeking is delayed for extended periods, with accompanying deterioration in mental health, relationships, and occupational functioning, making the task for treatment and rehabilitation much more difficult.

Theme 4: Optimising the quality of mental health care provided to serving personnel, veterans, and their families.

There is considerable variation in the quality of mental health care provided to serving members, veterans, and their families. While quality assurance is an issue across the whole mental health sector, it has the potential to be a particular issue in veterans' healthcare where arguably a broader range of services are available.

These themes were used as a framework for the literature review and the consultations with overseas experts. The results of that process are discussed in the next Chapter.



Chapter 5: Rapid Literature Review Summary and Overseas Consultation

This chapter presents a summary of findings from a rapid literature review designed to explore other veteran and military mental health service models. The review canvassed “grey” literature² and the limited academic literature available on this subject. It also included direct consultation with defence and veteran mental health experts from the United States, United Kingdom, Canada, New Zealand, and Sweden. The findings from both the rapid literature review and personal contacts are reported under the headings of the military-veteran Lifecycle framework and the four key themes identified at the end of Chapter 4. Each section is broken down into sub-headings reflecting the findings for each of the countries canvassed.

5.1: Overseas Consultation Methodology

Key international leaders in military and veteran mental health were invited to participate in the overseas consultation. Experts known to the ACPMH team from the United States, Canada, the United Kingdom and several other countries were approached via email and invited to participate. Using a “snowball” recruitment approach, these people were then encouraged to invite other relevant experts from their country to participate. The experts were asked to provide comments on the relevance of a “military-veteran lifecycle” framework, as well as the relevance of each of the themes introduced in Section 4.5 in their respective countries, and the extent to which these issues were being addressed. They were also encouraged to provide any other information they felt relevant. All experts were assured that their specific comments would be de-identified for the purposes of this report.

A list of overseas experts who participated in consultation process is included in Appendix 5. As well as military and veteran mental health experts from the United

² This term refers to literature not published in peer reviewed journals or as book chapters. Grey literature is typically produced by governments, business or associations and includes internal reports, business documents and newsletters. In this report grey literature refers to government department produced documents.



States, Canada, and the United Kingdom, two from New Zealand and one from Sweden also responded. The expertise of these latter three was predominantly military, rather than veteran.

Responses varied substantially in length from brief commentary to provision of extensive, detailed information and opinion. These responses were collated to develop the broad overviews of each theme provided in this chapter. Note that the purpose of this exercise is not to provide a definitive description of policies and procedures in other countries. Rather, the goal is to explore how our overseas colleagues view the key issues, as well as the extent of implementation in their country, as a way of stimulating ideas and discussion.

5.2: A “Military-Veteran Lifecycle” Framework

5.2.1: United States

Although the United States has not explicitly adopted a lifecycle framework, a review of the grey literature and consultation with U.S. military and veteran experts suggests that this approach is implicit in military/veteran daily operations, research programs and policy.

Early investigations into the mental health of Iraq and Afghanistan veterans in the United States sparked widespread concerns for their care. In recent years, the Department of Defense and Veterans Affairs have formed a closer working relationship to try to improve the continuity of care across the military-veteran lifecycle. In the early 2000s, the Veterans Affairs/Department of Defense Joint Executive Council was established, providing senior leaders from both departments with a forum for collaboration, resource sharing, and joint strategic planning. The Joint Executive Council has created a number of Working Groups that bring together leaders from Veterans Affairs and Department of Defense to address aspects particular to military and veteran life. For example, the Psychological Health/ Traumatic Brain Injury Working Group aims to increase and sustain communication and collaboration between the two departments on relevant issues. This includes the promotion of mental health and resilience as important concerns for Veterans Affairs and Department of Defense not only during or immediately after deployment, but also from enlistment onwards, across the adult lifespan. There is



also implicit acknowledgement of the lifecycle framework within the many other joint Veterans Affairs and Department of Defense working groups addressing issues such as: a shared electronic medical records, seamless transition from Defense to Veterans care for those in need, joint Veterans Affairs/Department of Defense clinical practice guidelines, and joint trainings for clinicians (especially in evidence-based care).

The military and veteran experts canvassed from the United States, considered that the lifecycle framework could be useful for understanding the psychosocial needs of serving members and veterans, and has considerable potential as a means to both advance knowledge and improve care. Currently, programs are aimed at various time points of the lifecycle, but are not explicitly considered or unified as a whole (as is conceptualised with the lifecycle framework). In one expert's view, the United States will begin to consider a lifecycle as the newest approach to understanding the needs of serving members and veterans. Indeed, there is currently a National Institute of Health funded program of research aimed to promote this understanding. The importance of acknowledging the different goals, cultures and approaches of the two organisations was also noted.

In terms of the Lifecycle's application, experts thought it could be particularly useful if there was a single group or collaborating groups thinking about how to connect the various phases of the lifecycle. For example, it would be helpful for guiding personnel training so that skills taught during service are consistent with those advocated immediately post-deployment, etc. Also, interventions and educational campaigns targeted at one time point could anticipate and prepare the individual for issues that are most likely to emerge in the next phase of the lifecycle.

One veteran mental health expert saw a related concept, a lifespan developmental perspective, becoming an increasingly useful approach as the large population of Vietnam-era veterans reach old age. In contrast to the military-veteran lifecycle, this expert's colleagues are approaching the lifecycle/lifespan from a relatively generic perspective that could apply to any stage of human development and to a spectrum of people, and just consider military service in terms of broader constructs (e.g., stressors, skills, etc.) that potentially apply to anyone. This expert recognised potential strengths and weakness to the generic (developmental) and narrower (military-veteran) approach.



5.2.2: Canada

Although Canada has not explicitly adopted a lifecycle framework, a review of the “grey” literature and consultation with Canadian military and veteran experts suggests that it is reflected in the current practices and policies of Defence and Veterans’ Affairs. For example, there is recognition of recruitment, active service and service end as points in service, during which the discharging member may need access to veteran health services. To that extent, the transition period is recognised, but only as part of terminal care planning. In its Strategic Plan for 2009-2014, Veterans Affairs Canada identifies its goal of harmonising policies, programs, and services with the Department of National Defence in order to ensure seamless transition from military to civilian life, and to meet the “veterans’ needs at every stage in their lives”.

One expert considered the lifecycle framework to be a powerful and useful overarching framework, as it identifies different opportunities to optimise mental health, and it makes explicit the links between mental health and the military occupational context (i.e., that the pre-recruitment, service and post-service phases of a veterans’ life course are all important). Indeed, an expert reported that Veterans Affairs Canada is currently finalising its new mental health strategy, part of which involves adopting a ‘life course’ approach (e.g., difficulties related to ageing, issues surrounding loss of military career as a young adult etc.). In contrast, another expert did not see a current need for this approach as Veterans Affairs and Canadian Forces health care systems are ‘significantly different organisations organised about differing service delivery paradigms’. This expert felt that the lifecycle framework would require a closer integration of the mental health care delivery systems than either organisation is prepared to undertake.

5.2.3: United Kingdom

A lifecycle framework has not been adopted by the United Kingdom, where serving members and veterans have traditionally been viewed as two distinct populations. This may be beginning to change, with the Murrison report released in 2010 proposing a mental health plan for serving members and veterans called “Fighting Fit” [10]. It outlines new initiatives designed to better manage the transition process and improve the mental health of serving members, existing veterans, and those caught in the middle. According to the experts consulted, the United Kingdom is in a state of transition following the release of the Murrison report, with changes continuing to be made in line with the



report's recommendations. One expert stated that a "Through Life" approach is being included in the new Ministry of Defence mental health strategy. At this stage it is not clear how successful the Murrison report has been, or will be, in improving the transition process and mental health across the military-veteran lifecycle. The Murrison report recommended that an evaluation be undertaken twelve months after full roll-out of the new initiatives.

Unlike the United States, Canada, and Australia, the United Kingdom has no specific Department of Veterans Affairs, so serving members, veterans, and their families are technically the responsibility of the Ministry of Defence. In practice, the Ministry of Defence continues to support veterans in a broad sense (e.g., advice, ensuring the society takes note etc.), while the National Health Service is responsible for caring for the physical and mental health of veterans (with very few exceptions). Veterans are entitled to priority care within the National Health Service only *on the basis of need*. There is also an ever-increasing number of charitable organisations that claim to provide specialised treatment for veterans. Due to this arrangement of care, there is little collaboration between the National Health Service and the Ministry of Defence, and therefore little consistency in approaches to mental health care across the military-veteran lifecycle.

This separation between the Ministry of Defence and the National Health Service is not always viewed as a significant problem, as most of the experts canvassed during the preparation of this report felt that integration of veterans into the general community was an important goal and that having separate services for veterans would result in their isolation. One expert referred to a publication under review showing that maintaining predominately military social networks is associated with alcohol misuse and posttraumatic stress disorder symptoms, but not other common mental health disorders.

The United Kingdom experts canvassed thought the lifecycle framework could be useful if used with caution. It was suggested that this framework could be most helpful for aiding communication with stakeholders, and in a research context rather than in a clinical context, as they considered most clinical problems in veterans not to be service related. The experts felt that serving members and veterans are more similar than different to the general population, and one expressed concern that the provision of veteran-specific mental health services would erroneously imply the need for special



training or treatment approaches. It was generally agreed that the difficulty developing successful mental health initiatives for serving members and veterans was not unique to this population but rather, one shared with any group of predominantly young men.

5.2.4: Other countries

The New Zealand respondents noted that the lifecycle approach to deployment related mental health training is utilised and that it was considered desirable that this would eventually be a part of a comprehensive lifecycle approach to military mental health training. However the development of this within the New Zealand Defence Force is currently in its infancy.

Similar to the United States, the Swedish Armed Forces have taken more of a “developmental lifespan” approach to the care of serving members and veterans, and are responsible for veterans’ rehabilitation until retirement age.

5.3: Theme 1

Improving the consistency of approaches to mental health across the military-veteran lifecycle, with an emphasis on ensuring continuity of care.

5.3.1: United States

In the United States, efforts are being made to improve consistency and continuity of care across the military-veteran lifecycle by aligning Department of Defense and Veterans Affairs processes and procedures. The development of the Integrated Mental Health Strategy is a significant example of these efforts. The Integrated Mental Health Strategy comprises more than 20 strategic work groups, bringing together leaders within the Veterans Affairs and Department of Defense with the explicit aim to align the two systems through, for example, rapid translation of research into practice, and outcomes monitoring. Another example is the Federal Recovery Coordination Program - a joint Veterans Affairs/Department of Defense initiative designed to provide wounded, injured, or ill veterans and their families with a consistent point of contact, regardless of their location or whether they remain in the military or separate. Other Veterans Affairs/Department of Defense joint ventures that assist continuity of care include shared clinical practice guidelines and alignment of training in evidence-based treatment to



ensure similarity of approaches, as well as the *inTransition* program and Pre-discharge Program (see Theme 2).

A major 'continuity of care' challenge faced when multiple organisations are responsible for the care of an individual is the management of health information, including recording, storage, and sharing of data. Transferring care across organisations presents the potential for information to be lost or misinterpreted. This has particular implications for the consistency and timeliness of care, especially for individuals with complex psychosocial issues. Over the last decade, several initiatives have contributed to a steady increase in the amount of information shared between Veterans Affairs and the Department of Defense, the most recent of which is the Integrated Electronic Health Record. When complete, the Integrated Electronic Health Record will allow an individual's health information to be stored, shared, and updated from enlistment through to discharge and throughout the individual's life as a veteran. The integration of health information can have benefits for the most at-risk veterans, as it will facilitate efforts to manage health, disease, and wellness in a more continuous manner. For example, clinicians who staff the Veterans Affairs suicide hotline are able to access each caller's electronic medical record and can refer veterans to an appropriate mental health provider, providing a streamlined pathway to care [11]. Established in 2007, the suicide hotline has not yet been formally evaluated, although early reports suggest that it is acceptable to the mostly older male veteran population. This is in contrast to traditional suicide hotlines, which are most effective in reaching young females at lower risk of self-harm.

The experts canvassed reported that this theme was relevant to the United States, and that efforts to improve consistency and continuity of care are ongoing. One expert stated that while consistency is a reasonable goal, it should not be sought at the expense of limiting local variation and innovation.

5.3.2: Canada

Initiatives to improve the consistency of approaches to mental health across the military-veteran lifecycle have included the Military and Veteran Health Research Forum (2010 and 2011). A collaborative effort between Veterans Affairs Canada and Department of National Defence (and the Canadian Forces), the forum brought together researchers, policy makers, and clinicians in the field of military and veteran mental health to discuss



current work and develop future plans. The Department of National Defence/ Canadian Forces and Veterans Affairs Canada have also collaborated in the development of Integrated Personnel Support Centres (see Theme 2) to assist transition. In addition, Department of National Defence (DND)/Canadian Forces and Veterans Affairs Canada (VAC) staff work together at the DND-VAC Centre for the Support of Injured Members and Their Families to identify and address gaps between programs administered by the departments.

Canadian experts reported that continuity of care and consistency issues present a significant challenge but are mostly well managed. One expert expressed concern regarding this issue for reserve members as their medical service arrangement is particularly complicated. Significant efforts have been made in regional Operational Trauma and Stress Support Centres to standardise assessment protocols, the use of collaborative care approach and the delivery of evidence-based treatment of service-related mental disorders. According to the Canadian Forces experts canvassed, there is some evidence that the assessment protocol is being followed reasonably well and that evidence-based therapeutic approaches are being recommended. However, they do not yet know conclusively if the actual care that is being delivered is consistent with the Canadian Forces' good intentions and careful plans. Efforts to standardise assessment and care for 'non-occupational mental disorders' are substantially less well advanced.

Currently, many former members rely on civilian treatment resources to meet their mental health needs. While not necessarily a problem (assuming such resources are available), this results in a lack of uniformity of service delivery, as each clinician the individual consults will be an independent provider. According to one expert, the vision with regard to continuity of care across the lifecycle is that serving members and veterans will receive care wherever it is most convenient, in either Canadian Forces or Veteran Affairs Canada clinics. This may include continued care in Canadian Forces clinics even after military release, should the client desire. While the current model of care is not quite at that point, an increasing amount of such collaboration/ continuity of care is occurring.

One expert felt that, given the logistical and practical boundaries that the two organisations are bound by, serving members and veterans are well served for their psychiatric injury care needs, especially when compared to the average Canadian.



Integration beyond what is happening is likely not possible as the scope, mandate, and organisation of the two Departments are different.

5.3.3: United Kingdom

The United Kingdom faces unique tasks in this area as health responsibility moves from Defence to civilian care (i.e., the National Health Service) at discharge. As described in the above section on the lifecycle framework across countries (Section 5.1.3), the Ministry of Defence and the National Health Service engage in little collaboration, resulting in limited consistency in mental health care across the military-veteran lifecycle. Policy changes made in isolation by each department can further impede consistency. For example, one expert consulted felt that recent National Health Service reforms that promote local decision making and general practitioner control of budgets would not see resources allocated to veterans, as most general practitioners do not have a significant number of veteran patients.

