Specialist Mental Health Services for Veterans

Model of Care

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Government of South Australia

SA Health

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VISION STATEMENT

A service that provides comprehensive (community) trusted and person centred, family orientated veteran mental health services to South Australia.

Specialising in mental health for veterans and opportunities for treatment of Post-Traumatic Stress Disorder for police and emergency service personnel, the service will be an evidence based and recovery focussed service that is built on trust and partnership between individuals, their families and health providers.

CONTENTS:

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Sandro Positano

Paul Roberts

Jonathon Wauer

Dr Elaine Waddell (Guest)

Traditional Land of the Kaurna People

SA Health would like to acknowledge that the land The Jamie Larcombe Centre is located on is the traditional lands for the Kaurna people and we respect their spiritual relationship with this country. We also acknowledge the Kaurna people as the custodians of the greater Adelaide region and their cultural and heritage beliefs are still as important to the living people today. SA Health also acknowledges this Model of Care provides care for patients who originate from other traditional lands across all of Australia.

"The term "Aboriginal" is used respectfully in this document as an all-encompassing term for Aboriginal and Torres Strait Islander people and culture"

Identifying Aboriginal Patients

Australian Aboriginal Culture is the oldest living culture in the world and yet Aboriginal people continue to experience the poorest health outcomes compared to non-Aboriginal Australians.

Abbreviations and Acronyms

ABH	Aboriginal Health Worker
ACT	Acceptance and Commitment Therapy
AMHW	Aboriginal Mental Health Worker
ADF	Australian Defence Force
AIU	Acute Inpatient Unit
ALOS	Average Length of Stay
AOD	Alcohol or Other Drug
CALD	Culturally and Linguistically Diverse
CBT	Cognitive Behavioural Therapy
CCAG	Consumer Carer Advisory Group
CFS	Country Fire Service
CL	Consultation and Liaison
CPAP	Continuous Positive Airway Pressure
CPT	Cognitive Processing Therapy
DASSA	Drug and Alcohol Services South Australia
DVA	Department of Veterans' Affairs
EBP	Evidence Based Practice
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDD	Estimated date of discharge
EMDR	Eye Movement Desensitization and Reprocessing
ESOs	Ex service organisation
GP	General Practitioner
MH	Mental Health
ITO	Inpatient treatment order

JMO	Junior Medical Officer
LHN	Local Health Network
LGBTI	Lesbian gay bisexual transgender intersex
MDT	Multidisciplinary team
MFS	Metropolitan Fire Service
MHA	SA Mental Health Act (2009)
MOC	Model of Care
MOHO	Model of Human Occupation
NICE	National Institute for Health Care and Excellence
NOCC	National outcomes and case-mix collection scales
PTSD	Post Traumatic Stress Disorder
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SAAS	South Australia Ambulance Service
SALHN	Southern Area Local Health Network
SAPOL	South Australia Police
SES	State Emergency Service
TGA	Therapeutic Goods Administration
TMS	Transcranial Magnetic Stimulation
TRP	Trauma Recovery Programme
VVCS	Veterans and Veterans Families Counselling Service
WHO	World Health Organisation

This poem reflects the strong sentiments of those who have attended the PTSD group and the bonds they have forged with each other and the staff of Ward 17. The new Model of Care aims to ensure that the positive culture and therapeutic alliances as captured in this poem will be transferred to the new Jamie Larcombe Centre.

Ward 17 PTSD Group

We found ourselves gathered in Ward 17
Wondering how we had come to be here
Never thinking our military service
Could have brought on a thing so severe

We were grieving for who we used to be
And feeling bewildered and cross
For PTSD took so much away
We were grappling with what we had lost

Well the very first day was "scary as"
While we each battled with our own fears
For the thought of sharing with strangers
Took our SUDS levels up to severe

But we soon got along with each other
With the help of the Day Patient team
And before long we felt kind of settled
It was not quite as bad as it seemed

Some sessions were focused on PTSD
Plus anxiety, anger and lifestyle
And while heavy at times, we used humour
To allow us to crack the odd smile

When it came to the ten-pin bowling day
It was Keith who could knock them all down
But don't mention that it's "a no-brainer"
Guaranteed you will soon see him frown

From time to time you'd look out for Geoff
And find that he just wasn't there
Then suddenly he'd come back in and say
That he'd just stepped out for some air

For Craig the real highlight of the course
Came mid-way through every day
It was chips and gravy piled high on a plate
From his favourite Springbank café

"Now I don't get angry" exclaimed our Rod
And made light of things on most days
For he feared that if he did get cross
There could be a nasty display

Our Pensions Officer did his best
To help all his fellow vet's
For Kevin found that in doing this work
It seemed to help him forget

Meanwhile Bob would have a think on things
And then after some little while
Would put together a string of verse
That sometimes could bring a slight smile

"We've been all over the place today"
You would often hear Sandro say
For it's hard to control these ex-soldiers
Who talk crudely and just blaze away

Now when Cathie asked about our SUDS
She sure wasn't checking our washing
But was concerned about our anxiety levels
And how far we might be from relaxing

Are we doing Tai Chi or else Chai tea?
Asks Peter, to get us all calm
He was trying to make us more restful
Through breathing and moving our arms

And while Linda talked of standard drinks
And suggested we all go on rations
We nodded about whatever she said
We were committed – well after a fashion

In Meredith's relaxation class
There is one thing that was for sure
It was a race between Geoff and Bob to see
Who would be first to snore

It was Judith who had the tricky task
Of aligning both Mars and Venus
For PTSD seemed to emphasise
A rather big difference between us

Now a problem shared is a problem halved
So our partners became quite involved
And although we still have some way to go
Seems some "comm's" issues have been resolved

And from here on in it's up to us
To put these new skills into place
Being mindful of thoughts and reactions
While addressing each challenge we face

And we must remember when things look black
To explain we are not doing well
So our loved ones can understand what's up
And not put themselves through sheer hell

We need to learn to be kind to ourselves
And work on our self-esteem
And accept that this is just how things are
We no longer need live that bad dream

So to the Repat' team we thank you all
And hope you have set us free
By teaching us more about ourselves
And how to deal with our PTSD

Bob Walter

Executive Summary

In February, 2015 it was announced that $15 million had been allocated to build a new facility for a statewide Veterans' Mental Health Care service to replace the existing Ward 17 and ambulatory services located at the Repatriation General Hospital. An Expert Advisory Panel was formed and made its recommendation to Government that the preferred location for the new ward and outpatient unit was on land available at the rear of the Glenside Health Services Campus. The recommendation of the Expert Advisory Panel was accepted by Government.

Whilst the target population for services is the Veteran community and serving members, the new ward and outpatient facility will also accept police and emergency service personnel who are referred for treatment of Post-Traumatic Stress Disorder (PTSD). Members of the general public who meet the admission criteria detailed in Section 8 who require an admission to a mental health facility, will be accepted should no other beds be available within the metropolitan SA health system.

Five distinct but interrelated work groups were established to progress planning of the Veterans' Mental Health Precinct. These included the building design, partnerships, research and memorialisation work groups, as well as the model of care work group.

A workshop was held on Monday 25 February 2016 to build on and inform the work of the model of care working party. Invitations were extended to clinicians and major stakeholders and the feedback received incorporated into the enhanced model of care.

Remaining under the governance of the Southern Adelaide Local Health Network (SALHN), the facility will be commissioned and gazetted as a mental health unit under the South Australian Mental Health Act (2009)[1].

The purpose-built facility at the statewide Veterans' Mental Health Precinct will include a 24 open bed inpatient unit configured to allow flexibility in care from acute mental health management through to stabilisation. The ambulatory care service incorporating specialist PTSD services and outpatient care will be co-located with the new unit. The facility will comply with the current quality and safety standards for a mental health facility to provide a safe clinical and therapeutic environment. Innovative models of care will be trialled and tested in partnership with patients, collaborating with the research partners in the research facilities.

The building design will acknowledge the unique nature of the military experience. This will be reflected through memorialisation in the design of garden spaces and commemorative

areas together with clinical care based on best practice in Veteran mental health treatment. The building design will also reflect the breadth and diversity in the current and future patient populations by enabling physical access for frailer, aged or disabled consumers, by providing a safe environment for female patients and through being responsive to gender, cultural and spiritual needs.

To enable continuation and further enhancement of the partnership arrangements between the existing service of Ward 17 and the ex-service organisations (ESOs), the new Veterans' Mental Health Precinct will be co-located with a Partnerships Hub. Not only does peer support play an important role in mental health but ESO support responds to the concepts of identity, camaraderie and sense of purpose that are features of the military experience.

Collaborative research partnerships will be developed and fostered at the new precinct, with the aim of drawing together research expertise in Veteran and serving member mental health issues, and in particular PTSD, across the state and nationally[2].