Greater collaboration and consistency in approach can be seen with the veterans' charity Combat Stress, which works in partnership on various initiatives with the Department of Health, Ministry of Defence, and the National Health Service. The charity has been advocating a collaborative, multi-agency clinical care model and this approach has begun to help close some of the gaps in care, particularly for more complex clients (e.g., those with comorbid mental illness and substance use).

5.3.4: Other countries

This theme is relevant to New Zealand, particularly given the high involvement of New Zealand in active theatres over the past decade, and the high rate of veterans who leave the service. The experts canvassed thought it would be of great use to have a seamless service to provide these people, and to have increased sharing of information between the relevant organisations.

This theme was considered less relevant to Nordic countries, as there is no specific veterans' administration. The Swedish Armed Forces have tended to lean towards the civilian systems for health and welfare, however efforts are being made for collaboration between the Department of Defence and others, such as the Department for Social Affairs.



5.4: Theme 2

Improving the process of transition out of the Defence Force, aiming for a seamless handover from Defence to DVA.

5.4.1: United States

A number of programs have been developed to improve transition out of active service into civilian life. For example, the *inTransition* program provides service members who are receiving mental health care and transitioning out of the service (or to a new location) with a transition coach. The coach provides support and guidance on mental health concerns during the transition period, and connects the transitioning member with a new healthcare provider in his or her local area. Another joint venture is the Pre-discharge Program, which is designed to smooth the transition out of the Defense Force by providing eligible service members with the opportunity to file Veterans Affairs compensation claims up to 180 days prior to separation from active duty. Recent efforts to improve participation in the Pre-discharge Program include mandatory Program counselling for all separating service members, posting information about the Program on a range of websites, including Facebook, and an awards program to recognise bases with high participation rates. There is also a range of relevant initiatives that aim to facilitate employment, education, and to assist veterans who have been arrested. Another initiative likely to improve transition and handover, by improving information sharing, is the Integrated Electronic Health Record (see Theme 1).

All the experts canvassed from the United States considered this theme relevant to their country, and reported that it is continually being addressed by initiatives such as those outlined above. Generally, there has been much activity aimed at reaching out to those leaving active duty service. One expert in particular felt that there has been excellent Veterans Affairs/Department of Defense collaboration on transition-related matters.

5.4.2: Canada

Improving members' transition out of the military is a goal that has received significant attention from both The Department of National Defence and Veterans Affairs Canada. The two departments have collaborated in the development of Integrated Personnel Support Centres, which are located on a number of military bases across Canada and



are designed to smooth the transition from military to veteran status. Veterans Affairs Canada staff provide serving members with transition interviews, case management, assistance with applying for Veterans Affairs Canada benefits and services, and coordination of Veterans Affairs Canada and local services. It may be, however, that the services provided by Integrated Personnel Support Centres are not reaching those who need the most assistance during the transition process. An evaluation of the support provided by Department of National Defence/ Canadian Forces to injured serving members and their families found that medical discharges faced significant issues in transitioning from Canadian Forces healthcare to the civilian system [12]. The evaluation recommended that the Canadian Forces maintain links with high-risk members during and after the discharge process, until both Veterans Affairs Canada and Department of National Defence agree that the transition has been successfully completed. In addition, the report recommended that both injured members and their families would benefit from being connected to Veterans Affairs Canada a minimum of six months prior to discharge. It is unclear whether these recommendations have resulted in changes in the discharge process for injured members.

The Canadian Forces experts consulted reported that this theme is relevant to Canada, and that there is much ongoing effort made to address this issue of transition especially for those with a medical (including psychiatric) condition. An expert stated that one of the biggest challenges for separating members who need care is the relative shortage of skilled care providers in the civilian health care community. Depending upon where the veteran retires, he or she may or may not have direct access to these care providers, which may make the transition to civilian health care a challenge. Consequently, Veterans Affairs Canada works closely with case managers from the Department of National Defence to ensure successful transition (including Veterans Affairs Canada administration of the Transition Interview screening tool to evaluate the needs of military personnel prior to leaving service). Another example of work in this space relates to “complex” clients. Where it has been recognised that there may be challenges in transitioning the member to the civilian health care system, his or her case can be identified as “complex” and his or her release delayed to allow time for the marshalling of necessary care resources.



5.4.3: United Kingdom

As mentioned previously, in 2010 the 'Murrison Report' proposed a mental health plan for serving members and veterans called "Fighting Fit". One of its key initiatives was the Veterans' Information Service, which at the time of writing was still under development. The Veteran Information Service was proposed in response to concerns that some individuals may be physically and psychologically well at the time of discharge, but at risk of developing mental health problems after leaving the service when military support structures are no longer available. Under the Veteran Information Service, personnel will be advised at their discharge medical assessment to expect a 12 month follow up, which will contain a questionnaire relating to health (including, but not limited to, mental health and alcohol use), and information about the range of services available in their local area. There was concern among some of the experts consulted that this basic screening would miss the veterans most in need, given the difficulty in maintaining contact with this population. Those most contactable are likely to be those who are employed, with plenty of social support and already connected to a general practitioner; in effect, those least likely to need following up.

Serving members are able to receive outpatient mental health care from the multidisciplinary Department of Community Mental Health. It is not clear the extent to which the Department of Community Mental Health provides information on how to access mental health care as a veteran, to members who are planning to separate from the military. The Murrison report suggests that serving members who are identified as requiring a mental health assessment at the time of discharge be eligible to present to a Department of Community Mental Health service for six months. One expert expressed concern that this policy will create confusion and hinder access to National Health Service care, with the potential for the National Health Service to argue that recent discharges are not their responsibility.

The experts canvassed reported that this theme is highly relevant to the United Kingdom, where it is reported that there is very little follow up of the member once they have been discharged. In general, the experts felt that although progress is being made in this area, there is still considerable room for improvement. Recent developments stemming from the Murrison Report are addressing this issue, but their effectiveness is not yet clear. There was some disagreement among the experts on the importance of



services for those who leave the military after only a brief period (i.e., “Early Service Leavers”). One felt that this group was the most likely to experience post-discharge problems, while another cautioned that the Early Service Leavers remain a minority of all service leavers, and that the majority of problems are to be found in the larger group.

Transition services in the United Kingdom have traditionally focussed on issues of “resettlement” (i.e., providing assistance with employment and training). Medical discharges are eligible for fast track career transition services, with the possibility of deferring for up to two years post discharge if the veterans’ medical condition makes it impossible to participate sooner. One expert expressed the view that the current resettlement processes worked well in most cases. However, another reported that while short-term follow-up of ex-service personnel is likely to show “successful” transition to civilian employment, longer-term follow-up may find more disruptive patterns of employability.

5.4.4: Other countries

This theme is relevant to New Zealand, and according to two experts is being addressed to some degree. One expert noted the importance of following up veterans after discharge, as in many cases, veterans develop mental health problems after leaving the service with no identifiable or known problems. Given that many New Zealand veterans emigrate (largely to Australia), the expert also mentioned that equitable access to veteran health care service in different countries would be of use, and acknowledged the existing relationship between New Zealand and Australia’s veterans’ services. Another New Zealand expert thought the transition theme was particularly relevant given the socio-economic status and cultural implications of some individuals leaving Defence. The expert identified Maori and Pacific Islanders as groups at particular risk.

This theme is also relevant in Sweden, where the need for cooperation between Defence, veterans’ organisations, and other societal organisations is recognised as imperative in the development of a smooth transition process.



5.5: Theme 3

Improving the engagement of serving members, veterans, and their families in psychological health and wellbeing initiatives.

5.5.1: United States

A range of initiatives have been introduced in order to improve engagement of serving members, veterans, and families in psychological health and wellbeing initiatives. Many of these follow a public health model, in keeping with the view that most individuals and families will not develop mental health problems, but all will face significant readjustment issues. The focus of these initiatives therefore is less on diagnosis and treatment, and more on assisting individuals and families maintain a healthy balance despite the stressors faced. Falling under the public health approach to engagement are several Veterans Affairs/Department of Defense public awareness campaigns, such as *Make the Connection*, which aims to connect veterans and families with information and services about mental health resources, and *Real Warriors*, which aims to promote resilience, dispel stigma, and support the reintegration of returning service members, veterans, and families. The effectiveness of these campaigns is not clear. Previous evaluations of non-military mental health literacy campaigns suggest that success is less likely when the message relates to prevention rather than actions with immediate positive consequences [13].

An increasing focus on families is evident across a broad range of Veterans Affairs/Department of Defense initiatives, however significant barriers to their engagement in services remain. One such initiative is the Families OverComing Under Stress (FOCUS) program, a resilience training program designed to enhance psychological health in military families affected by deployment related stress, including possible psychological or physical injury in the serving member. An evaluation of the program found that participation in the program resulted in significantly improved emotional and behavioural adjustment for both parents and children. However, one third of families who enrolled in the program did not complete it, and the majority of those who dropped out did so because of service-related relocation [14].

Veterans Affairs has increased new veterans' access to healthcare for five years after separation (for service related injury or illness), and recently conducted a mass mailout



to new veterans, reminding them of their eligibility for Veterans Affairs healthcare and other benefits. Whether this initiative will result in more veterans presenting for Veterans Affairs services sooner remains to be seen. A recent study found that on average the time gap for a combat veteran to transition from Department of Defense to Veterans Affairs' health care was 3.83 months, with the delay ranging from 0-44 months [15]. A primary reason for not presenting sooner was lack of awareness of Veterans Affairs' benefits.

In the United States, tele-mental health has been incorporated in mental health of veterans for over a decade, and Veterans Affairs has one of the largest tele-mental health networks in the world [16]. This network has allowed veterans in rural and remote areas to access mental health services they might not otherwise receive. Evidence suggests that treatment can be effectively delivered in this way and is acceptable to veterans [17, 18]. On military bases Warrior Transition Clinics have been established to treat serving members with significant mental health problems, however the increasing number of soldiers requiring these services has meant that supply of on-base clinicians has been rapidly outstripped by demand. One recent trial attempted to overcome this disparity, by piloting a collaboration between a Warrior Transition Clinic and a Veterans Affairs medical centre, using the tele-mental health network to connect serving members with Veterans Affairs mental health clinicians [19]. Following establishment of this service, delays between initial assessment and first mental health session were decreased, and the authors concluded that a Warrior Transition Clinic- Veterans Affairs tele-mental health collaboration was a feasible option for the timely assessment and treatment of new veterans. However, as no data were presented on the number of serving members seen by Warrior Transition Clinic clinicians before the collaboration, it is difficult to know the extent to which services were improved by the tele-mental health initiative.

Several peer-based initiatives have been introduced to smooth the transition process and improve engagement with mental health services. One such initiative is the Readjustment Counseling Service (more commonly known as the Vet Center system). Vet Centers are community based, multidisciplinary clinics, which focus on increasing the resilience of new veterans and their families, with the aim of preventing more chronic psychosocial problems. In an attempt to engage new veterans further, the Readjustment Counseling Service trained 100 Iraq and Afghanistan veterans as outreach workers to



provide briefings on readjustment and Veterans Affairs' services to serving members following deployment, and help enrol new veterans in Veterans Affairs' programs [20]. This may be particularly useful given that many young veterans view Veterans Affairs' services as not being relevant to them, but more oriented towards older, chronically ill veterans [21]. The question of whether 100 outreach workers can engage the million-plus new veterans remains unanswered.

There is some evidence to suggest that outreach programs can be effective in engaging the smaller population of veterans with recognised mental health problems. One study found that veterans with posttraumatic stress disorder (PTSD) who received outreach (including a letter with information on treatment, and an invitation from the PTSD program director to seek care with various options for responding) were more likely to schedule and present for an intake session, and more likely to attend at least one subsequent session [22]. Another common approach to improving engagement with mental health services has been integrating these services into primary care clinics, or vice versa. A recent review found limited research on this issue, but reported that the available evidence supported the integrated care model as an effective method of improving veterans' access to mental health services [23].

Veterans Affairs and Department of Defense staff contacted by ACPMH emphasised the recent use of '*About face*', a PTSD awareness campaign developed by the National Centre for PTSD that uses video clips and other educational material to inform veterans of all eras about PTSD, including issues such as diagnosis and treatment, and its impact on behaviour and family life. Another initiative is the '*after deployment*' website that attempts to promote veteran self-care skills and address issues of stigmatisation of post deployment problems. Finally, they reported that the evidence-based training they are offering Veterans Affairs clinicians have included modules on how to enhance the motivation of veterans to engage in treatment.

5.5.2: Canada

There has been significant attention paid to engaging serving members and veterans in mental health initiatives in Canada in recent years. The Canadian Forces health promotion program (*Strengthening the Forces*) includes awareness and prevention initiatives in areas such as suicide, anger, family violence, and addictions. The program is voluntary, however, and therefore attracts a minority of personnel with specific needs



or concerns. In contrast, the mental health training program, *Road to Mental Readiness* (R2MR), is delivered to all serving members at various times during their military career, including recruit training, before, and after deployment. Its messages include the importance of self- and peer-care, and the importance of seeking professional help when needed. A parallel program is run for military families. Serving members, veterans, and families affected by service-related mental health problems are able to access peer support through the *Operational Stress Injury Social (Peer) Support program*, with peer supporters also providing guidance on local Veterans Affairs Canada and Department of National Defence services.

The Department of National Defence and Veterans Affairs Canada are reported to be working together to engage both serving members (whether injured or not) and their families at an earlier stage of the discharge process, in the hopes of facilitating earlier identification of needs and providing better support during the transition. This move comes off the back of a recent evaluation of the New Veterans Charter, which found that the intended focus on military families had not translated into practice [24]. A systematic review of the care and treatment of military families was announced in early 2012.

Discussion with the Canadian representatives suggested that engagement in formal treatment is an ongoing issue in Canada. Veterans are happy for others to seek care but are reluctant to seek treatment for themselves. Self-care and peer support are seen as the preferred options. As in other countries, Canada continues to struggle with the problem of early treatment dropout in a reasonable proportion of veterans. Although this has not yet been a target area for reform, it is becoming an increasing priority. Some work has been done in educating veterans about the realities of treatment, including the need to seek out another provider if they do not feel comfortable with the provider they first engage with, understanding what good treatment looks like, and educating veterans that it is not necessary for the clinician to have had the same experiences as them (e.g., combat) in order to be helpful.

The Canadian experts report that there has been much work done over recent years to address 'barriers to care'. Relevant initiatives include:

- Strengthening medical confidentiality protections, by disclosing medical employment limitations only to the chain of command. Information on diagnosis or treatment is only disclosed with consent.



- Offering an open-access mental health capacity within the Canadian Forces, where all serving members are able to seek care or assessment from social workers and mental health nurses without referral.
- Offering an open-access employee assistance program, in which personnel or their families can access up to eight sessions of confidential care from civilian providers.
- Expanding the mental health workforce by a factor of two over the past 10 years.
- Starting up the Operational Stress Injury Social (Peer) Support program, which serves as a bridge to care for hard-to-reach clients.
- Including content on the full range of barriers to care (beyond stigma) in the Road to Mental Readiness program.
- Pursuing an active research program to better understand barriers to care.
- Offering Third-Location Decompression for major “difficult” deployments (e.g., those in Kandahar, Afghanistan), in which there is open access to a number of clinicians who provide the post-deployment piece of the Road to Mental Readiness training program.
- Providing strong career protections to those who are diagnosed with a mental disorder, whereby members are able to continue serving indefinitely after recovering enough to meet general medical standards. Members with a history of PTSD or who are currently taking psychiatric medications are considered eligible for deployment, provided that the clinician judges that the member is fit for duty, and does not have a markedly increased risk of later complications.

Future priorities for the Canadians in the area of engagement include:

- Further research on understanding barriers to care
- Evaluating the effectiveness of the *Road to Mental Readiness* program in increasing help seeking behaviour
- Aligning messaging on resilience and help seeking
- Measuring and managing stigma more effectively



- Ensuring that the first contact with a mental health provider is as easy as possible by ensuring co-location of mental health clinicians with primary care clinicians, providing after hours appointments and walk-in services, and ensuring rapid appointment availability.
- Exploring the use of mass media to overcome barriers to care.

5.5.3: United Kingdom

As described above, the 2010 Murrison Report provides a plan for reducing stigma and improving engagement through a range of initiatives, including the Veterans' Information Service. The Veteran Information Service follows in the footsteps of screening and monitoring initiatives designed for serving members, such as the Trauma Risk Management program. Under Trauma Risk Management Program, peer mentors are trained to identify, screen, and monitor serving members thought to be at risk of developing mental health problems after a potentially traumatic event. If necessary, the serving member is then assisted in referral to specialist help. This targeted model of screening contrasts with that of the United States or Australia, where all serving members are routinely screened for mental health problems following deployment.

Most of the United Kingdom experts canvassed shared the view that the issue of engagement was not so much a veteran-specific problem, as a predominantly male problem, and that decreasing stigma and increasing engagement with mental health services among males in the general community would also impact the males who happen to be veterans. It appears that recent initiatives (e.g., the British Army's "*Don't Bottle It Up*" anti-stigma campaign) may be having some effect in engaging new veterans with mental health services; between October 2003 and March 2011 one thousand veterans presented to Combat Stress requesting assistance, while the year to March 2012 saw some 500 new cases. It is possible, of course, that these veterans were previously seeking help elsewhere. United Kingdom experts have emerging evidence that suggests contemporary veterans are seeking help much earlier than previous cohorts are; an average of two years after separating from the military compared to 12 years for all other veterans.

It is worth noting here that different countries have different needs, and that the same intervention is not necessarily effective across different countries. For example, evidence



suggests that *Battlemind* reduces mental health symptoms in American soldiers exposed to high combat levels (compared to standard debrief), while the adapted United Kingdom version does not differ from the standard debrief in improving mental health[25].

There has been no specific focus in the United Kingdom on engaging families of veterans in care, although this is available through the National Health Service system if they wish to pursue it. No research has been done on military and veteran families that might guide policy development in this area.

5.5.4: Other countries

The experts in New Zealand felt that this was a topic of major relevance, as once veterans leave the armed forces the New Zealand Defence Force has no visibility of them unless they return and ask for assistance. One expert thought stigma was particularly a problem amongst Maori and Pacific Island populations, and stated that although there are some good external initiatives little is being done in military/veteran specific contexts. One expert reiterated their comment in relation to theme 2; that following up with veterans after discharge would be of use in improving their engagement with mental health services.

Consultation with a representative of the Swedish Armed Forces suggested that although steps have been taken to address the challenges of engagement, this issue is an ongoing consideration in that country.

5.6: Theme 4

Optimising the quality of mental health care provided to serving personnel, veterans, and their families.

5.6.1: United States

The focus of many of the initiatives described above in Theme 3 has been to increase both serving members and veterans' utilisation of mental health services, and analysis of the initiatives' success or failure is typically linked to this goal with limited attention paid to patient outcomes or the type of care received. Evidence suggests that the care provided to veterans varies widely; for example, a recent review of PTSD treatment provided in Veterans Affairs' clinics found that a range of treatments were being



delivered, including evidence-based and non-evidence-based techniques [26]. On the other hand, there is some evidence to suggest that incorporating mental health services into primary care clinics results in more veterans receiving optimal treatment for depression [23]. Increasing veterans' access to services is not necessarily the answer to reducing the burden of mental illness, if the services they are accessing are ineffective. According to the experts canvassed, the United States is working hard to optimise the care provided to veterans in the mental health arena. To that end, both the Department of Defense and Veterans Affairs have implemented initiatives aimed at increasing clinicians' knowledge and skills in delivering evidence-based practice. For example, the two organisations have collaborated to ensure consistency in training on best practice treatments for mental health conditions, and have jointly developed multimedia training for mental health practitioners, with a focus on military culture, and indicators of and effective treatments for deployment-related mental health conditions. This has involved a national rollout of evidence-based interventions for PTSD (i.e., prolonged exposure and cognitive processing therapy), and other problems (e.g., sleep difficulties). According to one expert, so far over a thousand Veterans Affairs, Department of Defense and community practitioners have received such training. In addition, the Department of Defense and Veterans Affairs have jointly published a number of clinical practice guidelines for the treatment of common mental health problems experienced by serving members and veterans.

Technology may play an increasing role in optimising the quality of mental health care provided to serving members and veterans. *PTSD 101* is a series of online courses available from the Veterans Affairs website, providing clinicians with information on the best practice assessment and treatment of PTSD, presented by experts in the field. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury recently released a smartphone application that provides clinicians with guidelines for assessing and treating service members and veterans who have sustained a mild traumatic brain injury. At the time of writing, the success of this initiative in improving the quality of care had not been evaluated. Veterans Affairs and the Department of Defense have also developed several smartphone applications to help serving members, veterans, and their families manage their own mental health. Individuals can monitor emotions associated with common mental health problems with *T2 Mood Tracker*, learn anxiety management strategies with *Breathe2Relax*, while *PTSD Coach* provides



education about PTSD and its treatment, and self-help tools including relaxation skills and anger management. One expert reported that in the longer term, it is envisioned that data gathered via tablet and smartphone application would go to a clinician dashboard, which could be reviewed by clinician and patient as part of care.

The United States representatives consulted considered outcomes monitoring as the most important precondition of quality improvement, and reported that Veterans Affairs is beginning to implement outcomes monitoring in mental health. They cautioned that any outcomes information would need to be transparent and viewable at multiple levels (i.e., individual, clinic, region, national).

One expert stated that the leadership provided by the United States National Center for PTSD's research divisions in Boston, Connecticut, and Vermont are unparalleled in their influence nationally and internationally in the area of deployment health and mental health. They thought the rich resources of the National Center for PTSD, including the website and many education/training programs, are fundamental to the success of the United States in addressing deployment mental health problems.

Some experts noted the increasing effort to involve families in mental health care. For example, Veterans Affairs involves families in the "caregiver program", "coaching into care" and the "veterans' crisis line".

5.6.2: Canada

Processes to ensure that serving members, veterans, and families are receiving optimal mental health care are being taken increasingly seriously in Canada. The previously mentioned evaluation of support for injured serving members noted that despite a high standard of care for physical injuries, the delivery of mental health care was somewhat lacking, due to service delivery capacity (i.e., no uniformed clinical psychologists) and infrastructure deficiencies in some areas [12]. Also, as noted by one expert, even with policies and processes in place to support the delivery of evidence based mental health care, it is difficult to know what type of care veterans actually receive behind closed doors. Some initiatives to ensure optimal care are underway. For example, there is now a commitment to procure a mental health outcomes management system called CROMIS (Client-reported outcomes monitoring information system) in the Operational Stress Injury Clinic network. CROMIS uses computer software (OQ-Analyst) which will



provide essential information on who is getting care, what care they are getting, and how they are faring in treatment. This will serve as the backbone of their quality assurance system. There are also quality assurance coordinators in all clinics, but they cover all of health care, not just mental health, and do not have the tools to do much in terms of quality improvement in mental health care specifically.

With regard to 'in-house' care, several strategies are used to optimise quality of care. For example:

- All the mental health clinicians have now had a formal course in cognitive-behavioural therapy.
- Specialty mental health care is done in a truly collaborative fashion—almost everyone sees both a psychiatrist and a psychologist, and reliance on medication alone as a treatment is uncommon.
- There are regular case conferences, and there are active mental health surveillance and research programs within health services.
- They conduct periodic surveys to assess need, barriers to care, satisfaction with services, etc.
- Finally, they are in the process of going through the accreditation process for their mental health clinics specifically.

According to one expert, outsourced care remains a tricky issue from a quality perspective (even though the use of outsourced care is declining as the Canadian mental health system has built over the last decade). The main mental health services outsourced are specialised substance use disorder programs, inpatient mental health care of all sorts, and some individual psychotherapy. The latter occurs largely due to the difficulty in attracting enough qualified clinical psychologists either as public servants or as consultants because the employment and contractual terms are less favourable than a fee for service approach. In order to optimise outsourced care, the Canadian Forces rely on a limited number of clinicians in whom they have developed confidence over time. Initial assessments are conducted in-house to establish the type of therapy required, and regular in-house re-assessments are carried out to ensure the treatment is having the desired effect and to assess the need for continued treatment. In the long



term, the Canadian Forces aims to continue building its in-house clinical capacity (particularly psychologists), so as to minimise the need to rely on outsourced care. One of the experts canvassed in the preparation of this report expressed concern that medical officers have traditionally referred almost everyone out for specialty mental health care, but that this practice is unlikely to be sustainable as the balance of supply and demand shifts. This expert stated that it may be necessary to investigate the effectiveness of other models of care (such as integrating primary and mental health clinics) building on the lessons learnt from the civilian community where specialty mental health care is less available, and military programs such as RESPECT-Mil which have proven effectiveness in enhancing primary mental health care.

5.6.3: United Kingdom

As stated previously, the United Kingdom has different responsibility of care arrangements and the services available to serving members and veterans differ markedly. The experts canvassed felt that the in-Service provision of care was generally very good, particularly in the context of what is primarily an occupational service. On the other hand, veterans seeking care from the National Health Service face the myriad issues inherent to public health, including difficulties with quality assurance and significant wait times in many cases. The United Kingdom also has a vast number of charities and ex-service organisations providing mental health care to veterans, most of which are unregulated. This was a concern for some of the individuals consulted during the preparation of this report, who felt that there was a need for (gentle) regulation of the charitable sector and had concerns about how well the National Health Service and charities work together. There was also concern that veterans in distress would be confused about where to turn for help and may end up receiving sub-standard care.

Information about services for veterans is available from a range of websites, including that of the Ministry of Defence. Veterans United Kingdom (also known as Service Personnel & Veterans Agency) is part of the Ministry of Defence and provides financial and other support to serving members, veterans, and families, including a 24 hour telephone hotline and an online service providing comprehensive information on entitlements and support available across the United Kingdom. The United Kingdom's foremost veterans' charity, Combat Stress, also runs a 24 hour hotline (funded by the Department of Health), which provides support and advice on where to seek further help.



Serving members, veterans, and their families are also eligible for free access to an online support network known as the Big White Wall. Experts saw the need for a 'one-stop shop' approach so a veteran can seek out the sorts of services he or she wants in an informed manner.

While military families are able to access the above websites for information, they are not specifically catered for by military mental health services. In-Service provision of care does not extend to family members, and therefore families of serving members and veterans who require formal mental health intervention must seek care from the National Health Service. Combat Stress runs carer support groups that aim to provide education on PTSD and its impact on relationships, increase coping strategies, and offer a forum for support and information sharing.

In response to concerns that veterans were not always understood or provided appropriate services by the National Health Service, a major initiative in 2007 was the Community Mental Health Pilot Projects. The initiative was rolled out across six pilot sites, which aimed to take a holistic approach to veteran care, including mental health, employment, housing, relationships, and so on. The evaluation of the project showed that the experiences of the pilot sites differed markedly. More successful features, not necessarily available at all sites, included the availability of staff who were themselves veterans, provision of multi-agency services, and the availability of combined assessment/treatment services (reducing wait times for treatment) [27]. However, overall the pilots saw relatively small numbers of veterans.

Based on these findings, the Murrison Report recommends a significant increase in the hiring of mental health professionals, who would undertake outreach work to identify veterans in need and referring as appropriate. Another initiative aimed at improving veterans' access to appropriate mental health care is a veterans' health e-learning package for general practitioners, under development by the Department of Health in collaboration with the Royal College of General Practitioners.

As discussed previously, the experts consulted shared the view that there are more similarities than differences between the mental health problems faced by the veteran and general populations. Whilst they do not see veterans as presenting with unique problems, the experts felt that like many others, veterans often present with complex psychosocial issues that the system does not deal with well. One expert also expressed



concern that in the military and National Health Service systems, the focus remains on PTSD, despite substance use being a much more common problem.

5.6.4: Other countries

One expert in New Zealand felt that although this theme was highly relevant to the standards of mental health provided within the Service at various locations around the country, it was not being adequately or systematically addressed.

An expert in Sweden reported that it was likely treatment facilities for veterans were not optimal, but that this was part of a broader problem with the delivery of effective treatment for mental health problems. This issue was seen to be receiving growing attention with increased public funding to be spent on psychiatry.



Chapter 6: Integration and Conclusions

This chapter integrates findings from the four sources of information explored in this project: a) the Lifecycle Initiatives review; b) the consultation process with Defence and DVA stakeholders; c) the literature review; and d) the overseas expert consultations. The chapter begins with brief mention of the recent Support for Injured or Ill Project (SIIP) review and the Support for Wounded, Injured and Ill Program (SWIIP) developments, which address some of the issues raised in the current project. The chapter then progresses to a discussion of the lifecycle framework and its overall value. The remaining discussions are grouped under each of the theme headings identified at the end of Chapter 4 and aim to include recent Australian developments in these areas. A record of implementation is also summarised in the two matrices included as Appendix 1. The first matrix illustrates initiatives that were underway in 2007 immediately prior to development of the Lifecycle Initiatives, while the second provides examples of recent and current initiatives. Comparing both of these matrices serves to highlight the significant increase in mental health programs across the Lifecycle in both DVA and the ADF between 2007 and 2012.

It is important to emphasise that this document is a discussion paper designed to raise issues for consideration. It does not attempt to provide specific recommendations, although this chapter does make some suggestions for possible future directions.