In the process of developing this model of care (MOC), Veteran members of the work group were asked to provide feedback on their preferred term: 'patient', 'consumer' or 'client'. An informal survey of their user groups and colleagues overwhelmingly supported the use of the term 'patient'. Throughout this document the term patient is therefore used going forward. Each member of the work group was asked to declare any perceived or real conflicts of interest and if declared were managed at the time within the context of that meeting.

Purpose

The purpose of this document is to guide service delivery and improvement through the identification of key components that make up the MOC for Veterans mental health. It is intended as a baseline document from which service development may occur over an extended period of time in response to changing patient needs and the emergence of new information that will inform evidence based practice.

Background

The nature of military service in the Australian Defence Force (ADF) presents a unique set of risks to the mental and physical health of those who serve. In recognition of these health impacts, the Australian Government provides funding to meet the specific clinical needs of the serving and former-serving population. In South Australia, the State Government provides evidenced-based specialist mental health care designed around the unique needs of this population group.

The Veteran Context

Historically, Veterans have been understood as older men who served during the World Wars or more recently in Korea or Vietnam. Over the past ten to fifteen years, a contemporary group of Veterans has emerged. These veterans may have been involved in peacekeeping activities, border protection or service in the Middle East or East Timor and they include a higher proportion of women compared to previous generations. The increasing proportion of women serving in the ADF requires a focus on gender specific issues.

These differences require flexibility in the approach to providing health care for Veterans and their families as well as the broader Veteran community. The age of the patient may range from 18 to 100+ years. While these different cohorts all share the military experience, they have diverse needs reflective of their age, specific deployment experiences and life course. These are all considerations for the MOC. The demography of future patient groups is dependent on the future operationalisation of the ADF. As the environment in which the ADF operates changes, so too does the composition and needs of future patients.

The needs of this diverse community have informed the physical design of the facility. The design will enable disabled access to cater for self-propelled wheelchairs and mobility aids such as walking frames. It will acknowledge the parenting roles of more contemporary Veterans through family and child play spaces.

Definition of 'Veteran'

We respect the meaning of the term 'Veteran' and acknowledge it has special meaning to Veterans themselves. For the purpose of this document, a Veteran is defined as anyone who has served in the ADF, including the Reserve forces. Some Veterans have service related injuries and illnesses and others do not. Similarly some Veterans have Department of Veterans' Affairs (DVA) entitlements and others do not. In order to develop best practice that incorporates Veterans' needs over time, we have chosen a broad definition which incorporates all those who have served. We also recognise that some people may not identify as a Veteran. While it is a term that confers a particular status, its definition can be dependent on the context in which it is used. In this document it will be used to broadly encompass any person who has served in the military in either a permanent or reservist capacity. It also acknowledges that some returned men and women of more recent deployments do not readily identify with the term or status[3]. Others may prefer terms that relate to their particular military cohort or nature of their operational service, such as 'peacekeeper', 'peacemaker', or 'Vietnam Veteran'.

The provision of quality health care does not and will not depend upon the definition of a Veteran or whether a person chooses to be identified as a Veteran or not. Many patients will have entitlements to mental health treatment through DVA, without having progressed completely through DVA approved eligibility.

Definition of 'Veteran Community'

Military service can have a significant impact on the lives of those close to Veterans, including their families, partners and dependants. As defined in South Australia's Charter for Veterans, the Veteran community is inclusive of Veterans and their families with a direct link to a service or a Veteran. This includes widows, widowers, partners, former partners, children, parents, siblings and relatives of ex-servicemen and women, and should include anyone with an evident link to, or interest in, matters associated with Veterans' welfare or wellbeing.

Police and Emergency Service Personnel

Police and emergency service personnel are those who work across a range of front line agencies providing care to the public. These agencies include South Australia Police (SAPOL), South Australian Ambulance Service (SAAS) and the Metropolitan Fire Service (MFS). As a result of service, members of these organisations and others such as the SES and CFS can experience stress related injuries and in particular PTSD. Research and

treatment facilities across Australia have worked to improve evidence-based interventions for this cohort, in line with treatment for PTSD for Veterans.

Aborginal Patients

The view of “mental health” for Aboriginal people is not taken in isolation but viewed in a holistic manner. It is extended beyond the individual to families and entire communities and is not separated from physical health or spirituality. Aboriginal people function from the perspective of wellness as opposed to illness. As such, the terms “mental health” or “mental illness” can be inappropriate from an Aboriginal person’s perspective.

The delivery of care will take into account the special relationship to family, community and Country and the significant sense of loss, grief and trauma from past and current events that many Aboriginal people experience. The MOC aligns to the SA Health, Mental Health Services Pathways to Care Policy Guideline[4] which provides specific inclusion principles and guidelines to cater for the needs of Aboriginal people, including:

- To provide diversity of choice within the design of care and treatment options for Aboriginal people, including access to Aboriginal traditional healers, translators or interpreters through the Traditional Healer brokerage program and the South Australian Aboriginal Languages Interpreters and Translators Guide.

Culturally and Linguistically Diverse (CALD) Consumers

This MOC recognises the importance of culture and the migration experience of South Australian consumers, carers and families of culturally linguistic and diverse backgrounds. This MOC will ensure that at every point of contact, services are provided in a culturally and linguistically appropriate manner, which is respectful of the cultural, linguistic, religious and spiritual needs, or other specific needs such as diet and gender, of people of CALD backgrounds. In addition, consumers and communities of CALD backgrounds are welcomed as active partners in the planning and development of culturally competent mental health care services.

Definition of ‘Carer’

As outlined in the SA Health Partnering with Carers Policy[5] a carer is defined as:

> *‘A person who provides care and support for their parent, partner, child or friend who has a disability, is frail, or who has a chronic mental or physical illness. An individual is not a carer merely because he or she is the spouse, de facto, partner, parent, guardian, child or other relative of an individual, or lives with an individual who*

requires care. Carers can include parents and guardians caring for children and children caring for parents and guardians.'

In the context of Aboriginal communities and kinship systems, caring is a collaborative act with many people who may provide care for a single person. Because of this, people looking after family and friends often do not recognise themselves as carers. Aboriginal carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or who are frail aged.

There is a significant amount of research literature highlighting the psychological health impacts on carers caring for a person with a mental illness. Research has consistently revealed the stresses associated with vigilance and worry, particularly for partners and parents. There is considerable research evidence about caring for a Veteran with PTSD in particular.

While many carers may not identify with the term, situating their roles and feelings within their relationships, they still have rights to recognition and access to support. These rights are articulated in the South Australian Carers' Recognition Act 2005[6], the South Australian Carers Charter[7] and the National Carer Strategy[8]. The Specialist Mental Health Services for Veterans MOC recognises not only that carers work in partnership with clinical staff within the person-centred recovery model, but that they have needs which should be recognised and addressed.

Clinical staff encourage carer participation at the individual patient level, and at the service development level through the Carer and Consumer Advisory Committee (CCAG). Clinical staff recognise the rights and needs of family and significant others as carers and provide information about appropriate services and support and referral to organisations, such as the Veteran and Veterans Families Counselling Service (VVCS) and through the Partnerships Hub. It is also important to recognise that a significant other may be a partner/family member not identified by the patient or themselves as a carer but someone who is actively engaged with the care of the individual.

Consumers

Rights and responsibilities are described in *A Framework for Active Partnership with Consumers and the Community*[9]. This includes rights to information, consent to treatment, confidentiality and right to receive appropriate care. The framework provides information about how consumers can participate in decision-making about their health care and outlines consumers' responsibilities. Feedback will be actively sought via the SA Health Consumer

Feedback Management Policy and the SA Health Consumer Feedback Management Guideline.

Guiding Principles

The agreed principles from the Expert Advisory Panel, which preceded the Model of Care Work Group, align with both the recovery model of mental health care and clinical evidence pertaining to best practice mental health treatment for the Veteran community. The guiding principles outlined by the Expert Advisory Panel in their recommendations were that:

- The service should have an embedded understanding of the Veteran culture, military ethos and the unique health consequences of service.
- The service should be a state-based facility that provides evidence-based best quality mental health care to the South Australian Veteran and service community.
- The service should be inclusive of the broad Veteran and service community, regardless of the nature of the service, geographic location or entitlements, and should develop a service capability to include Police and emergency service personnel requiring treatment for PTSD.
- The service should cater for the full spectrum of Veteran and service related mental health, recognising this can include a complex mixture of presentations that are not just reflective of PTSD, but also include depression, anxiety, psychosis, substance abuse, anger management and relationship difficulties.
- The service should enable integration of all current health providers, pathways and partners in the South Australian Veteran mental health care space to ensure seamless holistic care. Recognising the diversity of care providers and funding pathways, the service should cater for flexibility and networking of diverse care models, including private sectors and partnerships (e.g. Veterans and Veterans Families Counselling Service (VVCS), Australian Defence Force (ADF) mental health care teams).
- The service should be configured to meet the physical and mental health needs of diverse and different sub-cohorts (e.g. >65 year olds vs 19 year olds) and be adaptive and scalable to the needs of a changing Veteran demographic.
- The service should respect the central role that families, ESOs (e.g. RSL Active) and contemporary groups (e.g. Soldier On and Trojan's Trek) provide in wellbeing and recovery.
- The service should integrate research, teaching, clinical care monitoring, evaluation and quality assurance across its networks.