6.1: The SIIP Review and SWIIP

A significant innovation within the Department of Defence and with some involvement of the Department of Veteran Affairs in the past two years has been the commissioning of the Support for Wounded Injured and Ill Program (SWIIP). This program allows for the implementation of a series of 31 recommendations that were formulated as part of the Support for Injured or Ill Project (SIIP) report in 2010. The purpose of the SIIP review was to *"Develop a seamless and integrated support process for injured or ill ADF members throughout their service career and through transition from Defence"*. SWIIP is made up of 20 projects that have been developed out of the 31 SIIP report recommendations. At the time of writing, most of these projects are well underway, with approximately a third being completed. Of the 20 projects, at least 15 of them have



some impact, either directly or indirectly on the four core themes that have been identified in this lifecycle review. These are identified in Appendix 6.

Projects A1, A2, A3, 1.1 and 1.2, as overarching projects, have the potential to have a positive influence on the consistency of approaches to mental health across the military-veteran lifecycle (Theme 1). They also have potential to improve the process of transition out of the Defence Force, aiming for a seamless handover from Defence to DVA (Theme 2). Overall, 15 SWIIP projects might be expected to start to address Themes 1 and 2, while eight projects have the potential to begin to address Theme 3. Three projects may positively influence Theme 4.

SWIIP does not, and is not intended to focus specifically on mental health service delivery. It will however, provide a future platform for embedding mental health care into an overall support plan. Thus, while it is certainly a step in the right direction, and is likely to have a positive impact on the provision of mental health support for serving members and veterans across the lifecycle, there is scope for more targeted work to be done across the four themes identified in this lifecycle review.

It is significant that both the SIIP review and SWIIP have deliberately been built around a lifecycle framework, providing implicit support for the utility of this concept when approaching major policy reform involving health and mental health of serving members and veterans.

6.2: The Perceived Value of the Lifecycle Framework

Internationally, there was broad consensus that the military-veteran lifecycle was a useful framework around which to build a coherent and integrated set of initiatives. Several of the international experts consulted suggested that their country was (or should be) moving towards a more explicit use of a lifecycle framework. However, despite this recognition of the utility of a lifecycle concept, it is not yet a formal strategic model applied in any of the countries investigated (although Veterans Affairs Canada are planning to incorporate it in their next strategic plan). Rather, lifecycle was usually described as being “implicit” – that is, the concept has been applied to an existing range of programs rather than driving a strategic approach to mental health care across the



lifespan. The result is that initiatives are often not integrated in a way that a more systematic approach to a lifecycle framework would facilitate.

A caveat raised in several discussions was the extent to which all stakeholders would commit to a lifecycle framework as a basis for strategic planning in mental health. One overseas expert noted that, for example, “the lifecycle framework would require a closer integration of the mental health care delivery systems than either organisation is prepared to undertake”. Whilst this does not necessarily apply to the Australian context, it could be argued that the ‘whole of life’ model has potentially more utility in DVA than in Defence.

The literature review and overseas consultations indicated that a lifecycle framework is a concept applied more consistently within military service than across the lifespan more broadly. The defence environment lends itself well to the concept of stages – recruitment, training, deployments, transition, –readily demarcated phases that can be neatly applied to a timeline or military lifecycle. The duty of care carried by Defence as the employer provides the context and justification for regular monitoring and intervention. Points for potential intervention are clear and definable, and compliance is relatively easy to measure (e.g., did the person get a pre-deployment health check or not?). Serving members are relatively easy to access at any point in their military employment/service. Even variations in the duration of service do not need to compromise the framework; the stages will be comparable whether the person stays in the military for three years or thirty years.

The same cannot be said once the person leaves the Defence Force and moves back into civilian life. Life stages may then become much less well defined and much more variable. For younger members, this may be the start of a long civilian career. They may be starting families, embarking on a new career and be decades away from retirement. For older members, their occupational, family, and other social environments may be very different. For some discharging members, basic needs such as finances, jobs, accommodation, and social networks will already be established. For others, these may represent critical points in their personal trajectory or lifecycle. While their service career may confer some risk and/or protective factors, they essentially confront the same challenges as people without service backgrounds. Thus, the concept of a lifecycle for



veterans following discharge continues to be useful at key transition points but in a way that is consistent with the application of the concept to the general community.

An important question raised in the consultations is the extent to which the lifecycle framework should be viewed specifically as a “military-veteran” lifecycle rather than a more generic lifecycle with its own transitions from cradle to grave. Certainly, military service would be an important component (more so for some than for others) but it is reasonable to argue that it should not be allowed to dominate the whole picture. This view was common in the United Kingdom, where there is no specific department for veterans’ affairs equivalent and healthcare is the responsibility of the National Health Service. It speaks to the on-going debate of whether specialist services targeting veterans best meet the needs of veterans, or whether specialist services simply entrench isolation and feelings of being “different” or “special”. This latter standpoint would propose that veterans are better served by increased integration with, and use of, mainstream services (a discussion taken up later in Section 6.6).

The question of whether a specific military-veteran lifecycle is more or less useful than a generic lifecycle may represent an artificial dichotomy. Rather, both lifecycles are relevant with the former being subsumed into the latter. The goal is to recognise the impact that particular periods of the person’s life may have on his/her subsequent adjustment and functioning – for some it will be negligible, for others it will dominate. Most transitions and key points in the person’s life will be comparable to those of civilians, and therefore the lifecycle approach to healthcare adopted in many mainstream health systems is equally relevant for veterans. Such a framework allows identification of key risk points and life events, recognising military service in the context of the complete human lifecycle in much the same way as one might recognise any other significant period in a person’s life as an influence on health outcomes. Risks may emerge in childhood for example that make the person vulnerable to adverse mental and physical health outcomes from occupational and life stressors that occur later in life.

In Australia, a lifecycle framework is implicit in several of the new initiatives identified in the 2012 matrix in Appendix 1. Many of the recent collaborations between Defence and DVA are Lifecycle consistent. In particular, SWIIP and recommendations from the recent review seek to enhance recognition of key points in the lifecycle, and to intervene accordingly.



In summary, the lifecycle framework appears to be a useful tool for developing military and veteran mental health strategy. Not only does it inform intervention opportunities at key points of military service and adjustment to civilian life, but it also sits comfortably alongside more generic healthcare lifecycle models that take account of other key points that characterise human progression from cradle to grave. The Lifecycle framework will be of most value if it is used strategically – to drive an integrated approach to mental health care across the lifespan – rather than being used simply as a framework upon which to hang various initiatives.

If the benefits of a lifecycle framework are accepted, then achieving a consistent approach to mental health across both DVA and Defence – from the point of recruitment through to old age – becomes a high priority.

6.3: Consistent Approaches to Mental Health: Continuity of Care from Recruitment to Old Age

Whether or not a lifecycle framework is used to drive strategic directions in mental health, it is reasonable to assume that enhanced consistency of approach across Defence and DVA will be in the best interests of serving members and veterans. Improved consistency can greatly enhance continuity of care and a seamless transition. This was clearly an issue of high importance in most of the overseas countries consulted. Chapter 5 highlights several useful examples of such initiatives. As for the lifecycle concept as a whole, however, continuity of care should be easier to achieve within the confines of a Defence Force environment, where it could be argued that it is easier to monitor health status on a regular basis and to provide early (and preventive) interventions. It should also be easier to maintain consistent records and to ensure standards of practice among one's own providers. The challenge is to maintain that consistency of approach and continuity of care through the period of transition and on into civilian life. One way to achieve that is by enhancing collaboration between Departments of Defence and Veterans' Affairs, an issue that has received considerable attention in Australia in recent years. The SWIIP is an excellent example of such a collaboration, with some of the projects flowing from it serving to further enhance collaboration.



The first step in enhancing collaboration is to ensure forums and structures exist to facilitate communication on key issues. The Defence/DVA Health Consultative forum in Australia is one such structure that until recently had operated in various forms for many years. Other collaborative forums addressing specific areas of common interest also exist. In the United States, the Joint Executive Council, which includes senior leaders from both departments, provides a forum for communication and joint strategic planning. Under the auspice of the Joint Executive Council are several work groups that bring together leaders from Veterans Affairs and Defense in specific areas with the explicit aim of aligning the two systems in key areas (e.g., psychological health, translating research into practice, outcomes monitoring). Although similar initiatives are underway in Canada, they are fewer and less advanced than in the United States. Some of these initiatives are undoubtedly easier to achieve in the United States because Defense and Veterans Affairs are sufficiently large to have multiple leaders in several specialist areas and because they retain their own healthcare services.

In the United Kingdom, and other European countries, the opportunities are much more limited. Not only do they not have veteran specific healthcare services like the United States, many do not even have a specific department for veterans' affairs to promote consistent practice. In the United Kingdom, maintaining continuity of care when switching from Defence to mainstream and over-stretched mental health services is a particular challenge. These systemic problems may be exacerbated by recent National Health Service reforms that promote local decision-making and autonomy, potentially making consistency even more difficult. It is unlikely that any National Health Service regional service will see a sufficient number of veterans to make it worth their while to devote resources to enhancing continuity of care with Defence. The Australian system differs in important ways from the National Health Service, particularly as it applies to veterans. Australia's mix of public and private sector services arguably offers greater scope to address the needs of veterans, particularly since most are treated by private providers. Nevertheless, it will be important to monitor developments in Australian state and territory health systems with the increased autonomy provided by the structures being rolled out through the National Health Reform agenda, including Medicare Locals and Local Hospital Networks. There may be potential to further explore partnerships with these services. This issue is addressed further below in the context of mainstream services in Section 6.5.



An obvious collaborative initiative likely to improve continuity of care, and one that could help to bridge the gap between specialist and mainstream services, is that of shared health records. The United States is developing the Integrated Electronic Health Record system, a model that looks similar to the Joint e-Health Data and Information System (JeHDI) in Australia. These systems, once implemented, may serve to improve quality and consistency of care, as well as making it more likely that serving members and veterans will perceive their healthcare to be more seamless. Other valuable collaborations to promote continuity of care in the United States include having a consistent point of contact for people regardless of their serving status. This interesting initiative resembles a case manager approach, a service model designed specifically with continuity of care in mind. As a strategy for high risk veterans, it certainly has some merit. In Australia the current national roll-out of the Personally Controlled Electronic Health Record (PCEHR) provides a potentially complicating context as there would need to be effort to ensure both PCEHR and JeHDI can relate to one another for true consistency.

The United States devotes considerable resources to the development of shared Veterans Affairs/ Department of Defense clinical practice guidelines, an initiative designed to increase the chances of serving members and veterans receiving consistent, evidence based treatment. The United States also align training in evidence-based treatment (e.g., exposure and cognitive processing therapy for posttraumatic stress disorder) to ensure consistency of approaches. Again, Australia is adopting similar models, with DVA offering subsidised training to community based providers who see both veterans and serving personnel. These initiatives are discussed further in Section 6.6 below.

Although consistency across DVA and Defence in the mental health area is a reasonable goal, it should not come at the expense of limiting local variation and innovations that may enhance services. Initiatives need to be tailored to suit the relevant stage of the military-veteran lifecycle and the particular context in which the intervention is provided. It is possible to retain consistency of approach without being overly restrictive regarding how that approach is implemented. It is important to also note that continuity of care becomes complex whenever people move location – a circumstance that happens often within the Defence Force.



In summary, enhancing consistency across Defence and DVA initiatives in the mental health arena is an important goal and one towards which progress is being made. Further developments over coming years may include continued efforts to ensure consistency across the two organisations in mental health policy, with a view to increasing uniformity of approach across the full military-veteran lifecycle. With the two policies interlocking in key areas, there is greater chance of achieving a consistent approach in areas such as screening, mental health literacy, e-health initiatives, and provider management (for example, optimising the consistency of accountability, referral and reporting requirements). Although each such initiative would need to be adapted for the particular point in the lifecycle, the same consistency could apply throughout. The philosophy behind the Defence SMART resilience building initiatives (same core principles but adapted for recruits, pre-deployment, pre-discharge, etc.) is a good example. There is no reason why this same SMART approach could not be extended into self or assisted care models for veterans.

6.4: Improving the Process of Transition: A Seamless Handover from Defence to DVA

The point of transition is, perhaps, the clearest opportunity for a collaborative approach in the military-veteran lifecycle. While DVA is not contracted to provide transition services, some involvement of DVA in the transition process is evident through programs such as SWIIP, On Base Advisory Service and the Defence Transition Program. All of these programs aim to ensure that an injured veteran's 'handover' from ADF to DVA is done as seamlessly as possible. Notwithstanding DVA's limited role in transition, the term "transition" is used in this report to cover the whole process, since it has shared meaning internationally.

A key challenge in transition is to ensure that vulnerable veterans do not slip through the gap, becoming lost to appropriate care services, and many initiatives are designed to address this issue. In another example of a case management approach, anyone receiving mental health care in the United States Defense Force is provided with a "transition coach" prior to discharge to provide support, guidance, and assistance engaging with a new provider in the veterans' healthcare system. These are, perhaps, analogous to the "Member Support Officers" recommended in the SIIP review. Those



recommendations are in the process of being implemented (SWIIP project 2.1). A potential successful enabler of transition would be to ensure that this role does not end at the point of discharge, and that an integral part of the duties includes working with the veteran to engage in appropriate services following discharge (including, of course, DVA). The Canadian Integrated Personnel Support Centre model on military bases is very reminiscent of earlier transition arrangements in Australia, with Veterans Affairs Canada providing a range of veteran support services prior to the point of discharge. Again, SWIIP appears to support a return to this kind of model, with co-location of various support and advice services. Canada also has a system whereby discharge can be delayed for complex cases until systems are in place to support their move into the civilian sector.

The above initiatives are designed to engage vulnerable veterans prior to discharge, facilitating a successful transition and reducing the chances of those with mental health issues experiencing gaps in services. There are obvious benefits to engaging people in treatment early in the course of their illness, rather than trying to engage them down the track when the disorder has become chronic and damage to social and occupational functioning has occurred. This was a key theme to emerge from the Lifecycle Initiatives reviews and was discussed by several people from Australia and overseas in the consultation process. Early intervention does, however, depend on early recognition of need. For those who have already acknowledged a mental health problem while still serving, this should not be a problem (although it still relies on effective handover from Defence to DVA). A substantial group, however, will not recognise or acknowledge these problems, highlighting the importance of an effective mental health assessment being conducted in the period leading up to the person's discharge – a process that occurs more effectively in some systems than others.