- The service should reflect changing mental health care models which emphasise 'wellness' and rehabilitation rather than a 'sickness' focus, and acknowledge the importance of a holistic approach to mental wellbeing, including the importance of fitness, social activities, occupational rehabilitation and integration within a broader community.
- The service will establish partnerships and collaboration between mental health and physical health care clinicians to ensure that the physical health needs of mental health consumers are met.

What is a Model of Care?

A model of care "broadly defines the way health services are delivered. It outlines best practice care and services for a person or population group or patient cohort as they progress through the stages of a condition, injury or event."[10]

It also "aims to ensure people get the right care, at the right time, by the right team and in the right place"[10].

When designing a new MOC, the aim is to bring about improvements in service delivery. Developing models of care is considered a key change management process and broadly follows a project management methodology. In Australia and globally, there are multiple definitions of 'model of care'. The description we have chosen for this MOC is one that is:

> "*An overarching design for the provision of a particular type of health service that is shaped by a theoretical basis, EBP [evidence-based practice] and defined standards.*"[11]

Whilst this document outlines the MOC for Veterans' mental health services, it is underpinned by a detailed operational document which outlines the patient care journey.

1. The Model of Care

1.1 Key Principles

SA Health's key principles are to optimise patient outcomes by providing the 'best care, first time, every time'. The six Quality Principles of Transforming Health are that it is:

- Patient centred
- Safe
- Effective
- Accessible
- Efficient and

- Equitable.

1.2 Guiding Principles

The guiding principles of this model of care are that it:

- Is patient centric and in keeping with the national recovery framework
- Has localised flexibility and considers equity of access
- Supports integrated care
- Supports efficient utilisation of resources
- Supports safe, quality care for patients
- Has a robust and standardised set of outcome measures and evaluation processes
- Is innovative and considers new ways of organising and delivering care
- Sets the vision for services in the future.

1.3 Strategic Links to Policy Directives and Plans

At the local level, the model of care aligns with:

- SA Health and SALHN policy directives and clinical procedures.

At the State level, the model of care aligns with:

- South Australia's Mental Health and Wellbeing Policy 2010-2015
- SA Government Framework for Veterans' Healthcare 2016-2020
- Restraint and Seclusion in Mental Health Services Policy Guideline
- Restraint and Seclusion Recording and Reporting Chief Psychiatrist Standard (July 2015)
- Mental Health Act 2009 (MHA 2009)
- Electroconvulsive Therapy Policy Guideline and Chief Psychiatrist Standard (February 2014)
- Management of patients at risk of alcohol withdrawal in acute hospitals policy guideline (April 2016)
- Medical management of patients at risk of opioid withdrawal Policy Guideline (April 2016)
- South Australian Carers Recognition Act 2005.

At a National level, the model of care aligns with:

- National Mental Health Policy 2008
- Veteran Mental Health Strategy 2013-2023
- National Standards for Mental Health Services 2010

- National Practice Standards for the Mental Health Workforce 2013
- A National Framework for Recovery-Oriented Mental Health Services 2013
- Roadmap for National Mental Health Reform 2012-2022
- National Drug and Alcohol Guidelines 2015.

2. Evidence

The model is based on national mental health frameworks and standards, best practice evidence for Veteran mental health care and the agreed principles developed by the *Transforming Health Expert Advisory Committee.*

2.1. National Mental Health Framework: A Recovery Focus

The overarching framework for the MOC is based on the principles outlined in the *National Framework for Recovery-Oriented Mental Health Services*[12]*.* This will be achieved through:

- A multidisciplinary team model, with a focus on providing evidence-based treatment and patient centred care.
- A person centred, strengths based approach which emphasises participation, choice and self-determination in care planning, within the constraints of the medico-legal requirements and duty of care.
- In accordance with a recovery orientation, the model emphasises collaborative and partnership approaches with both the CCAG and service providers including the VVCS. Involving the carer, whether partner or other family member/friend, is an essential part of a recovery-focussed model, as are peer/other social supports.

2.2. Trauma-Informed Treatment of PTSD

With the prevalent diagnosis of PTSD in the Veteran population generally, and in the patient demographic for this facility, the MOC is trauma informed:

- It provides a safe environment, promotes the development of clinical relationships based on trust, expertise and understanding of military culture, and enables delivery of evidence-based best practice pharmacological and therapeutic interventions.

Information about the most effective treatments for PTSD is provided by Phoenix Australia in the *Australian Guidelines for the Treatment of Acute Stress Disorder and Post-Traumatic Stress Disorder*[13].

These guidelines provide the evidence and recommendations for pharmacological, psychological, psychosocial and physical therapy interventions.

Mental health hospitals across Australia have been contracted to provide evidence-based trauma recovery day programs (TRP) for former members of the Australian Defence Force (ADF) who meet eligibility criteria. In 2015, DVA released the *National Accreditation Standards for Trauma Recovery Programs – Post-Traumatic Stress Disorder Day Programs*[14]. These standards directly influence the MOC in relation to PTSD group programs.

2.3 Best Practice Treatment for a Broad Range of Mental Health Conditions

Clinical evidence for a range of mental health diagnostic categories is provided through the guidelines developed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP)[15] and the British National Institute for Health and Care Excellence (NICE)[16]. Best practice treatment is ensured through clinical professional development and the meeting of required standards under professional practice.

Thirteen standards for the workforce working in mental health settings are provided within the *National Practice Standards for the Mental Health Workforce 2013*[17]. The standards include common ways of working and the skills required for practitioners working across mental health care.

3. Comorbidity

Comorbidity is defined as the presence of two or more diseases or conditions simultaneously. This can include comorbid psychiatric conditions, medical conditions and/or substance addiction.

Veterans with mental health conditions can present with a range of comorbid mental and physical health issues in addition to inter-related psychosocial issues. For example, up to 90 per cent of Veterans with PTSD will meet criteria for another mental health diagnosis, primarily depression, generalised anxiety disorders, substance use/misuse and somatic disorders[2].

Substance abuse and misuse among Veterans may be a means of coping with, or a consequence of, a mental health issue and is a frequent therapeutic challenge. The clinical evidence for substance misuse and abuse in Veterans is that it should be treated alongside the Veteran's symptomatic distress where PTSD or another mental health diagnosis is the predominant presenting condition[18].

The management of chronic pain has been identified as a physical health care need that impacts on mental health. For this cohort, pain is often due to the substantial wear and tear

on the musculoskeletal system as a consequence of service or can, in some circumstances, be psychosomatic in nature. A dual diagnosis may exacerbate or at least mutually maintain each condition and therefore the management of chronic pain is paramount to evidence-based clinical practice[19].

Increasingly, dementia and other neurological conditions associated with ageing are present in the Vietnam Veteran and older Veteran populations.

Many studies have suggested an increased risk between PTSD and coronary heart disease, inflammatory, autoimmune disease, diabetes and poorer quality of life[20]. The impacts of smoking, poor diet and lack of exercise result in presentations which include Type 2 Diabetes, vitamin deficiencies, malnutrition and obesity.

Psychosocial issues in Veterans can include relationship difficulties, unemployment, lack of financial and/or social support, impacts of high risk behaviours such as gambling, and homelessness. Psychosocial interventions are used to reduce or mitigate some of these negative consequences. Occurring alongside treatment for the mental health diagnosis, the focus is on community integration and improved community functioning[21]. The aim is to provide optimal vocational, family and social functioning and begins early in the admission phase with Veteran and family therapeutic interventions.

Physical illness can trigger psychiatric admission impacting upon psychiatric care. Through the delivery of evidenced-based practice and clinical assessment, the sequencing of treatment will be tailored to maximise clinical outcomes for the patient. A holistic approach to care is essential.

In view of the established physical comorbidities experienced by some Veterans and serving members, robust and responsive medical and allied health care is required. A visiting physician will provide on-site services, which will include assessment and management of inpatients, advice to mental health staff and facilitation of referrals to specialty services off-site when required. Agreements will be held with units, such as pain, sleep, surgical and ophthalmological, to prioritise assessment of patients from The Jamie Larcombe Centre. Allied health services will, where possible, be provided in-house or through visiting services. Where this is not possible, prioritised pathways for rapid assessment and treatment off-site will be created.

4. What does Recovery mean?

The concept of recovery describes a person's unique and personal journey to create a fulfilling, hopeful and contributing life and achieve his or her own aspirations, despite the

difficulties or limitations that can result from the experience of mental illness. It does not necessarily mean the elimination of symptoms or return to a person's pre-illness state.

Each person will experience the recovery process differently and will have differing recovery goals. While recovery can be understood as an overall process of positive personal growth, this process may be lengthy and complex, involving periods of growth, setbacks and relapses. The concept of self-management of the chronic condition by the patient and its related concept of self-management support of the patient by clinical staff, family and carers, provide a set of clinical tools and processes which underpin the concept of recovery[22].

Family, friends, community members, mental health and other community services can all play an important role in encouraging and supporting a person's individual recovery journey.

Recovery orientated and patient centred care is central to the MOC for Veterans mental health. The services provided will focus on flexible partnerships with Veterans experiencing a mental health illness, their family, carers or significant others in order to encourage and empower a person to facilitate their own recovery. Patients can achieve an improved level of wellbeing, identity, purpose and meaning in life in the presence or absence of symptoms of illness[22].

The principles of recovery should be transferred into organisational culture and behaviours with all interactions and interventions designed to support self-development related to the recovery of the patient and life skill development that supports building of resilience.

5. What is patient centred care?

The definition of patient centred care is taken in part from the document *Australian Commission on Safety and Quality in Health Care (ACSQHC) Patient-Centred Care: Improving Quality and safety through partnerships with patients and consumers*[23].

Patient centred care is particularly important among the vulnerable or disadvantaged populations, such as the young, elderly, disabled or mentally ill, those from culturally and linguistically diverse backgrounds, rural and remote areas and Aboriginal peoples. Patient centred care is defined within this report as:

> *"Care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensures that patient values guide all clinical decisions."*

In addition, self-management support approaches provide practical clinical tools which put the patient at the centre of their care and build a collaborative approach between clinicians, patients and their families.

6. Definitions of Associated Terms

A number of terms are used interchangeably or associated with “patient centred care”. All terms are based on the fundamental concept of partnership and collaboration between healthcare professionals and patients, families, carers, consumers and significant others.

7. Pathways to Care

The primary role of The Jamie Larcombe Centre is to provide acute, sub-acute and rehabilitative mental health care to men and women aged over 18 years who are current or former serving members of the Australian Defence Force. Emergency service personnel, such as police, ambulance officers or fire service personnel, are also eligible to attend the PTSD program as part of a rehabilitation program approved by their respective organisation.

8. The Inpatient Unit

The Adult Acute Unit is a 24 bed unit that provides short to medium term inpatient management and treatment during an acute phase of mental illness.

- The acute inpatient service will function 24 hours, 7 days a week for those patients who are unable to receive care in a less restrictive environment.
- Patients remain as an inpatient until they have recovered to the point where they can be treated effectively and safely in the community.
- The target population is primarily veterans, war widows/widowers, serving members and ex-serving members.
- Other community admissions are accepted when possible and after clinical assessment and admission criteria are met.

The presenting psychiatric diagnosis will include, amongst others, post trauma conditions, mood and affective disturbance, psychosis, impulse control disorders, anxiety and somatoform disorders. Both mental and physical comorbidity is common, including substance misuse, psychosocial issues, pain and somatic health complaints.

8.1 Referral for Inpatient Treatment

Referrals will be primarily for Veterans and DVA entitled war widows or widowers. However, police and emergency service personnel may be accepted for admission where treatment is required for PTSD. Patients requiring admission for a mental health diagnosis from within the general population meeting the admission criteria will be accepted when beds are available.

- All referrals are to include a medical and psychiatric assessment (preferably a psychiatrist or psychiatric registrar) and can be made direct to the ward.

- Where a referral is received from a service such as the VVCS, an ESO or is made by the Veteran/family, the treating General Practitioner (GP) should be involved.
- The involvement of GPs, private psychiatrists, Aboriginal Health Workers/Aboriginal Mental Health Workers, and other cultural brokers, where possible, should be involved in the intake process.

Referrals are received from a broad range of public and private services and from metropolitan, regional and national centres.

8.2 Referral Pathway from Emergency Departments

Acceptance of patients for admission is a collaborative process between the mental health clinician assessing the patient in the Emergency Department (ED), duty Consultant Psychiatrist/ED Consultant Psychiatrist or Registrar and the admission staff or after hours delegate of the unit.

In accepting a transfer of a patient from the Emergency Department, it is important to consider a range of factors that may include:

- Is there a less restrictive alternative to admission?
- Should the patient be referred to another public hospital facility, a private hospital, or drug and alcohol detoxification centre prior to admission?

In line with SA Health policy, all patients who are to be admitted from an ED are required to have had a physical health assessment clearing them for a mental health admission and the patient is to be medically stable, with any medical issues stabilised prior to transfer. To minimise the risk of medically compromised patients being transferred to a mental health bed, the ED medical staff are required to document in the medical record that there are no further investigations or treatments pending subsequent to a comprehensive physical examination.

8.3 Admission Criteria

For patients to be admitted to the inpatient unit, they will have a primary diagnosis recognised by the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*. A person seeking admission will:

- Usually be admitted on a voluntary basis, although involuntary admissions will be accepted
- Be able to participate in the therapeutic process
- Have a reasonable expectation that the presenting acute mental health symptoms can be reduced or controlled

- Require medical stability that does not require ongoing, significant active or invasive medical treatment for management.

Patients do not meet the criteria for admission if the following are present:

- The person has significant active or invasive medical treatment needs
- The person is under a criminal court order for treatment
- The person is eligible for a forensic treatment setting
- The person is assessed as requiring a long-term treatment setting ie psychiatric rehabilitation, high level long term care for personal care needs and drug and or alcohol rehabilitation programs
- The person's primary diagnosis (or diagnoses) is/are: substance abuse, substance dependence, dementia, intellectual disability or high acuity psychiatric presentations requiring closed ward, seclusion management or psychiatric intensive care
- The person is experiencing substance intoxication
- The person is actively suicidal or highly agitated, at risk of violence or harm to self or others, actively seeking substances or is a high absconding risk under an Inpatient Treatment Order (ITO)
- The person has a primary diagnosis relating to a physical health care need that may need to be treated within a specialist unit prior to being admitted to The Jamie Larcombe Centre
- Patients should not be transferred to a psychiatric unit with a medical condition unless that medical condition is stable to the point that the patient could otherwise be discharged as detailed by the SALHN Clinical Review Committee (May, 2016)[24].

Where an admission has not been able to be facilitated, a clear and documented pathway to alternative care must be made.

8.4 Admission Procedure

Admissions may occur 24 hours a day, 7 days a week providing that the criteria for admission and admission procedure is followed, consistent with Local Work Instructions and the National Standards for Mental Health Services. The admission process aims to maintain the Veteran's and family/carer's rights to respect and dignity, while ensuring safe admission, assessment and management. Admissions will:

- Have a clear pre-admission process in place to ensure that no patient experiences an avoidable delay in their admission
- Ensure carers and/or family members are involved in the admission process where consent has been given

- As per SALHN Work Instruction, a face-to-face assessment by a consultant psychiatrist occurs on the day of admission, or if not practicable, the following day
- Utilising a multidisciplinary approach, an individually tailored, recovery-focused, person-centred care plan is developed. Both the patient and carer/family support systems (subject to informed consent) are involved as part of the care team in development of the plan
- Discharge planning, which is an essential component of every admission, commences early in the admission process and is undertaken in partnership with the patient, together with their nominated carer/family or significant other identified by the patient (subject to informed consent).

9. Inpatient Care

As a matter of policy, each patient, their carer or identified significant other will be directly involved in planning their own care, in accordance with the *SA Mental Health Care Plan Information Booklet*[25] and associated care plan documents. The care plan remains with and travels with the patient and the carer or significant other and is tailored to the patient's physical and mental health care needs. It will be easily available and will apply across all components of the mental health care service system. The care plan will be regularly updated with the patient, carer or significant other to reflect the patient's strengths, needs and goals. The care plan is to be used as a statement of current interventions. Information about treatment choices will be provided to patients and carers in a clear and easy to understand manner.

9.1 Chaplaincy/Spiritual Care

Spirituality is a dynamic and intrinsic aspect of humanity, through which people seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature and the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices.

Spiritual care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and includes the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in a compassionate relationship, and moves in whatever direction needs require.

A variety of people informally care for the human spirit in a mental health ward, and spiritual care practitioners, or chaplains, pay special attention to this aspect of care. With ex-service

patients, that care often feels familiar to the 'padre' from military days, although without the sense of coercion that sometimes accompanies the context of the latter role.

Spiritual care aligns closely to the Recovery Model of service delivery, with both focussing on those areas of life that give hope, meaning and purpose, both considering the whole person, both supporting an individual's authentic expression in the world, both valuing the role of community and so forth.