Much can be done to optimise the recognition and engagement of vulnerable veterans during the transition phase. Despite the best efforts, however, some will not be recognised or problems may not emerge until they have confronted the realities of adjustment to civilian life. Thus, finding ways to keep track of all veterans for a period following discharge (i.e., subsequent to the handover to DVA – the second phase of the transition process) is crucial. Most countries have a period following discharge during which veterans can still access military healthcare services if they wish in order to ease the process of transition. A recent initiative in the United Kingdom, for example, requires



Defence to provide healthcare for the first 6 months following discharge prior to handover to the National Health Service. It is too early to assess how this model will work, although it does raise some issues that are worthy of consideration. First, should it apply only to those with identified mental health problems at the point of discharge, or can those with newly emerging problems make use of the service? Is it only for problems that are demonstrably service related? This is important, since research evidence from the new veteran assessment service in the United Kingdom suggests that at least 40% of mental health problems do not seem to be service related [28] It would be interesting to explore comparable figures for Australia. Second, like Defence healthcare facilities around the world, they have few alternatives to admission and their threshold for admitting serving members is considerably lower than the National Health Service. While this strategy may be appropriate for serving members (indeed, there may be few alternatives), it may not be so appropriate for discharged veterans who are now living in the community. It would seem logical to aim for a service delivery model in this period immediately following discharge that is compatible with the kinds of services the veteran will receive into the future. That, of course, is likely to be predominantly community based care from public or private health providers. Third, this model may actually hinder access to National Health Service care – the local National Health Service facility may simply refer back to these facilities rather than taking on a veteran within six months of discharge. While this is less likely to be a problem in Australia, the underlying theme is well known to all those working in public sector healthcare. Demarcation of clinical responsibility, and the tendency to pass on complex cases because they “don’t belong in this service”, is not uncommon. Clearly, this creates problems for continuity of care. Many of these problems would be eased if the same practitioner is able to provide treatment while the person is serving and following discharge. The Australian system, with its reliance on private community based providers, is well set up for this although, as noted in Section 6.3, greater consistency in provider management across the two organisations may help.

It goes without saying that the transition and handover process is more important for some (e.g., those with high psychosocial vulnerability, mental health symptoms, poor employment prospects) than for others (e.g., those with low vulnerability, clear employment and accommodation options, stable support networks). It is reasonable that some initiatives, although not all, will be targeted exclusively at the former group,



provided that they can be identified. In this identification process, it is likely that a focus exclusively on expressed mental health symptoms will miss many vulnerable veterans, and that practical issues such as employment prospects, accommodation, and social support may be valid foci for attention in the pre-discharge period. These psychosocial stressors are high risk factors for the subsequent emergence of mental health problems. Thus, there may be benefit to considering a standardised assessment of broad psychosocial needs prior to discharge, as well as at (for example) 12 months post-discharge. This latter initiative has just been introduced in the United Kingdom and it will be interesting to monitor its success. Experience from the Transition Mental Health and Family Collaborative (Townsville) Lifecycle Initiative lends weight to the emphasis within DVA of enhancing family sensitive practices, ensuring that partners are actively involved in transition and handover activities and, where appropriate, in health care during the process. That Lifecycle Initiative also demonstrated the value of having a coherent strategy for routine involvement of other key agencies as required in an individually tailored transition process (e.g., CRS Australia (formerly known as the Commonwealth Rehabilitation Service), VVCS, etc.).

Australia has undergone significant changes in the area of transition and handover in recent years and no doubt more changes are on the horizon. Many of the recommendations of the recent SIIP review relate to this period in the military-veteran lifecycle and, if implemented successfully will do much to reduce the chances of vulnerable veterans falling through the gaps and enhance early engagement in treatment. The advent of electronic health records through the Joint e-Health Data and Information System (JeHDI) has great potential to assist this process also.

6.5: Improving Engagement in Psychological Health and Wellbeing Initiatives

If managed well, the process of transition and handover may serve to identify vulnerable and injured veterans, linking them into appropriate services as early as possible and preventing them from “falling through the gaps”. This process, however, is still likely to miss those veterans who do not have (or, at least, do not admit to having) adjustment problems at the point of discharge but who develop problems related to their military service in the subsequent months or years. Strategies to keep track of these veterans



and to engage them in services as early as possible are the next important link in the lifecycle chain.

The difficulty of engaging contemporary veterans in mental health care, and the importance of using innovative approaches to target that population, emerged repeatedly in the Lifecycle Initiative reviews, as well as during the consultations with Australian and overseas stakeholders. It is important to recognise that difficulties engaging this demographic (a high proportion of young males) are not limited to military and veteran populations. On the contrary, males are notoriously reluctant to seek healthcare of any kind, including and especially mental health care [9]. This demographic is also likely to be reasonably transient, creating problems for consistent communication strategies. The military-veteran context, however, provides many advantages that do not exist for this demographic in the general community, including contact details (at least at the point of discharge) and an explicit duty of care. It is important to leverage off these advantages in order to optimise engagement.

One group for whom these advantages are perhaps less clear is reservists, a group known to have poorer mental health outcomes [29, 30]. They are harder to keep track of and may be more likely to use mainstream services if they require assistance. Although this is not necessarily a bad thing, it does make it hard to keep track of them and to ensure that they are receiving optimum care. It may be worth considering strategies for enhanced contact and monitoring for this high risk group.

Improving recognition and engagement is likely to be a multifaceted task, potentially involving increasing self-awareness, reducing stigma, enhancing awareness among families and peers, and more assertive outreach strategies such as targeted screening programs. Families have a key role to play here – it is often the case that people only take the step of seeking treatment when pressured to do so by family members. Any strategies that reach out to, and engage, families of serving members and veterans are likely to pay off in terms of longer term mental health outcomes. As noted in Chapter 5, several initiatives are targeted at families in overseas systems, as they are in Australia.

With the target population increasingly being younger people, it is reasonable to assume that social media and web-based initiatives may be valuable ways in which to engage veterans. The United States has developed several smartphone applications on a range of topics relating to mental health. The United Kingdom provides free access to veterans



and serving personnel to a National Health Service web initiative known as “The Big White Wall”. This innovative online initiative allows people to talk about their problems, to share with others experiencing similar issues, and to get information and self-help, all in an anonymous environment. There are, of course, multitudes of other web-based services for veterans – most countries have several – as well as information and treatment sites for high prevalence disorders targeted at the general community. DVA has been pursuing this line for some time with sites such as At Ease and the Right Mix. Although empirical data are hard to come by, and research on social media as a tool for engaging people in treatment is in its infancy, it is reasonable to assume that these new technologies will become an increasingly important part of the picture. Web-based treatment programs, for example, are gaining increasing credibility and do provide an option for reaching “hard to engage” veterans. They also have the advantage of enhancing consistency by being highly applicable throughout the military-veteran lifecycle. Australia’s Wellbeing Toolbox is a fine example and one that, with minor changes to branding, could be targeted at anyone from new recruits to ageing veterans.

As noted in Chapter 5, the United States has adopted a broad range of strategies designed to increase engagement of veterans with mental health problems in appropriate services. These include public health awareness campaigns, resilience training for families, tele-mental health initiatives for those in rural and remote locations, and easier access to healthcare. Most countries operate some kind of telephone counselling and support lines, an approach that has potential to engage veterans in more mainstream treatment. In an interesting initiative, the United States Readjustment Counselling Service (comparable to VVCS in Australia) has trained 100 recent Iraq and Afghanistan veterans as outreach workers with a goal of engaging other veterans in Veterans Affairs and related services. This use of peer support models is worth considering, building as it does on the long running and successful Canadian Operational Stress Injury Social Support program. They recruit veterans who have a history of mental health problems (but who are now stable) to reach out to vulnerable veterans in the community and help them to engage with services. Using real veterans, even those with mental health problems is thought to make the pathway to care easier for vulnerable veterans in the community. Using real veterans has also been trialled in web-based awareness campaigns, with short video clips covering issues such as diagnosis, family issues, and treatment. These initiatives all point to a fact that has been



well known to social psychologists for decades: when it comes to “modelling” behaviour, the most effective models are those who resemble the target population and who demonstrate “coping” rather than “mastery” [31]. By using veterans, and veterans who are willing to acknowledge that they too have experienced mental health problems, the chances of getting the message across effectively to the target population of unwell veterans in the community is greatly enhanced.

Of course, getting veterans to see a mental health provider is only the first step. Getting them to commit to treatment, and stay engaged through what will be some difficult times, is a great challenge. Noting the high number of treatment drop-outs, the Canadians have developed education programs to encourage people to seek out a different provider if they don't feel comfortable with the first one, to recognise that a good clinician can help even if they have not had the same experiences (e.g. combat), and about how to recognise quality mental health care. This is an important initiative, since it is an issue rarely considered or addressed in many countries.

Engaging serving members and veterans (particularly males) will continue to be a challenge. No doubt the future will bring developments in this area such as enhanced consistency of mental health literacy and self-awareness strategies, as well as consistency of mental health screening approaches. The sense of familiarity provided by increased consistency – standard, simple key messages repeated often throughout the lifecycle – is likely to facilitate engagement. More direct strategies to engaging veterans, such as personalised letters and social networking, may continue to be worth considering. The future may also bring greater collaboration with non-military mental health bodies in Australia (e.g., Mental Health Foundation, *beyondblue*) to target stigma, especially among young men. It is reasonable to assume that initiatives designed to reduce stigma and increase engagement with mental health services in young males generally will also influence young male veterans.

To end this section on a note of cautious optimism, there is some evidence veterans from recent conflicts in the Middle East are tending to present for treatment earlier than their counterparts from earlier deployments. The United Kingdom based charity Combat Stress (the biggest provider of specialist veteran mental health services), for example, reports that the Middle East veterans are presenting an average of two years after discharge, compared with 13 years for previous conflicts. This presumably reflects the



progress being made more generally in society, with greater awareness and reduced stigma around mental health.

6.6: Optimising the Quality of Mental Health Care

The difficulty of ensuring the quality of mental health care is not unique to military and veteran settings, and has been the focus of several initiatives in the broader health sector. It is a difficult conundrum, with most mental health treatment being provided behind closed doors in a confidential therapeutic environment. It is also a problem across all the countries involved in the consultation, with variable quality of care and relatively common use of non-evidence-based interventions. Nevertheless, there is increasing recognition that it is important to face this challenge and strive to improve the quality of mental health care provided to serving personnel and veterans. It is particularly an issue in those systems (unlike the US) that rely heavily on mainstream mental health services, primarily community based private practitioners. In an important development, the Canadian Institute for Military and Veterans Health Research has been established specifically to promote collaboration among networks of clinicians and researchers in order to improve mental health care for veterans and serving members. Several quality assurance strategies were suggested during the consultations as ways of enhancing the quality of care and achieving greater consistency of approach across the military-veteran lifecycle. The first, and most discussed, approach to improving the quality of care is offering training for providers.

The strategy of improving training for mental health providers was used to good effect in the recent Lifecycle Initiatives and other DVA projects. The learning collaborative approach adopted in that project (forming participants into geographical groups prior to the first workshop, with those groups continuing to meet for an extended period after the training) addresses the crucial element of on-going supervision that is often forgotten in training initiatives. The United States has devoted enormous resources in the last two years to rolling out training in the top two evidence-based treatments for posttraumatic stress disorder (prolonged exposure and cognitive processing therapy). Canada is also training all their Veterans Affairs Canada and Department of National Defence providers in cognitive behavioural evidence-based approaches to treatment. The difficulty with that approach is that in their system (like Australia's) most veterans are receiving treatment



from community based private providers and it is hard for Veterans Affairs Canada and Department of National Defence to provide training for that potentially vast network.

Still under the broad heading of training, technology has an increasing role to play in improving clinical practice standards. The United States Veterans Affairs/Department of Defense clinical practice guidelines referred to above, for example, are available online as algorithms; the clinician can work through, clicking appropriate boxes (and being taken to the relevant material), while the patient is in the consulting room. In Australia, the updated Mental Health Advice Book (under development) will also be produced as an online tool for general practitioners. These approaches are ideal for busy primary care providers (although less so for those providing more structured and on-going mental health treatment). As noted in Chapter 5, several multi-media online training programs have also been developed.

Theories about effective knowledge translation – particularly around health-related skills and knowledge transfer – are being developed and studied. Although still a developing area of inquiry, it is reasonable to assume that research will provide more evidence about what strategies are effective in disseminating clinical skills over the coming years. In the meantime, adherence to good learning principles, active training opportunities, and on-going supervision seem to be important components.

A second approach to improving the quality of care is to implement routine monitoring of services. Although sometimes resented by providers, who see it as an additional burden and a disregard for their clinical expertise, it can be valuable in ensuring standards are maintained. In Australia, VVCS have several practices in place to provide quality assurance with their contracted counsellors. Like Canada when they use non-Veterans Affairs Canada/ Department of National Defence providers, VVCS performs the initial assessments before referring on, requires regular re-assessment and reports, and uses only a select group of clinicians.

One of the most effective ways to monitor clinical mental health services and to improve clinical practice is to implement routine outcome monitoring. The lifecycle initiative focussed on rehabilitation assessed the feasibility of a routine outcome measure (Goal Attainment Scaling) for rehabilitation providers. Routine outcome measures not only provide valuable data to the clinician, the patient and the purchaser (possibly de-identified), but also ensures that treatment remains firmly outcome focussed. Although it



is reasonable to assume that good mental health clinicians will be monitoring outcomes as a matter of course, the reality is that many do not and it is often only when imposed from outside (e.g., by a funding body) that it becomes routine practice. Only recently have the United States and Canadian Veteran Affairs systems begun to introduce routine outcome monitoring for psychological services. The Canadian model (CROMIS: client-reported outcomes monitoring information system) is particularly interesting. Consultation suggests that the system improves clinical outcomes in clients otherwise vulnerable to deterioration and/or premature terminations. It will be important to observe the success of this national, web-based psychometric assessment and reporting system as it is rolled out. Clearly, it is something that other countries may be tempted to adopt if the outcomes are as good as expected. Several key bodies in Australia have made tentative steps towards routine outcome monitoring, including the Department of Health and Ageing through the Better Access to Mental Health Care scheme and related initiatives. It is reasonable to assume that outcome monitoring will be most effective if clinicians are given regular feedback, ideally with a chance to benchmark themselves (anonymously) against their peers. This system has yet to be adopted in any military or veteran healthcare system as far as the writers of this report are aware.

Outcome monitoring is an important part of quality assurance when community based private practitioners form the predominant service providers. Clearly, there are pros and cons to using these mainstream services and different countries adopt different approaches. Interestingly, it emerged from the consultations that Canada aims to increase the numbers of mental health providers for current serving members from within their own ranks, reducing the need to use external clinicians. This approach would take them more in line with the United States, and away from countries like Australia and the United Kingdom who are most likely to use mainstream community providers to provide mental health care. Mainstream services, on the positive side, are generally easily accessible in the veteran's geographical area and have undergone some form of basic accreditation (for example, to meet Medicare standards in Australia). They are acceptable to most (albeit not all) veterans, who are happy to see community-based private providers. On the down side, consistency and quality of care is much harder to control and monitor in private community providers (many of whom see few veterans in their caseload). For Australia, the argument is somewhat irrelevant – a return to the United States model of veteran-specific healthcare services is inconceivable. Rather,



veterans will continue to use primarily mainstream services, with specialist services such as VVCS being available when required. In that scenario, quality assurance is particularly important.