Practice should align with the Spiritual Care Australia *Standards of Practice*[26] and with the broader spiritual care framework being developed within SALHN.

9.2 Clinical Interventions

The clinical team will provide clinical assessments and a range of best practice and emerging therapeutic interventions including, but not limited to, the following:

- Psychoeducation
- Pharmacological interventions and medication review
- Electroconvulsive therapy (ECT)
- Mindfulness therapy
- Cognitive Behavioural Therapy (CBT)
- Cognitive Processing Therapy (CPT)
- Exposure therapy
- Eye Movement Desensitization Reprocessing (EMDR)
- Supportive counselling
- Stress management
- Relaxation, guided meditation
- Social emotional rehabilitation
- Vocational rehabilitation
- Occupational therapy
- Group therapy
- Smoking cessation therapy and support.
- Physical/exercise therapy (including gym based)
- Art Therapy
- Yoga.

The unit provides a range of therapeutic interventions and programs available to patients and their families to learn more about the impact of the illness, explore ways to better manage the illness, improve coping strategies and move towards recovery. Initial treatment

goals will be established either prior to admission or through goal setting during an early assessment phase of the admission. Goals are not limited to mental health issues but may cover comorbid physical and psychosocial stressors, improving functional status and the patient's health and social needs.

9.3 Milieu

The unit milieu will influence patient outcomes and behaviour as well as staff morale. This MOC embraces the concept of a therapeutic milieu or "optimal healing environment", focusing on recovery-orientated person centred care, continuous healing relationships, safety as a system priority and co-operation amongst the clinicians and patients receiving care.

Special consideration will be given to the appropriate milieu for Aboriginal people, people from CALD backgrounds and for people who have experienced trauma.

9.4 Psychotherapy

An individualised approach to psychotherapy which draws on available evidence and incorporates patient preference will be offered within the inpatient unit for those patients who are considered suitable for psychotherapy prior to discharge. The treatment team should have sufficient understanding and familiarity with psychotherapeutic interventions to provide empathic listening, gentle confrontation (e.g. pointing out obvious avoidance) and clarification to help patients recognise feeling states that they may not be aware of.

While empirically supported psychotherapies are well established for post trauma conditions it is increasingly acknowledged that they are not the only pathways to better outcomes. Additionally there are varying degrees of evidence for psychotherapy in other diagnostic categories. An awareness of these and an approach which encourages participation by patients while taking into account their personal preferences for their recovery approach is a priority.

Within an acute setting, psychotherapy is often directed towards engagement and crisis management and includes a range of modalities beginning with psychoeducation, and including CBT, problem solving, grief therapy, stress reduction, mindfulness techniques and supportive psychotherapy.

Along with this is a strong behavioural approach incorporating behavioural activation, exposure, relaxation techniques including Tai Chi, progressive muscle relaxation and yoga can be valuable to certain patient groups. Strategies that are also known to be effective with

this cohort of patients are distraction, diversion, music, art therapy, exercise and socialisation.

9.5 Restraint and Seclusion

Restraint and seclusion are interventions of last resort, used when other options have failed to maintain safety for the person experiencing distress, staff or others. Restraint and seclusion are not therapeutic interventions. Staff are required to adhere to the Restraint and Seclusion Policy Guidelines[27] based on the current best available evidence on the prevention and elimination of restraint and seclusion and the management of restraint and seclusion, where it is used as a last resort. Set in the context of early intervention measures to prevent restraint and seclusion occurring, staff will adopt a trauma informed approach to care. In line with the World Health Organisation (WHO) requirements, patients will have access to a 'comfort room', 'sensory room' or a 'sensory cart' to help reduce a person's level of agitation, aggression or anxiety[28].

9.6 Trauma Informed Care

Prevention strategies can be implemented within the health setting. The awareness of how past experience of trauma can impact on clinical interactions can help prevent the emergence of challenging behaviours.

From a neurobiological perspective, trauma survivors are sensitised to stimuli that may trigger fright, fight or flight response. In order to minimise challenging behaviours, practice needs to be aimed at preventing this fear response. People presenting to The Jamie Larcombe Centre may have experienced high rates of past trauma.

9.7 Tele-Psychiatry

The Australian Government has supported initiatives to increase the use of telehealth for rural and remote Australians. It is well documented that psychiatric interviews conducted over videoconferencing can be reliable for diagnostic assessment and treatment and can be as effective as face to face consultations in achieving improved health outcomes[29].

The needs of country patients can be met by following the lead of the Country Health SA Local Health Network (CHSALHN) in the delivery of tele-psychiatry and therapeutic interventions through a planned and co-ordinated approach. Links with family can also be identified, supported and incorporated into all aspects of care including transition planning on discharge for those who live outside of the metropolitan area.

The use of ICT systems such as video conferencing or skype will promote stronger partnerships with primary care and further enhance the exchange of information and clinical

support provided at a local level. It can be effective for case conferencing and consultation-liaison work. This may reduce the need for travel and will enable care to be provided locally. Further development in the use of this technology and its applications could see improved access to services for Veterans who live in rural and remote locations from this new site. The Royal Australian College of Psychiatrists has produced Professional Practice Standards and Guides for Tele-psychiatry[29].

9.8 Accredited Assistance Dogs

Accredited assistance dogs have been proven to enhance the lives of Veterans experiencing the symptoms of PTSD[30]. Trained to undertake specific tasks based on the needs of the Veterans, assistance dogs can alert or interrupt certain physical stress cues, turn on switches and also pick up and retrieve objects. For the purpose of The Jamie Larcombe Centre, assistance dogs are classified into three types:

- Guide Dogs for the visually impaired (e.g. Guide Dogs SA and NT)
- Hearing Dogs for the hearing impaired (e.g. Lions Hearing Dogs)
- Accredited assistance dogs for those experiencing mental illness.

The owner of the assistance animal is required to carry an identification card stating that the animal is certified by the appropriate agency. Every effort will be made to ensure that the accredited assistance dog will be able to stay with the patient in line with legislative requirements.

9.9 In-Reach Services

As a standalone mental health facility, there will be a consultant led physician service provided on site to provide general medical consultation and treatment at the Glenside Campus. This service will triage and manage referrals to ensure a timely response to comorbid conditions that have a direct impact on engagement in hospital based treatment and discharge. A number of Veterans have a dual diagnosis therefore this MOC adopts a collaborative focus with providers in the public and private health systems. Pre admission policies and processes for inpatient care determine the extent of medical acuity and the need for medical stabilisation prior to admission for mental health treatment.

In-reach services are provided to inpatients on referral from a psychiatric registrar or consultant in situations where the complexity of the medical or physical health condition:

- impacts on effective engagement in treatment
- is a barrier to discharge
- is required as part of an assessment of care needs on discharge.

These services include:

- Neuropsychology where an assessment of cognitive issues is required in relation to management at home and for driving
- Podiatry where foot complications could impact upon mental health care within the ward and/or discharge
- Diabetes education where mental health factors impact upon inpatient management and/or where a new psychotropic medication may increase the existing level of diabetes
- Sleep clinic, where provision of Continuous Positive Airway Pressure (CPAP) machines and mask fitting is required
- Pain unit where poor pain management can impact on inpatient psychiatric care
- VVCS provide a visiting service to both enable continuity of care and to address the mental health needs of entitled veteran community family members.

9.10 Outreach Services

Referral of inpatients to an outpatient service (e.g. to another tertiary treatment facility) is made on the basis that treatment of the condition requires another speciality team to review and provide care.

9.11 ECT Treatment

In line with the *Electroconvulsive Therapy Chief Psychiatrist Standard*[31] services, managers and clinicians will be guided by the following principles in the provision of Electroconvulsive Therapy (ECT):

- ECT services should be designed to bring about the best therapeutic outcomes for the patients and, as far as possible, their recovery and participation in community life
- ECT services should be guided by evidence-based practice
- ECT should be provided on a voluntary basis whenever possible
- There should be regular medical examination of every patient's mental and physical health
- The needs of patients, their families and carers including cultural and linguistic requirements should be considered in providing treatment that is accessible and responsive to these specific needs
- Patients, and their families and carers, should be provided with information about their illness, treatment options and rights, unless there are specific reasons that it is not practicable and safe to do so

- All aspects of the provision of ECT should be documented, including assessment, education and preparation, treatment, recovery and ongoing review.

9.12 Tobacco, Alcohol and Other Drug Recovery

There are high rates of alcohol and other drugs comorbidity amongt patients who have a mental health diagnosis (National Drug and Alcohol Guidelines 2015)[32]. Patients with a substance use disorder may experience an array of psychological, medical and social impairments that require a range of interventions during a period of hospitalisation. The co-location of Drug and Alcohol Services SA (DASSA) Withdrawal Service at the Glenside Health Service Campus provides a unique opportunity to improve the clincal interface between the two services. A co-ordinated approach to agency interaction and communication will ulitmately improve patient outcomes and enhance capacity building opportunities for staff. Membership on the Inter Agency Clinical Lead Forum will provide opportunities to further enhance existing relationships and referral pathways.

9.13 Patients, Staff and Visitors Security and Safety

The design, construction and operation of The Jamie Larcombe Centre will provide all those who come in contact with the facility with the confidence that a high level of physical security is met through the application of policies, standard operating procedures, routines and checking.

A balance will be maintained between the degree of intrusiveness of any security system/s and the level of risk when implementing safety for patients, staff and others working or visiting the facility. The provision of security systems will enable effective responses for staff to enact whilst ensuring that the privacy of patients is maintained.

Safety and security systems in clinical areas will be managed by clinical staff. All incidents of aggression or violence will be managed by clinical staff who will be trained in the de-escalation of aggression or violence. A facility-wide personal duress alarm system and telephony will ensure that staff are able to request assistance in an emergency. Hardwired duress, medical emergency and fire alarms will be located across the facility to ensure easy staff access under all situations. Where clinical staff are unable to safely manage a person who is violent or aggressive, immediate assistance will be called for by campus security.

Detailed operational approaches to ensure a systematic response by staff in all emergencies will be provided within the facility's operational document. This will include responses for the following situations:

- Evacuation

- Fire and flood (internal and external)
- Unlawful departure
- Failure to return from leave
- Hostage
- Barricade
- Roof top occupancy
- Critical infrastructure failure (e.g. power or water outage, communication system failure).

Sexual safety is a state in which physical and psychological boundaries of individuals are maintained and respected. The Jamie Larcombe Centre will have systems that promote sexual safety through the provision of policies and procedures that will:

- Support the right of patients and staff to physical and psychological safety
- Encourage and educate staff regarding the monitoring of physical and psychological safety and the setting of professional boundaries
- Respond quickly and appropriately to breaches in personal boundaries
- Support professional development.

Assessment and identification of persons at risk of potential harm, or of increased vulnerability, will be made at initial assessment on admission and will be reviewed regularly to reduce risk. The inpatient unit will provide safe and secure space for males, females, lesbian, gay, bisexual, transgender and intersex (LGBTI) patients admitted to the facility. A pod of 4 beds has been allocated for gender specific treatments if required.

9.14 Transfer of Care and Supported Discharge

The length of episode of inpatient care is primarily determined by clinical need. On occasion, it may be necessary to transfer care to another facility or service. The Transfer of Care may be temporary, and the nurse on the Unit remains involved unless a long-term transfer is required. For each transfer, a full comprehensive handover must take place, with names of transferring and receiving parties clearly documented in the electronic record. The Guiding Principles for Transfer of Care are available within the Operational Policy Document for The Jamie Larcombe Centre. Transition of care and discharge from the unit, takes place in consultation and in partnership with the patient and as appropriate, their carer/family/social supports. A short period of home leave may be implemented to trial readiness for transition back into the community. The collaborative model ensures liaison with, and information flow to, the GP and other key care providers, including ESOs where appropriate, occurring prior to discharge. Discharge planning is the role of the multidisciplinary team and will comply with the operational standard of the unit. The standard will include a process whereby a

discharge summary is made available to the patient's GP and treating psychiatrist. The discharge care plan developed with the patient will include relapse prevention strategies. The Veteran and carer/family are fully involved in the process and aware of all follow up appointments and ongoing care arrangements. Patients will be contacted within seven days of discharge by phone by a member of the clinical staff.

10. Outpatient and Ambulatory Care

Ambulatory and outpatient care are terms that refer to services provided as a day attendance at a health care facility or at a patient's home. Services can range from preventative and primary care through to specialist services, and are also referred to as outpatient or non-inpatient care. It is recognised at both an international and national level that timely access to ambulatory care can reduce the need for a tertiary hospital admission[33]. Conversely, a patient on discharge from a tertiary setting is best supported by the provision of access to all clinical, allied health and community health services that have been identified to support their ongoing recovery in line with the patient's clinical needs.

The guiding principles for care in a community outpatient setting are:

- Care should be provided in a community or ambulatory setting unless considered inappropriate due to safety, quality of care and efficiency reasons
- Services should ensure equity of access, timely and appropriate access to services
- Non-inpatient services should be co-located and/or integrated where there is a service or patient synergy.

10.1 Outpatient Appointments

On discharge from the inpatient setting, patients will be provided with a collaboratively arranged care plan including details of follow up appointments. Follow up may be with a range of private and public providers.

10.2 Veterans Mental Health Rehabilitation Unit (Outpatients)

The unit provides an accredited PTSD group program, Veterans and seniors group programs, individual and couple counselling and a Transition to Care service. Referrals may be received from a range of health and community organisations, self/family, ex-service organisations and the inpatient unit. Priority is given to Veterans and DVA entitled war widows and widowers. Policy and emergency service personnel may participate in the PTSD programs on a fee for service basis.

10.3 PTSD Group Program

An eight week intensive PTSD group program is provided around three times per calendar year. A minimum of five and a maximum of ten participants attend each program on a non-inpatient basis. It includes specific sessions for partners. The aim of the program is to provide specialised evidence-based care to promote self-management of PTSD through understanding of symptoms and learning of strategies to manage them.

The program complies with the *Australian Government Accreditation Standards for Trauma Recovery Programs*[34] and the *Australian guidelines for the treatment of acute stress disorder and post-traumatic stress disorder*[35]. It is provided through a direct contractual arrangement with DVA which funds on an individual basis at completion of a program. To attract funding, participants must have DVA treatment eligibility and complete a minimum of 15 days of the intensive phase of the program.

10.3.1 Assessment

Program participants will have a diagnosis of PTSD, be able to meaningfully engage in the full program offered, and be able to abide by the program Code of Conduct. Assessment for admission will also consider the group profile for each program. Part of this process includes four one-to-one sessions of two hours each, prior to commencement of the program. This assists Veterans in preparing psychologically for undertaking the program and is aimed at reducing participant drop out.

10.3.2 Treatment

The program content responds to the particular learning needs of the individual cohort while complying with evidence-based treatment and the accreditation standards. It involves components of group, individual and couple therapy. In–reach sessions are provided in relation to the needs of the group (e.g. education by a dietician). Sessions delivered by external clinicians such as VVCS helps to ensure continuity of care after the program is completed.

10.3.3 Discharge

Discharge planning occurs during the course of the program with identification of ongoing clinical and community supports. This is to enable continuation of self-management strategies learned during the course and to ensure continuity of care.

10.3.4 Other Group and Individual Treatment Provided as Outpatient Care

Other group programs are provided based on the mental health needs of the changing patient demographic in relation to psychosocial therapy. Planning should be informed by regular review and evaluation to ensure that the programs are meeting the needs of patients. Staff availability and expertise in delivery of evidence-based group therapy, assessment of priorities for service delivery along with practicalities such as the availability of space, form part of the considerations to schedule activities.

Current programs include:

- Day programs for Veterans and seniors (Vietnam and older Veteran cohorts)
- MAP (an eight week mindfulness program for pain management)
- In-patient therapeutic discussion groups
- Smoking cessation support
- Meditation
- Tai chi
- Guided relaxation
- Art therapy
- Yoga.

11. Multidisciplinary Workforce

The Tertiary Veterans MOC requires an integrated multidiscipinary team approach. Staff require extensive knowledge and skills relating to the management of mental illness often coupled with physical health conditions and the uniqueness of a Veteran's journey. The profile of staff and the approach to care should enable the patient's goals of care to be realised. At the clinical level, an embedded understanding of military culture in workforce training will enable programs to be responsive to gender differences, in both response to trauma and in mental health presentations.

Members of the team will have a range of skills and experience. Some staff will prefer to work in an area of particular skills and experience whilst others will bring a broad range of clinical expertise to the setting. Most staff will have a shared set of generic skills in clinical assessment, risk assessment and care planning. The delivery of particular interventions however may be a specialised skill. The unit should adopt the person centred bio-psychosocial, goal focused care philosophy. Recruitment should focus on building a strong team across disciplines with the skills and knowledge to provide comprehensive mental health care and treatment.

- Staff should be trained in cultural awareness and cultural competence.

- All staff should promote mental health and support prevention and early intervention for patients, families and significant others.
- All staff should have the appropriate skills, knowledge and attitudes to provide safe and effective care, and this should be supported by recruitment, professional development, clinical supervision and performance review (with reference to relevant core competencies).
- Staff should be trained in the management of short-term intravenous and sub-cutaneous fluids, intravenous medication, ongoing oxygen therapy and incontinence.
- Staff should be able to manage escalating behaviour especially aimed at reducing or eliminating restraint use with training provided as required.
- Staff should be informed on how to access policies, procedures and guidelines and are able to do so when required.
- All staff should be consulted in the development of policies, procedures and guidelines that relate to their practice.
- Managers should audit the implementation of policies and procedures and provide feedback to staff.
- A policy and procedure on the recruitment of volunteer staff on the unit should be in place.
- The unit should have agreed minimum staffing level across all shifts and should be consistently met.