There is considerable scope to continue initiatives to improve the quality of mental health care provided to veterans by, for example, developing procedures to ensure providers engage in appropriate treatment planning, goal oriented treatment, and standardised outcome measures. Although objective data are lacking, clinical experience suggests that the active involvement of family members can do much to enhance engagement and treatment outcomes and providers should be encouraged to engage family members early in the treatment process. Many organisations are moving towards preferred provider and/or accreditation models. While these are not without problems, they do make it easier to ensure a reasonable standard of care (and seem to work well, for example, for VVCS contract counsellors). DVA has made important moves to encourage evidence-based approaches such as trauma focussed cognitive behavioural therapy for posttraumatic stress disorder and it is worth considering whether other similar options may exist for related disorders. It may also be worth considering partnerships with private provider groups, Medicare Locals, and local hospital networks in the area of mental health.

6.7: Conclusions

This review of the Lifecycle Initiatives and the subsequent consultations has highlighted several issues. First, it is clear that substantial progress has been made in several key areas since these initiatives were conceptualised in 2007. The matrices in Appendix 1 are testament to the depth and breadth of work that has occurred in these areas, independently of the Lifecycle Initiatives. These matrices can also provide a useful tool for highlighting potential program gaps and for understanding how newly proposed or developed programs may slot into or overlap with current services.

Second, the concept of a lifecycle is considered a useful strategic framework from which to work when considering potential mental health initiatives. It is important, however, to see military service in the context of a broader lifecycle and not allow it to completely dominate the picture. Serving members and veterans experience most of the same milestones and challenges throughout their lives as civilians.



Third, several potential areas for consideration emerged as a result of this review and consultation process. Since they are discussed in context in the above sections, they will not all be repeated here. Suffice to say that potential exists in each of the theme areas. While great strides have been made in improving consistency of approaches across Defence and DVA, further development of interlocking mental health policies in areas of mutual interest may be valuable to drive consistency across the military-veteran lifecycle in areas such as screening, mental health literacy, e-health initiatives, and provider management. Recent developments, particularly through SWIIP, have the potential to enhance the quality of transition to DVA services, although there may still be potential for greater use of case manager models to provide a stable point of contact through the process, particularly for at risk veterans. Engaging veterans, particularly young males, in appropriate services will always be a challenge, but the discussion above provides options for further consideration, including the potential for partnerships with civilian mental health bodies confronting similar issues. The quality of care provided by mainstream services may be enhanced in a few ways, especially through increased use of outcome monitoring tools.

Clearly all these key areas feed into each other. Improved collaboration and consistency of approach across Defence and DVA will facilitate smoother transition and handover. Successful handover facilitates keeping track of and engaging entitled veterans, making it easier to ensure they are receiving high quality evidence-based care. Consistent approaches to mental health care across the lifecycle have the potential to improve outcomes for Australia's veterans and their families.



Appendix 1: Lifecycle Matrices for 2007 and 2012

The following pages contain the Lifecycle Matrices for 2007 and 2012. This list of programs and activities has been compiled by key stakeholders from ACPMH, DVA and Defence. The Lifecycle Initiatives are italicised.

The acronyms used in the table are detailed at the end of the report.


Defence/DVA Mental Health and Wellbeing Projects Matrix - 2007

Audience

Life Stage	ADF Members	ADF Families	Health Services	DVA or VVCS Staff	Health Providers inc. VVCS	DVA Clients (Post 1999 Service)	DVA Clients (Pre 1999 Service)	DVA client families
ADF Entry	<ul style="list-style-type: none"> • CIMHS • AToDP • MH Strategy 	<ul style="list-style-type: none"> • DCO 	<ul style="list-style-type: none"> • Area health services 	N/A	N/A	N/A	N/A	N/A
ADF Service	<ul style="list-style-type: none"> • ADF-VVCS MOU • CIMHS • AToDP • MH Strategy 	<ul style="list-style-type: none"> • DCO 	<ul style="list-style-type: none"> • Area health services • Unit Climate Surveys (PULSE) • MH Surveillance (RtAPS/ POPS) 	<ul style="list-style-type: none"> • ADF-VVCS MOU 	<ul style="list-style-type: none"> • ADF TSS Training 	<ul style="list-style-type: none"> • ADF-VVCS MOU 	<ul style="list-style-type: none"> • ADF-VVCS MOU 	
Transition	<ul style="list-style-type: none"> • ADF-VVCS MOU • Transition Seminar • CIMHS • AToDP • MH Strategy 	<ul style="list-style-type: none"> • DCO 	<ul style="list-style-type: none"> • Area health services 		<ul style="list-style-type: none"> • Case Management (VVCS) 	<ul style="list-style-type: none"> • ADF-VVCS MOU • DVA Client Liaison Unit 	<ul style="list-style-type: none"> • ADF-VVCS MOU 	<ul style="list-style-type: none"> • ADF-VVCS AFS Counselling/ CM
Post Service – 5 Years	N/A	<ul style="list-style-type: none"> • VVCS (subject to eligibility) 		<ul style="list-style-type: none"> • Managing Challenging Behaviour • Accidental Counsellor 	<ul style="list-style-type: none"> • Case Management (VVCS) • Counselling and Group Programs • ACPMH PTSD Practitioner Resources • ADF-VVCS MOU • MH Advice Book • 'Can Do' for Veterans Program • Alcohol Practice Guidelines, The Right Mix 	<ul style="list-style-type: none"> • VVCS Counselling & Case Management • VVCS Group Program • Hospital PTSD Programs • The Right Mix • DVA Client Liaison Unit • Men's Health Peer Education • Men's Sheds • Day Clubs 	<ul style="list-style-type: none"> • VVCS Counselling & Case Management • VVCS Group Program • Hospital PTSD Programs • The Right Mix • DVA Client Liaison Unit • Men's Health Peer Education • Men's Sheds • Day Clubs 	<ul style="list-style-type: none"> • ADF-VVCS AFS Counselling/ CM • Men's Health Peer Education • Men's Sheds • Day Clubs • VVCS group program
Post Service – 5+ Years	N/A	<ul style="list-style-type: none"> • VVCS • Community 		<ul style="list-style-type: none"> • Managing Challenging Behaviour • Accidental Counsellor 	<ul style="list-style-type: none"> • Case Management (VVCS) • Counselling and Group Programs • ACPMH PTSD Practitioner Resources 	<ul style="list-style-type: none"> • VVCS Counselling & Case Management • VVCS Group Program • Hospital PTSD Programs • The Right Mix 	<ul style="list-style-type: none"> • VVCS Counselling & Case Management • VVCS Group Program • Hospital PTSD Programs • The Right Mix 	<ul style="list-style-type: none"> • ADF-VVCS AFS Counselling/ CM • Men's Health Peer Education • Men's Sheds • Day Clubs • VVCS group program

Defence/DVA Mental Health and Wellbeing Projects Matrix - 2007

Audience

Life Stage	ADF Members	ADF Families	Health Services	DVA or VVCS Staff	Health Providers inc. VVCS	DVA Clients (Post 1999 Service)	DVA Clients (Pre 1999 Service)	DVA client families
Post Service – 5+ Years 					<ul style="list-style-type: none"> • ADF-VVCS MOU • MH Advice Book • 'Can Do' for Veterans Program • Alcohol Practice Guidelines, The Right Mix 	<ul style="list-style-type: none"> • DVA Client Liaison Unit • Men's Health Peer Education • Men's Sheds • Day Clubs 	<ul style="list-style-type: none"> • DVA Client Liaison Unit • Men's Health Peer Education • Men's Sheds • Day Clubs 	
Later Life Stage	<p align="center">N/A</p>	<ul style="list-style-type: none"> • VVCS • Community 		<ul style="list-style-type: none"> • Managing Challenging Behaviour • Accidental Counsellor 	<ul style="list-style-type: none"> • Case Management (VVCS) • Counselling and Group Programs • ACPMH PTSD Practitioner Resources • ADF-VVCS MOU • MH Advice Book • 'Can Do' for Veterans Program • Alcohol Practice Guidelines, The Right Mix 	<ul style="list-style-type: none"> • VVCS Counselling & Case Management • VVCS Group Program • Hospital PTSD Programs • The Right Mix • DVA Client Liaison Unit • Men's Health Peer Education • Men's Sheds • Day Clubs 	<ul style="list-style-type: none"> • VVCS Counselling & Case Management • VVCS Group Program • Hospital PTSD Programs • The Right Mix • DVA Client Liaison Unit • Men's Health Peer Education • Men's Sheds • Day Clubs 	<ul style="list-style-type: none"> • ADF-VVCS AFS Counselling/ CM • Men's Health Peer Education • Men's Sheds • Day Clubs • VVCS group program • Respite care

Defence/DVA Mental Health and Wellbeing Projects Matrix - 2012
Audience

Life Stage	ADF Members	ADF Families	Health Services	DVA or VVCS Staff	Health Providers inc. VVCS	DVA Clients (Post 1999 Service)	DVA Clients (Pre 1999 Service)	DVA client families
ADF Entry	<ul style="list-style-type: none"> • LASER Longitudinal Resilience Study 	<ul style="list-style-type: none"> • DCO 	<ul style="list-style-type: none"> • Garrison health 	N/A	N/A	N/A	N/A	N/A
ADF Service	<ul style="list-style-type: none"> • Garrison Health services, including: medical and dental care, occupational rehabilitation (assessments and programs), physiotherapy, psychology and mental health services • LASER • BattleSmart • ASIST • ADF-VVCS AFS • RESET developed • Mental Health & Wellbeing after Military Service Booklet • AToDP • Keep your mates safe • OBAS • SWIIP • Touchbase • Dents in the Soul 	<ul style="list-style-type: none"> • DCO • Defence Family Helpline • VVCS (subject to eligibility) • RESET developed • Mental Health & Wellbeing after Military Service Booklet • Family sensitive POPs trial 	<ul style="list-style-type: none"> • Contracting and implementing a new integrated health services model for Garrison Health • Regional MH teams x 32 FTE • MH & psychology Sections • ADF Centre of MH • Suicide Risk Assessment Training • Telepsychiatry Trial • Second Opinion Clinic • Traumatic Stress Clinic • ADF MH and Psychology Services Delivery Model • Defence Clinical Masters Program • ADF Alcohol Management Strategy • AREP redesign project • Civilian Psych Examiner Training • Unit Climate Surveys (PULSE) • MH Surveillance (RtAPS/ POPS) 	<ul style="list-style-type: none"> • <i>Rehabilitation Needs Assessment</i> • ARP 	<ul style="list-style-type: none"> • <i>Training for secondary MH Workers</i> (one off/ complete project) • VVCS FSP • VVCS CPT • ADF TSS Training • ASIST • PTSD GP algorithm • Mind the Gap 	<ul style="list-style-type: none"> • ADF-VVCS AFS Counselling / CM • VVCS (subject to eligibility) 	<ul style="list-style-type: none"> • ADF-VVCS AFS Counselling / CM • VVCS (subject to eligibility) 	


Defence/DVA Mental Health and Wellbeing Projects Matrix - 2012

Audience

Life Stage	ADF Members	ADF Families	Health Services	DVA or VVCS Staff	Health Providers inc. VVCS	DVA Clients (Post 1999 Service)	DVA Clients (Pre 1999 Service)	DVA client families
ADF Service			<ul style="list-style-type: none"> • CIMHS • ADFRP updated model and procedures for new internal workforce and external service providers 					
Transition	<ul style="list-style-type: none"> • Transition Seminar • Stepping Out • ADF-VVCS AFS • Mental Health & Wellbeing after Military Service Booklet • SWIIP • OBAS • Touchbase • Beyond the Call 	<ul style="list-style-type: none"> • DCO • VVCS (subject to eligibility) • Mental Health & Wellbeing after Military Service Booklet • Beyond the Call 	<ul style="list-style-type: none"> • Garrison Health • SWIIP 	<ul style="list-style-type: none"> • <i>Rehabilitation Needs Assessment</i> • ARP 	<ul style="list-style-type: none"> • <i>Townsville Collaborative</i> (one off/ complete project) • <i>Training for secondary MH Workers</i> (one off/ complete project) • VVCS FSP • Case Management (VVCS) • VVCS CPT Training Roll out • PTSD GP algorithm • Mind the Gap • Beyond the Call • Dents in the Soul 	<ul style="list-style-type: none"> • <i>Wellbeing Toolbox</i> • ADF-VVCS AFS Counselling / CM • VVCS (subject to eligibility) • VVCS Stepping Out • VVCS FSP • DVA Case Coordination • DVA Client Liaison Unit • Mind the Gap • OBAS • SWIIP • Touchbase 	<ul style="list-style-type: none"> • <i>Wellbeing Toolbox</i> • ADF-VVCS AFS Counselling / CM • VVCS (subject to eligibility) • VVCS Stepping Out • VVCS FSP • DVA Case Coordination • DVA Client Liaison Unit • Mind the Gap • OBAS • SWIIP • Touchbase 	<ul style="list-style-type: none"> • <i>Wellbeing Toolbox</i> • VVCS Stepping Out (accompanying discharged members) • ASIST safeTALK • Mental Health & Well-being after Military Service booklet
Post Service – 5 Years	<ul style="list-style-type: none"> • Touchbase 	<ul style="list-style-type: none"> • VVCS (subject to eligibility) • VVCS FSP • Community services • Dents in the Soul 	<ul style="list-style-type: none"> • Purchasing arrangements • Rehabilitation – GAS • SWIIP • Practice Managers 	<ul style="list-style-type: none"> • <i>Rehabilitation Needs Assessment</i> • Managing Challenging Behaviour • Accidental Counsellor • ASIST and SafeTALK • Online: <ul style="list-style-type: none"> - Managing Challenging Behaviours - Suicide Awareness 	<ul style="list-style-type: none"> • ASIST safeTALK • <i>Hard to Engage</i> • Rehabilitation – GAS • At Ease materials • MH Advice Book & algorithm • ACPMH PTSD Practitioner Resources • <i>Training for secondary MH Workers</i> (one off/ complete project) • VVCS FSP • Case Management (VVCS) 	<ul style="list-style-type: none"> • At Ease • <i>Hard to Engage</i> • <i>Wellbeing Toolbox</i> • VVCS Counselling & Case Management • VVCS Group Program • VVCS FSP • DVA Case Coordination • DVA Client Liaison Unit • Hospital PTSD Programs • ASIST safeTALK • Mind the Gap • SWIIP 	<ul style="list-style-type: none"> • At Ease • <i>Wellbeing Toolbox</i> • VVCS Counselling & Case Management • VVCS Group Program • VVCS FSP • DVA Case Coordination • DVA Client Liaison Unit • Hospital PTSD Programs • ASIST safeTALK • Mind the Gap • SWIIP 	<ul style="list-style-type: none"> • VVCS Counselling / CM if eligible • VVCS Stepping Out • ASIST safeTALK • Mental Health & Well-being after Military Service booklet • Wellbeing Toolbox • Day Clubs • Veterans' Health Week • Beyond the Call