Members of the team will meet the National Practice Standards for Mental Health Services[36] to deliver person centred approaches to health care.

To achieve the National Practice Standards and guiding principles of this MOC, the workforce needs to be adaptable and flexible, and include the skills discussed for each discipline under the following headings.

11.1 Medical

In an acute inpatient setting, all patients are admitted under a consultant psychiatrist. Providing clinical expertise and leadership within the inpatient setting, the consultant psychiatrist provides the diagnosis and initial management plan on admission and overseeing of patient care. As an accredited teaching facility, the delivery of the MOC will also be supported by Registrars and Resident Medical Officers (RMO) who provide support to the consultants and broader clinical team.

Psychiatrists will align their practice with The Royal Australian and New Zealand College of Psychiatrists':

- Position statements
- Clinical practice guidelines
- Ethical guidelines
- Code of conduct
- Code of ethics.

To address the physical comorbidity needs that impact on the mental health of Veterans, the provision of both in-reach and out-reach medical services, such as chronic pain physicians and anaesthetists for the provision of ECT, will be important to the care of Veterans. Referral and visiting arrangements will be required as part of the MOC.

11.2 Nursing

Nursing staff provide a person centred recovery based approach to mental health care. Supporting the clinical care of patients, nursing staff will be responsible for monitoring the patients' mental state, completion of risk assessments and monitoring skin integrity. In addition to the completion of comprehensive risk assessments (such as harm to self or others), nursing staff assist with activities of daily living and provide treatments as required.

Nurses will align their practice with:

- The Australian College of Mental Health Nurses' Standards of Practice for Australian Mental Health Nurses, 2010
- The Nursing and Midwifery Board of Australia's:
    - Code of Ethics for Nurses in Australia (2008)
    - Code of Professional Conduct for Nurses in Australia (2008)
    - National Nursing Competency Standards for the Registered and Enrolled Nurses.

The nursing model is guided by the recovery model of care, encompassing patient centred and culturally safe care, recognising the strengths of the individual in their journey to recovery. The inpatient nursing team use evidenced-based, up to date practice to empower the patient group, recognising their experiences and accepting that they are the expert in their own illness. The recovery model is utilised to promote patient education around their illness and individual triggers and to assist in the setting of and achieving individualised goals to support necessary lifestyle changes and relapse prevention. Throughout this process, the role of the family, carer and wider community supports is acknowledged and partnerships encouraged through supportive care.

11.3 Occupational Therapy

Occupational therapists (OTs) have an important role in optimising the independence, autonomy and occupational performance of patients with mental illness and/or cognitive impairments. OTs also have a major role in discharge planning to ensure that patients are safe and supported within the community. Interventions on discharge can include education of carers or significant others about the patient's ability to function, timing and type of assistance required, including safety precautions and behavioural cues.

Occupational therapists will align their practice with:

- The Australian Association of Occupational Therapists' Code of Ethics (revised 2001)
- Australian Minimum Competency Standards for New Graduate Occupational Therapists 2010
- The Occupational Therapy Board of Australia's Code of Conduct for registered Health Practitioners (2012).

Occupational therapists will work from a recovery approach, focussing on the strengths and values of patients to facilitate their return to engaging in meaningful life roles. Assessment tools utilised are based on the Model of Human Occupation (MOHO) which incorporates domains of motivation, performance, routines and environment. Sensory modulation assessment and intervention also forms an integral component of Trauma Informed Care which assists patients to self-regulate their emotional responses to environmental stimulus.

11.4 Social Work

The role of a Social Worker within the MOC is to assist patients with a range of issues that may include but not be limited to, financial difficulties, accessing community supports, relationship and accommodation difficulties. Social work assistance is particularly valuable for patients who have complex psychosocial problems or vulnerabilities. Social workers provide the interface between patients and the multidisciplinary team working towards an optimal outcome for patients.

Another key role for social workers is discharge planning, maintaining continuity of care and facilitating community reintegration. Education and liaison with community based services, other government services and non-government services such as ex-service organisations, including those provided at the Partnerships Hub, is essential.

Social workers will align their practice with the:

- Australian Association of Social Workers Australian Social Work Education and Accreditation Standards (2012)
- Code of Ethics (2012)
- AASW Practice Standards for Mental Health Social Workers (2008).

Following the recovery model and using a patient centred approach, social workers work with inpatients and outpatients on a wide range of issues which can impact on a successful transition from inpatient care to home and community and maintenance of independent living. Commonly these issues in Veterans include the consequences of their ill mental health, which can result in relationship difficulties, unemployment, lack of financial and/or social supports, and the impacts of high risk behaviours such as gambling and homelessness. Social workers are involved in housing and accommodation issues, organising aged care placements and supports, linking patients with advocacy services and psychosocial supports, and addressing complex financial situations through advocacy with Centrelink and the Department of Veterans' Affairs. Social Workers also work closely with family members, particularly partners, in provision of psychoeducation and in addressing needs for support services.

11.5 Pharmacist

Hospital pharmacists are committed to facilitating the safe and effective use of medicines. The pharmacist is responsible for documenting an accurate medication history, including allergies, for patients on admission and assessing how well patients are managing their medications. All currently prescribed medications are reconciled against those taken prior to admission. Drug-drug interactions and drug-patient interactions are identified. Medications are reviewed to determine if they are therapeutically appropriate and recommendations are made to the team in order to optimise patient therapy. The pharmacist contributes to ward rounds, liaises with nursing staff about medications and participates in research projects. Investigation is undertaken when necessary to review a patient's historical use of psychotropic medications. All patients are provided with counselling and written information about their medication on discharge, and appropriate communication is undertaken with the community in order to facilitate a smooth transition of care.

Ward 17 has a full-time pharmacist who provides a high level of service, seeing patients the day of their admission and reviewing them daily (except weekends).

Hospital pharmacists provide a service encompassing the:

- APAC (Australian Pharmaceutical Advisory Council) Guidelines on the Continuum of Care and in accordance with

- The Society of Hospital Pharmacists of Australia Standards of Practice for Clinical Pharmacy guidelines.

11.6 Clinical Psychology

Services offered by clinical psychologists cover a broad range of activities, including the delivery of evidence-based treatment for psychological disorders through cognitive and behavioural therapies and counselling. Clinical psychologists are well placed to provide treatment of PTSD.

Clinical psychologists will align their practice with the Australian Psychological Society's:

- Code of ethics
- Ethical and practice guidelines and procedures.

Within The Jamie Larcombe Centre, clinical psychology services focus primarily on the assessment and treatment of PTSD and its comorbidities. Treatment is based solely on the use of evidence based interventions such as exposure therapy, cognitive processing therapy and eye movement desensitization and reprocessing (EMDR).

Clinical psychology services are used extensively in the PTSD program and such services adhere to DVA accreditation standards for Trauma Recovery Programs.

Clinical psychology provides individually based trauma focussed work throughout the program period.

Specific groups run by psychology include the following:

- PTSD Education
- Anger Management
- Managing Depression
- Treatment of Nightmares
- Group Psychotherapy.

Clinical psychologists are also involved in service evaluation and ongoing clinical research.

11.7 Physiotherapy

Physiotherapists (PTs) aim to engage patients in meaningful, goal-driven active rehabilitation programs. These may include:

- Mobility and falls risk assessments and rehabilitation, including the provision of mobility aids as appropriate, to enable safe and effective mobility
- Assessment and treatment of musculoskeletal injuries and limitations

- Provision of chronic pain management strategies
- Exercise programs to address individual rehabilitation needs as well as enhancing overall wellbeing
- Facilitating transfer to outpatient and community exercise and rehabilitation services.

Physiotherapists within mental health settings provide these services with sensitivity to the specific needs of mental health patients. Physiotherapy practice is aligned with:

- The Australian Physiotherapy Association guidelines
- The Code of Ethics
- The Code of Conduct for Registered Health Professionals.

12. Partnerships and Linkages

Partnerships are a collaborative relationship with a clear and shared sense of purpose involving identified key stakeholders. In the context of The Jamie Larcombe Centre, as a result of the establishment of the Partnerships Hub on site, information relating to other services offered (particularly by ex-service organisations) will be available on site for Veterans and their families.

Establishing strong and ongoing relationships with stakeholders is crucial to ensuring that referral pathways to VVCS, providers in both the public and private sectors and to the non-government/ESOs, such as RSL Active and Soldier On, occur and are maintained. These stakeholders have an interest in improving the delivery of services to Veterans and their families with a view to improving engagement and wellbeing. In order to facilitate a broad stakeholders' range of services for optimal treatment, the MOC, embraces the development of effective partnerships with a range of other services, particularly with ex-service organisations.

13. Teaching and Training

The Jamie Larcombe Centre is an accredited teaching post affiliated with the major universities across South Australia. All levels of teaching can be accommodated, from student placements through to postgraduate training for the specialist colleges. This is applicable across medicine, nursing and allied health.

Intern positions (PGY1) and Resident Medical Officer (RMO and PGY2) and beyond are available in both the general streams and in the SAMET (South Australian Medical Education and Training pre training for psychiatry stream).There are four accredited registrar

posts associated with the service. A half time physician trainee registrar post is shared and the service is able to accommodate general practice training registrars on request.

14. Research

Opportunities for integration of clinical and academic research will be developed at The Jamie Larcombe Centre. Research is integral to improving clinical outcomes through the generation of new knowledge that will translate to evidence-based care. The development of a research institute will enhance opportunities for universities and other stakeholders to collaborate on research innovation and discovery. Based on sound research ethics and within a governance structure, this work will complement individual and national initiatives across research into Veterans' mental health, Police and Emergency Service Personnel and more broadly into the health and wellbeing of Veterans' families. The benefits will span across care to Veterans and their families, opportunities for staff to be part of a research culture that enhances clinical care and the ability to attract PhD students to be involved within the research hub.

15. Innovation

Collaboration between academic, research and clinical settings promotes the development of evidence-based programs and activities. Opportunities exist to trial specific interventions linking the inpatient and ambulatory services with the patient and their families in the community and with other providers such as the VVCS. Other opportunities include:

- Incorporating the ***Flinders Program of Chronic Condition Management***[37] into the discharge planning pathway for the inpatient unit and to evaluate the effectiveness of the model in reducing readmission rates. A web based version of the Flinders Program 'Flincare' has been developed by Flinders University which enables care planning to be conducted remotely (e.g. in rural SA) and follow up provided using text messaging. The Flinders Program care planning process is integral to the DVA's Coordinated Veteran's Care program which has been provided nationally to over 23,000 Veterans, with funding provided to GPs to enable practice nurses to provide assessment, self-management care planning and coordination. Nurse or allied health coordinators based with the Veterans Mental Health service could be involved in piloting the web based version of the care planning tool – www.**flincare**.com linking with the VVCS, the patient's GP and related service providers to improve self-management by the patient as well as provide a platform to coordinate care. Patients will be able to access their care plan via home based computer or mobile phone and receive reminders about appointments and goal directed activities by the

coordinator. The expected outcomes would include improved self-management, improved quality of life, better coordination and communication between the patient and their care providers and reduction in readmission rates.

- Enhanced community care coordination and outreach services with self-management care planning and greater web based outreach to outer metropolitan and rural sites. The Ambulatory service could provide coordinated care and case management for veterans and their families with complex and co-morbid conditions.
- Early intervention for anxiety and depression using stepped care models of ***low intensity guided self-help*** as developed in the successful New Access projects delivered by *beyondblue* and Flinders University. This model is based on the national Improving Access to Psychological Therapies (IAPT) program developed in the UK and adapted for Australia in the New Access projects recently completed in three national demonstration sites, achieving a 68% recovery rate with five telephone sessions delivered by low intensity coaches who came from non-health professional backgrounds. The program was part funded by Movember to increase the uptake of mental health support by men. This was achieved with a 40% enrolment rate by men in New Access. Hence the potential applicability of this model for male Veterans. This approach is cost-effective, providing evidence-based cognitive behaviour therapy guided self-help using workbooks, social prescribing and community services engagement. This model is suitable for peers with Veteran experience to be trained as coaches in combination with health professionals who act as supervisors. The use of a web based PC-MIS patient management and outcome system provides a real time supervision platform so that supervision can be provided to coaches and patients anywhere in SA or nationally. This platform also enables outcomes to be measured on all patients and recovery rates to be determined based on validated outcome measures. An inpatient version of this program has been implemented in the private sector by Remedy Healthcare as **MindStep** for patients with anxiety and depression who have been discharged from private psychiatric hospitals. DVA now has the potential to trial this model of guided self-help, either in the community early intervention or acute post discharge environment.
- ***Peer support programs***: Trialling a peer support program similar to those that have been successful overseas[38]. DVA is currently trialling peer support programs in other parts of Australia. Models which should be investigated and trialled include peer leaders being trained to deliver a range of possible programs including Stanford chronic disease courses (six weeks, 2.5 hours per week) focussed on developing

self-management skills, stress and anxiety management groups led by peers supported by psychiatrist or mental health professional, and those specifically designed for women. These could complement the clinical care provided to Veterans.

- Neurostimulation: Recent advances in various technologies including Transcranial Magnetic Stimulation (TMS) and other forms of neurostimulation will supplement ECT. TMS is currently provided under research conditions required before Therapeutic Goods Administration (TGA) approval is obtained. The centre may decide to be involved in collaborative research programs with TMS and other technologies as they emerge.Trialling the use of telehealth (i.e. video-conferencing or skype) for rural, remote and outer metropolitan locations to provide greater access to services as demonstrated through the Telehealth and eHealth Australia Pilot Project Program.
- Art therapy is currently being trialled successfully through a grant program for outpatient attendance. Art therapy which can incorporate painting, drawing, collage, sculpture, music and journaling helps to develop self-awareness, create emotional change leading to optimal living relative to the individual. Opportunities to incorporate art therapy into the suite of therapies offered within the inpatient setting should be explored and, if implemented, evaluated.

16. Safety and Quality

The Veterans Mental Health Service will operate under the safety and quality principles and priorities described within the:

- South Australian Mental Health and Wellbeing Policy
- National Standards for Mental Health Services
- Australian Council for Healthcare Standards
- Key Performance Indicators for Australian Public Mental Health Services.

These safety and quality documents will inform the implementation, evaluation and continuous improvement within the service in line with national and state policy directions. In particular:

16.1 Patient and Carer Participation

- Ensure that patients and, where appropriate, their carers are informed and involved in all aspects of safety and quality programs, ensuring that feedback on service is provided to health professionals and that patients are involved in the planning and delivery of services and service improvement strategies.

16.2 Monitoring and Evaluation

- Ensure that services are monitored and evaluated across the continuum of care to ensure that the best possible health care is provided to people with a mental health condition
- Ensure that safety and quality audits and risk assessments are undertaken
- Ensure that monitoring systems are based on measurable standards, with appropriate benchmarking and outcome measures.

16.3. Physical Health and Wellbeing

- Prioritise the physical health and wellbeing of patients with mental illness, ensuring that their physical health care is assessed and monitored, particularly if the physical health care is impeding their care for their mental health diagnosis.

16.4 Safe Use of Medicines

- Ensure the use of medications has a sound evidence base and takes into account potential side effects and other adverse reactions that may affect a person's mental and physical health care needs and is in compliance with relevant policies and procedures governing the use of medication.
- Facilitate partnerships between general practice and mental health professionals in relation to the medical treatment of people with a mental illness, to achieve the highest possible standard of care and consistency of treatment regimes.
- Support further research and the collection of accurate data on the use of medications to inform policies and procedures governing best practice use of medicines.

16.5 Reduce Adverse Events

- Ensure mental health assessments, including risk assessments and physical health assessment are conducted in a timely manner.
- Ensure the recommendations and strategies are incorporated into patient care plans.
- Ensure that all risk management and care plan information is communicated with the patient and all involved in the care of the patient and that these are consistently implemented.

16.6 Evaluation and Accreditation

In using evidence-based protocols, the facility will continue to adopt, adapt and develop new measures for evaluation based around clinical outcome measures.

Key current outcome measures include use of the Mental Health National Outcomes and Casemix Collection (NOCC) and patient satisfaction surveys. As part of meeting the contractual requirements with DVA, the PTSD Program complies with the provision of clinical outcome data to the Phoenix Organisation. Specific data is required per participant at intake, discharge, three and nine months post discharge and determines the overall program outcomes.

16.7 Key Performance Indicators

Reviews and evaluations of the clinical practice and outcomes will be inbedded into service delivery. These will be linked to evidence-based clincal practice for care. Safety and quality, along with performance indicators, will monitored based on the national minimum data set of:

Other indicators to be monitored include the following:

- Length of stay
- Care and treatment plans
- Admission and discharge time
- National outcomes and case-mix collection scales (NOCC)
- Seven day follow up
- Involuntary status/number of patients under ITO
- Complaints and feedback
- Sentinel and adverse events
- Restraint events
- Clinical outcomes using validated clinical outcomes for a range of disorders e.g. PTSD, depression, anxiety and quality of life.

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