Defence/DVA Mental Health and Wellbeing Projects Matrix - 2012

Audience

Life Stage	ADF Members	ADF Families	Health Services	DVA or VVCS Staff	Health Providers inc. VVCS	DVA Clients (Post 1999 Service)	DVA Clients (Pre 1999 Service)	DVA client families
Post Service – 5 Years 				<ul style="list-style-type: none"> - Building Resilience • Beyond the Call • ARP 	<ul style="list-style-type: none"> • Case Formulation (VVCS) • VVCS FSP • VVCS CPT • PTSD GP algorithm • Mind the Gap • vetAWARE • MH Clearing House (in development) • Understanding the Military Experience (in development) • ARP • Beyond the Call • Dents in the Soul 	<ul style="list-style-type: none"> • Touchbase • Mind the Gap • OBAS • ARP • Men's Health Peer Education • Day Clubs • Men's Sheds • Veterans Health Week • National MH Forum • Touchbase 	<ul style="list-style-type: none"> • ARP • Men's Health Peer Education • Day Clubs • Men's Sheds • Veterans Health Week • National MH Forum • Touchbase 	<ul style="list-style-type: none"> • VVCS group program
Post Service – 5+ Years	<ul style="list-style-type: none"> • Touchbase 	<ul style="list-style-type: none"> • VVCS (subject to eligibility) • FSP • Community services • Dents in the Soul 	<ul style="list-style-type: none"> • Purchasing arrangements • Rehabilitation – GAS • Practice Managers 	<ul style="list-style-type: none"> • <i>Rehabilitation Needs Assessment</i> • Military Culture • Accidental Counsellor • ASIST and SafeTALK • Online: <ul style="list-style-type: none"> - Managing Challenging Behaviours - Suicide Awareness - Building Resilience • Beyond the Call • Dents in the Soul • ARP 	<ul style="list-style-type: none"> • ASIST safeTALK • Tune up • <i>Hard to Engage</i> • Rehabilitation – Goal Attainment Scaling • At Ease materials • MH Advice Book & algorithm • ACPMH PTSD Practitioner Resources • Training for secondary MH Workers • VVCS FSP • Case Management (VVCS) • VVCS FSP • VVCS CPT • PTSD GP algorithm • vetAWARE • MH Clearing House (in development) 	<ul style="list-style-type: none"> • At Ease • <i>Hard to Engage</i> • <i>Wellbeing Toolbox</i> • VVCS Counselling & Case Management • VVCS Group Program • VVCS FSP • DVA Case Coordination • DVA Client Liaison Unit • Hospital PTSD Programs • ASIST safeTALK • Operation Life Online (in development) • Youtube videos • Phone Apps (in development) <ul style="list-style-type: none"> - PTSD coach - The Right Mix 	<ul style="list-style-type: none"> • At Ease • <i>Wellbeing Toolbox</i> • VVCS Counselling & Case Management • VVCS Group Program • VVCS FSP • DVA Case Coordination • DVA Client Liaison Unit • Hospital PTSD Programs • ASIST safeTALK • Operation Life Online (in development) • Mind the Gap • ARP • Men's Health Peer Education • Day Clubs • Men's Sheds 	<ul style="list-style-type: none"> • VVCS Counselling / CM if eligible VVCS Stepping Out • ASIST safeTALK • Mental Health & Well-being after Military Service booklet • Wellbeing Toolbox • Day Clubs • Veterans' Health Week • Beyond the Call • VVCS group program

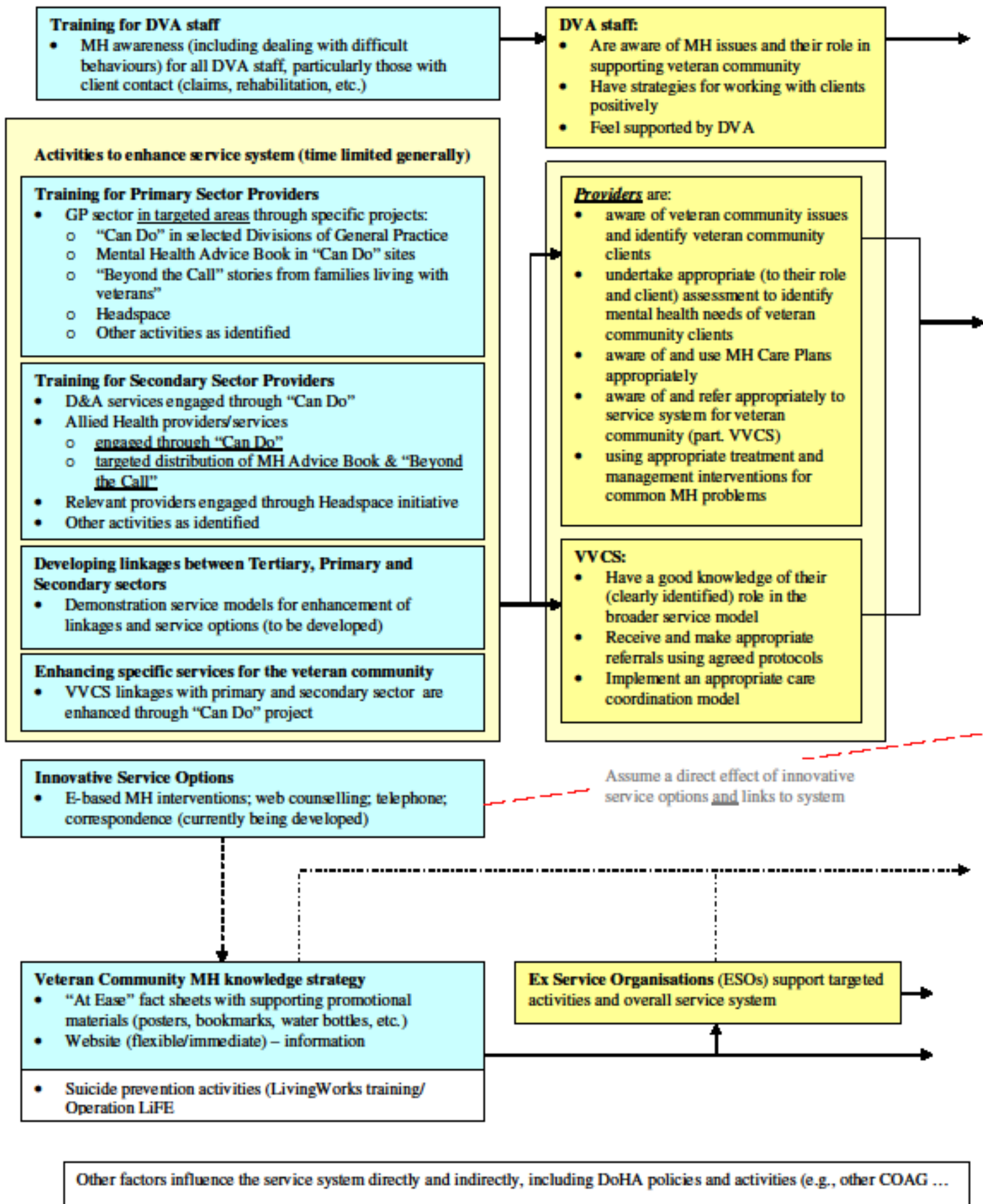
Defence/DVA Mental Health and Wellbeing Projects Matrix - 2012

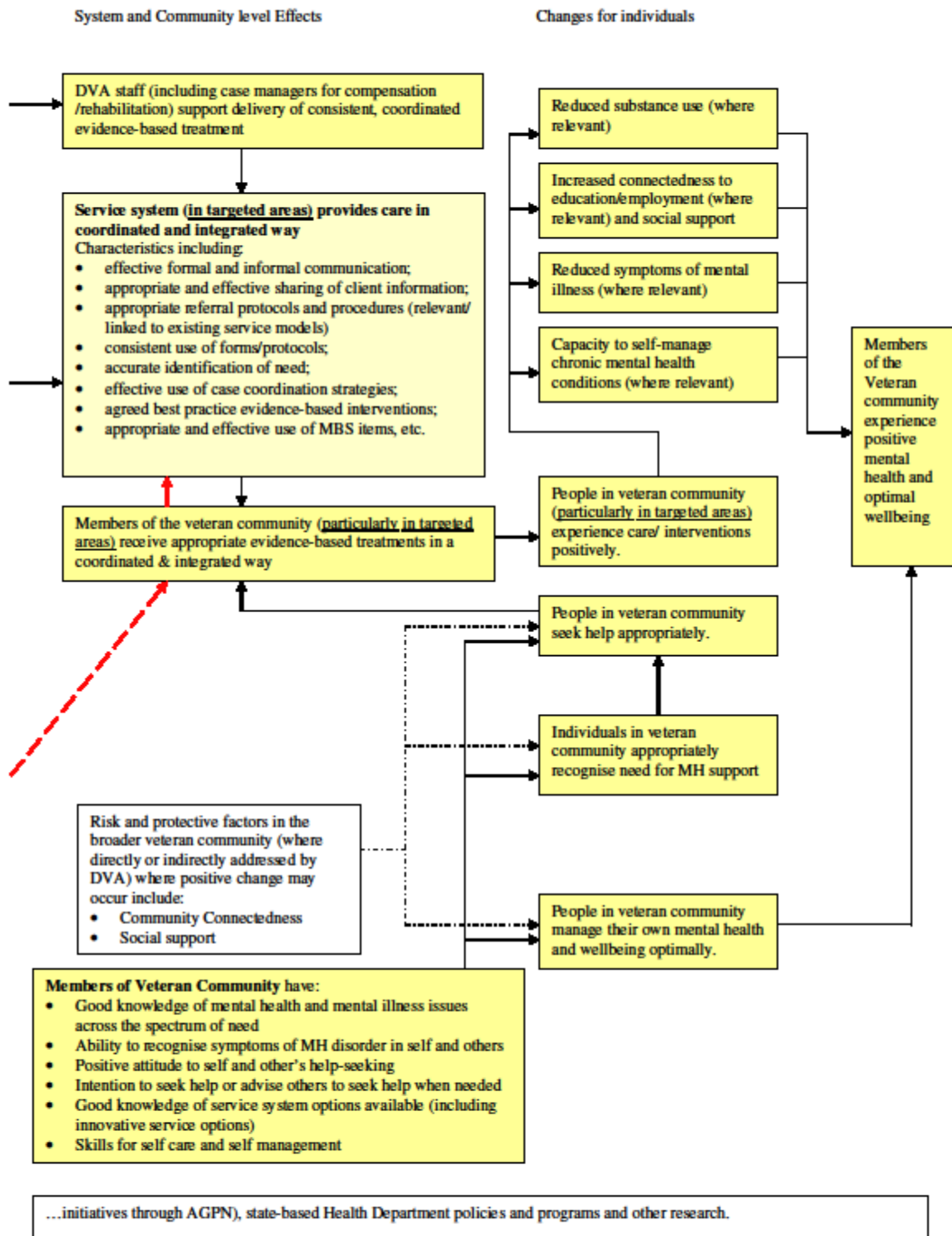
Audience

Life Stage	ADF Members	ADF Families	Health Services	DVA or VVCS Staff	Health Providers inc. VVCS	DVA Clients (Post 1999 Service)	DVA Clients (Pre 1999 Service)	DVA client families
Post Service – 5+ Years 					<ul style="list-style-type: none"> • Understanding the Military Experience (in development) • Mind the Gap • ARP • Beyond the Call • Dents in the Soul 	<ul style="list-style-type: none"> • Mind the Gap • ARP • Men’s Health Peer Education • Day Clubs • Men’s Sheds • Veterans Health Week • National MH Forum • Touchbase 	<ul style="list-style-type: none"> • Veterans Health Week • National MH Forum • Touchbase 	
Later Life Stage	N/A	<ul style="list-style-type: none"> • VVCS (subject to eligibility) • FSP • Community services 	<ul style="list-style-type: none"> • Purchasing arrangements 	<ul style="list-style-type: none"> • Online: <ul style="list-style-type: none"> - Managing Challenging Behaviours - Suicide Awareness - Building Resilience • Accidental Counsellor • ASIST and SafeTALK • ARP 	<ul style="list-style-type: none"> • ASIST safeTALK • <i>Hard to Engage</i> • Rehabilitation – Goal Attainment Scaling • At Ease materials • MH Advice Book • ACPMH PTSD Practitioner Resources • Training for secondary MH Workers • ADF-VVCS AFS • VVCS FSP • Case Management (VVCS) • VVCS CPT • PTSD GP algorithm • vetAWARE • MH Clearing House (in development) • Understanding the Military Experience (in development) • Mind the Gap • ARP • Beyond the Call • Dents in the Soul 	<ul style="list-style-type: none"> • At Ease • <i>Hard to Engage</i> • <i>Wellbeing Toolbox</i> • VVCS Counselling & Case Management • VVCS Group Program • VVCS FSP • DVA Case Coordination • DVA Client Liaison Unit • Hospital PTSD Programs • Mind the Gap • ARP • Men’s Health Peer Education • Day Clubs • Men’s Sheds • Veterans Health Week • National MH Forum 	<ul style="list-style-type: none"> • At Ease • <i>Wellbeing Toolbox</i> • VVCS Counselling & Case Management • VVCS Group Program • VVCS FSP • DVA Case Coordination • DVA Client Liaison Unit • Hospital PTSD Programs • Mind the Gap • ARP • Men’s Health Peer Education • Day Clubs • Men’s Sheds • Veterans’ Health Week • National MH Forum 	<ul style="list-style-type: none"> • VVCS Counselling / CM if eligible ASIST safeTALK • Mental Health & Well-being after Military Service booklet • Wellbeing Toolbox • Day Clubs • Veterans’ Health Week • Beyond the Call • VVCS group program • Respite Care



Appendix 2: Program Logic Map from MHPU Evaluation (2010)







Appendix 3: Project Personnel and Position

Project 1: Transition mental health and family collaborative (Townsville)

Project's relevance across the lifecycle							
Entry		Service	x	Transition	x	Post-service	
DVA/ Defence lead personnel							
Stephanie Hodson (ADF); Vicki Pethybridge (DVA) ; Chris Clarke (DVA)							
ACPMH lead personnel							
Darryl Wade, John Pead							
Where implemented							
Townsville							
Who was involved							
DVA staff		Health providers	x	ADF members in service	x	DVA / VVCS clients	
VVCS staff	x	Health services	x	ADF families	x	VVCS providers	
				ADF staff	x	ADF providers	x
ACPMH budget*							
\$498,600 (excluding GST)							

Project 2: A study into the barriers to rehabilitation

Relevance across the lifecycle							
Entry		Service	x	Transition	x	Post-service	x
DVA/ Defence lead personnel							
Simon Graham (DVA)							
ACPMH lead personnel							
Virginia Lewis, Lisa Gardner							
Where implemented							
Townsville, Brisbane, Melbourne, Adelaide							
Who involved							
DVA staff	x	Health providers	x	ADF members in service	x	DVA / VVCS clients	x
VVCS staff		Health services	x	ADF families		VVCS providers	
ACPMH budget*							
\$449, 500 (excluding GST)							



Project 3: A study to trial a method to improve treatment options for ‘hard to engage’ clients

Relevance across the lifecycle							
Entry		Service		Transition		Post-service	x
DVA/ Defence lead personnel							
Chris Reed (DVA)							
ACPMH lead personnel							
Andrea Phelps							
Where implemented							
Barwon South-Western Region (Victoria)							
Who involved							
DVA staff	x	Health providers	x	ADF members in service		DVA / VVCS clients	x
VVCS staff	x	Health services	x	ADF families		VVCS providers	
ACPMH budget*							
\$150,000 (excluding GST)							

Project 4: Training for Secondary Mental Health Workers Initiative

(formerly Competency Development for Community-based Mental Health Practitioners)

Relevance across the lifecycle							
Entry		Service		Transition		Post-service	x
DVA/ Defence lead personnel							
Lynne Terry (DVA)							
ACPMH lead personnel							
David Forbes Anne-Laure Couineau							
Where implemented							
Nationally							
Who involved							
DVA staff	x	Health providers	x	ADF members in service		DVA / VVCS clients	
VVCS staff	x	Health services		ADF families		VVCS providers	
ACPMH budget*							
\$297,674 (excluding GST)							



Project 5: Self-care trial for ‘hard to reach’ ex-service members (“Wellbeing Toolbox”)

Relevance across the lifecycle							
Entry		Service		Transition		Post-service	x
DVA/ Defence lead personnel							
Stuart Bagnall (DVA)							
ACPMH lead personnel							
Andrea Phelps							
Where implemented							
Nationally (website launched March 2011)							
Who involved							
DVA staff	x	Health providers	x	ADF members in service	x	DVA / VVCS clients	x
VVCS staff	x	Health services	x	ADF families	x	VVCS providers	x
ACPMH budget*							
\$125,000 (excluding GST) for Stages 1 and 2; \$115,000 (excluding GST) for Stage 3							

* Note that these figures represent the ACPMH budget for each of these projects. The figures do not include additional costs incurred by DVA that are related to each project.



Appendix 4: Consultation Information

Document and Consultation Participants

Analysis of the Australian Government Mental Health Lifecycle Initiatives

Consultation Process, February to March 2012

The Lifecycle Working Group (LWG), consisting of staff from DVA, Defence and ACPMH, invites you to participate in the consultation process for this Australian Government project. You have been selected due to your knowledge of ADF/DVA mental health service provision and policy, and/or your involvement in one or more of the following Lifecycle Initiatives projects:

- Transition mental health and family collaborative
- A study into the barriers to rehabilitation
- Improved treatment options for hard to engage clients
- Competency development for community-based mental health practitioners (later referred to as Training for Secondary Mental Health Workers Initiative)
- Self-care trial for hard to reach ex-service members

Background

The package of mental health Lifecycle Initiatives (listed above) implemented by the Government as a component of their Veterans' Affairs Policy Document in 2007 was designed to pilot interventions and explore strategies that have the potential to improve psychological wellbeing at each stage of military life. The stages around which the projects were organised ranged from initial recruitment, through early and subsequent years of service, and through transition out of the Defence Force to life as a civilian. Each of the initiatives had one or more of the following goals:

- To enhance psychological resilience among service personnel;



- To ensure better early intervention and mental health surveillance;
- To support successful transition from defence to civilian life for the member and their family; and
- To provide effective rehabilitation and support, and timely mental health treatment.

What is the 'Analysis of the Lifecycle Package' project?

This new project, Analysis of the Lifecycle Package, aims to bring together the common learnings from the Lifecycle Initiatives (listed above), and develop an overarching framework for representing strategies that promote psychological wellbeing of current and former service members across the lifecycle.

It is proposed that this framework will support and assist future policy and program development by providing a quick reference map of past, present and planned future services. It will assist by identifying service gaps and priorities for future development of projects and services that will ensure optimal management of the psychological wellbeing of the ex-serving member, veteran and their families.

What is involved in the consultation process?

The consultation interview will be facilitated by ACPMH using a structure approved by the Lifecycle review working group. There are three primary aims of the consultations:

1. To complete the gathering of information for summaries of each of the Lifecycle Initiatives
2. To review how these particular projects addressed service gaps that had previously been identified, and to understand how they have impacted upon and influenced current and future ADF/DVA Mental Health policy and organisational priorities
3. To identify current gaps in the DVA/ADF Mental Health service provision framework and determine future priorities to be targeted

The matrix (Appendix 1) provides an overview of the mental health and wellbeing programs and services that are available to current and former serving members. Projects that formed part of the Lifecycle Initiatives are italicised. It is not intended to be an exhaustive list. This matrix will be used throughout the consultation process to guide discussion and assist in achieving the above primary aims.



It is intended that the consultation interviews will run for 60 minutes for individuals and 90 to 120 minutes groups. If you have been involved in any Lifecycle projects (listed on the previous page), the first part of the consultation will focus on gathering information specific to projects and will cover topics such as:

- What has happened since the project has been implemented?
- What else has happened as a result of the project or what developments have taken place in this area since the project was completed?
- Are there still issues or gaps that need to be addressed in this area?

The second part of the interview will involve a broader discussion on the current state of mental health and wellbeing programs and activities; identify where they sit/how they fit within current ADF and DVA policy framework and will canvass your individual vision for future policy and program development within the mental health field.

Information gathered throughout the course of the interview will be used to develop the LWG framework document. Individual responses to questions or comments made by individuals will not be identified in any report or document.

For further information please contact:

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We appreciate your support of this project and thank you for your participation in this consultation process.



Consultation Participants

The following table lists the participants that took part in the consultation phase.

Participant	Organisation	Type of Consultation	Project
Jim Porteous	Defence	Group 1	Strategic
Stephanie Hodson	Defence	Group 1	Strategic
David Morton	Defence	Group 1	Strategic
Carole Windley	Defence	Group 1	Strategic
Wayne Penniall	VVCS, National Manager	Individual	Multiple projects
Stuart Bagnall	Defence Links	Individual	Multiple projects
Simon Graham	DVA	Group 2	Rehab
Graeme Bell	DVA	Group 2	Rehab
Chris Reed	DVA	Individual	Multiple projects
Joy Russo	DVA	Individual	Self-care
Chris Clarke	Defence Links	Individual	Multiple projects
Judy Daniel	Health & Community Services, First Assistant Secretary	Group 3	Strategic
Kym Connolly	Director, Mental Health Programs	Group 3	Strategic
Sandy Bell	Client Contact, Policy & Communications, Assistant Secretary	Group 3	Strategic
Sean Farrelly	Rehabilitation & Support, First Assistant Secretary	Individual	Strategic
Gail Yapp	Mental & Social Health, Assistant Secretary	Group 4	Broad



Participant	Organisation	Type of Consultation	Project
Marion Springer	DVA	Individual; Group 4	Broad
Lyn Needham	VVCS State Director, QLD	Group 5	MH workers
Russell McCashrey	VVCS State Director, TAS	Group 5	MH workers
Belinda Hearne	VVCS State Director, NQLD	Group 5	MH workers
Matthew Jackson	Mental & Social Health, Acting Assistant Secretary	Individual	Broad
Mary Murnane	Former Deputy Secretary, Department of Health and Ageing	Individual	Broad
Emma Parker	MH Policy Team (on behalf of Karen Campbell)	Individual	Self-care
Anne O’Kane	VVCS	Individual	Multiple projects
Katherine Herlihy	R&C, Melbourne	Group 6	Rehab
Rebecca Crowther	R&C, Melbourne	Group 6	Rehab
Lynne Holland	R&C, Darwin	Group 6	Rehab
Meg Kerr	Rehab & Benefits, Brisbane	Group 6	Rehab
Lynne Terry	DVA	Individual	Multiple projects
Cathy Davis	DCO (on behalf of Michael Callan)	Individual	
Darryl Wade	ACPMH	Group 7	Transition
Anne-Laure Couineau	ACPMH	Group 7	MH Workers
David Forbes	ACPMH	Group 7	MH Workers



Participant	Organisation	Type of Consultation	Project
Andrea Phelps	ACPMH	Group 7	Multiple projects
John Pead	ACPMH	Individual	Transition



Appendix 5: Overseas Experts Consulted

Participant	Organisation and/or Role
United States	
Dr Amy Adler	Research Psychologist, US Army Medical Research Unit-Europe, Walter Reed Army Institute of Research
Dr Matt Friedman	Executive Director, National Center for PTSD
Dr Danny Kaloupek	Deputy Director, Behavioral Science Division, National Center for PTSD
Prof Terry Keane	Associate Chief of Staff for Research & Development, VA Boston Healthcare System; Director, Behavioral Science Division, National Center for Posttraumatic Stress Disorder
Dr Joe Ruzek	Director, Dissemination and Training Division, National Center for PTSD
Canada	
Dr Mark Zamorski	Head of Deployment Health, Canadian Forces, National Defence HQ, Ottawa
Dr Don Richardson	Consultant Psychiatrist, Veterans' Affairs Canada
COL Randy Boddam	Specialist Medical Officer, Canadian Forces
Mr Raymond Lalonde	Director General, Operational Stress Injuries National Network, Service Delivery Branch, Veteran Affairs Canada
Ms Lina Carrese	Scientific Director, National Centre for Operational Stress Injuries, Strategic Policy Integration Directorate, Veterans Affairs Canada
Dr Jim Thompson MD	Medical Advisor, Research Directorate, Veterans Affairs Canada
United Kingdom	
Dr Ian Palmer	Consultant psychiatrist, Ministry of Defence



Participant	Organisation and/or Role
Dr Hugh Milroy	Chief Executive, Veteran's Aid
CAPT Neil Greenberg	Consultant Psychiatrist, Royal Navy & Defence Professor of Mental Health, Kings College London
Prof Simon Wessley	Director, King's Centre for Military Health Research, King's College London
Dr Jamie Hacker-Hughes	Visiting Professor of Military Psychology, Anglia Ruskin University
Dr Walter Busuttil	Director Medical Services, Combat Stress
CAPT John Sharpley	Defence Consultant Advisor in Psychiatry, Ministry of Defence
Dr Martin Deahl	Consultant Psychiatrist, National Health Service and Department of Defence
Other countries	
New Zealand	Two uniformed members of New Zealand Defence Force Health Services
Sweden	A former Consultant Psychiatrist in the Swedish Armed Forces



Appendix 6: SWIIP projects supporting Lifecycle review themes

SWIIP Program ID/SIIP recommendations	Theme 1: Improving the consistency of approaches to mental health across the military-veteran lifecycle, with an emphasis on ensuring continuity of care	Theme 2: Improving the process of transition out of the Defence Force, aiming for a seamless handover from ADF to DVA	Theme 3: Improving the engagement of serving members, veterans, and their families in psychological health and wellbeing initiatives	Theme 4: Optimising the quality of mental health care provided to serving personnel, veterans, and their families
A.1 SWIIP Governance and Policy	A.1.1 A.1.2 A.1.3 A.1.4	A.1.1 A.1.2 A.1.3 A.1.4	X	X
A.2 Information Sharing	A.2.1	A.2.1	X	X
A.3 Education and Communications	A.3.1 A.3.2	A.3.1 A.3.2	X	X
1.1 System Owner and Performance Matrix	Yes as facilitator/enabler	Yes as facilitator/enabler	X	X
1.2 Program of Works/Program Managers	Yes as facilitator/enabler	X	X	X
2.1/2.2/2.3 Member Support Officers	Yes	Yes	Yes - potentially	X
2.4 Priority Liability Determination	Yes	Yes	Yes - potentially	X
2.5 Liability Determinations and Claims Processing Efficiencies	Yes	Yes	Yes - potentially	X
2.6 Individual Member Welfare Board	Yes	Yes	Yes - potentially	Yes - potentially

3.1 (Inc SIIP recommendations 3.2/4.1/4.2/6.4/8/2/8.3) Effective management of Information	Yes	Yes	Yes - potentially	Yes – potentially
5.1 Program Governance	X	X	X	X
5.2 Review of Defence/DVA MOU	X	X	X	X
6.1/6.2 Establish performance metrics for MERCB	X	X	X	X
6.3 Claims Processing Enhancements including incident reporting	Yes	Yes	X	X
6.5 Co-Location of Member Support Services	Yes	Yes	Yes	X
6.6 Establish a visiting advisory service	Yes	Yes	Yes	X
7.1 inc 9.1/9.4 Health Policy Development	Hopefully	Hopefully	Hopefully	Hopefully
8.1 Develop a comprehensive list of roles and responsibilities for the SWIIP schema	X	X	X	X
9.2 Address trainees separating medically as MEC3	Yes	Yes	X	X
10.1/10.3 ADF Rehabilitation Program Transformation	X	X	X	X
10.2 MEC3 to pool positions	X	X	X	X



Acronyms

ACPMH	Australian Centre for Posttraumatic Mental Health
ADF	Australian Defence Force
ADFRP	Australian Defence Force Rehabilitation Program
AFS	Agreement for Services
ARP	Applied Research Program
ASIST	Applied Suicide Intervention Skills Training
AToDP	Alcohol, Tobacco and Other Drugs Program
CIMHS	Critical Incident Mental Health Support
CM	Case Management
CPT	Cognitive Processing Therapy
CROMIS	Client-Reported Outcomes Monitoring Information System
DCO	Defence Community Organisation
DND	Department of National Defence (Canada)
DVA	Department of Veterans' Affairs
FOCUS	Families OverComing Under Stress
FSP	Family sensitive practice
FTE	Full-time equivalent
GAS	Goal Attainment Scaling
GP	General Practitioner
iEHR	Integrated Electronic Health Record
JeHDI	Joint e-Health Data and Information System
K10	Kessler Psychological Distress Scale
LASER	Longitudinal ADF Study Evaluating Retention
LSQ	Life Satisfaction Questionnaire
LWG	Lifecycle Working Group
MEC	Medical Employment Classification
MEC3	Medically unfit for deployment or seagoing service for 2-12 months
MEC4	Medically unfit for deployment or seagoing service for 12+ months
MH	Mental Health
MHPU	Mental Health Promotion Unit
MOU	Memorandum of Understanding



MRCA	Military Rehabilitation and Compensation Act 2004
MSO	Member Support Officers
NA	Needs Assessment
NQLD	Northern Queensland
OBAS	On-Base Advisory Service
PCEHR	Personally Controlled Electronic Health Record
POPS	Post Operation Psychological Screening
PTSD	Posttraumatic Stress Disorder
PULSE	Profile of Unit Leadership, Satisfaction and Effectiveness Survey
QLD	Queensland
R2MR	Road to Mental Readiness
RtAPS	Return to Australia Psychological Screening
SIIP	Support for Injured and Ill Project
SMART	Self-Management and Resilience Training
SRCA	Safety, Rehabilitation and Compensation Act 1988
SWIIP	Support for Wounded, Injured or Ill Program
TAS	Tasmania
TPI	Totally and Permanently Incapacitated
TRiM	Trauma Risk Management
TSS	Traumatic Stress Syndromes
UK	United Kingdom
US	United States
VA	United States Department of Veterans Affairs
VAC	Veterans Affairs Canada
VVCS	Veterans and Veterans Families Counselling Service



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