Submission No 33

Inquiry into the Care of ADF Personnel Wounded and Injured on Operations

Organisation: Veteran’s Health Advisory Council

Joint Standing Committee on Foreign Affairs, Defence and Trade

Government of South Australia
Veterans Health Advisory Council

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CMDR Crouch
Committee Secretary
Joint Standing Committee on Foreign Affairs, Defence and Trade
Department of House of Representatives
PO Box 6021
Parliament House
CANBERRA ACT 2600
AUSTRALIA

Dear Sir

Re: Late submission for the enquiry into ADF personnel wounded and injured on operations

Attached submission on Provision of Mental Health Services for Veterans in South Australia – "A Co-ordinated Service Delivery Paradigm"

This submission was prepared by the South Australian Government's Veterans' Health Advisory Council (VHAC) - Mental Health sub-committee chaired by Professor Alexander McFarlane AO, MBBS (Hons), MD, Dip. Psychother, FRANZCP. The submission is supported by both the VHAC and the Veterans' Advisory Council (VAC)

Professor McFarlane will speak to this submission at the public hearing of the Joint Standing Committee on Foreign Affairs, Defence and Trade being held at Parliament House, Adelaide 8th February 2013.

Yours sincerely

Jock Statton AM
Presiding Officer, Veterans' Health Advisory Council

07/02/2013

PROVISION OF MENTAL HEALTH SERVICES FOR VETERANS IN SOUTH AUSTRALIA - "A CO-ORDINATED SERVICE DELIVERY PARADIGM"

The Need for Coordinated Health Services

Co-ordination of mental health services for younger veterans will be a critical issue in the coming years as this large cohort transitions from the Australian Defence Force (ADF) into the wider health sector.

Adding to the challenges of an increased number of veterans is the expected level of care they will require. The 2010 ADF Mental Health Prevalence Study identified that younger Defence personnel have significantly greater rates of depression and posttraumatic stress disorder than in the general community. This was not previously identified as a potentially significant issue requiring clinical planning. It also found a significant percentage of individuals with mental health disorders leave Defence without being diagnosed or seeking care. Furthermore, there is often an increasing severity of symptoms following discharge. This landmark study has established a greater need for care than has been planned for to date.

Multiple service providers for both Defence and DVA at a State level have little awareness of the plans or initiatives that are federally directed. This highlights the potential for currently serving and ex-ADF members to be inadequately managed by the health system. The goal is to enhance clinical outcomes through early intervention. The critical challenges are firstly transitioning the younger ex-ADF member into care and secondly effectively coordinating the delivery of that care.

In essence, it is critical to develop a model of health service delivery for current ADF members and ex-serving personnel that take account of the structure and interfaces of service delivery at a State based level. To date, no initiative has taken this perspective in order to optimise health care through federally funded programs that are provided by state based services.

Service Delivery Disconnects

At a State level, there is little integration between the services addressing the needs of veterans and ADF members. While there are major active interfaces between these services at the level of service providers and clients, there is no effective administration of the link. This situation contrasts to probably the most successful and comparable model existing today in Canada.

Canada's recent history of deployments following Rwanda and the mental health burden led to a reinvigoration of mental health services in the Canadian Defence Force and this progress flowed into the veterans system. This impetus has led to the establishment of a properly staffed workforce of psychiatrists, psychologists, and other mental health professionals in uniform. This body of expertise has been used to develop and direct veterans' health services that are provided at a

state based level. The relative uniformity of assessments and treatment driven from within Defence has ensured better standards of care, cleaner transitions and adequate follow up for members leaving their Defence community.

It is not likely that the ADF would be able to establish such a model in the short to medium term noting their current budgetary constraints. The ADF currently has limited personnel employed directly by Defence in and out of uniform to provide mental health services. The development of regional mental health teams has not progressed as rapidly as had been anticipated meaning that there is relatively little visible coordination of services. It will remain the case that private practitioners, both from psychiatry and psychology continue to provide a significant proportion of the services for ADF members, with public mental health services caring for the more severe patients. Furthermore, Defence personnel utilise the services of the VVCS without needing to seek a referral from an ADF Medical Officer.

The service delivery models for DVA are also based on national programs with similar issues. DVA purchases the services of private practitioners, State run public hospitals, private sector in-patient services and the VVCS. These models of service delivery are not well understood at a State level in both the public and private sectors.

This is particularly the case with the SA Department of Health. An example highlighting the issue is their recent plan to close mental health beds. This included the closure of beds at the Daw Park Repatriation Hospital without an understanding of their lines of funding from the Department of Veterans' Affairs. Equally, the Department of Health had no awareness of the health service demand implications of the relocation of 7RAR to Adelaide from Darwin.

The civilian health sector is also often unaware of a younger veteran's service history and little systematic assessment occurs of the associated risk factors which may have contributed to their current health status. The significance of military service with this cohort does not get systematically assessed or documented because of the lack of record keeping of ADF service in private or State based health records. The pattern of presentation and the treatment provided to these individuals is not adequately documented.

Amongst health administrators and providers at a State based level, there is little understanding of the fact that members leaving the ADF do not automatically become DVA clients on discharge. The fact that ADF members may leave Defence with health conditions that do not attract a DVA entitlement, as well as having deployment related health conditions, adds to this confusion. The State health system only identifies members with a DVA entitlement rather than ex-ADF members more generally. This lack of identification of military service means that some ADF members may present with an illness that would attract a DVA entitlement but its relationship to military service has not been identified or assessed as the individual is not recognized as being an ex ADF member.

It has also become apparent that the existence of multiple providers creates a system where it is difficult to ensure and report the quality of service delivery and to address the importance of providing evidence-based care following appropriate assessment of ADF members. This is in part a consequence of the lack of clinically trained mental health staff in the Department of Defence.

Capacity within South Australia

In South Australia, the development of State based centres of excellence and the coordination of care remains fragmented however an excellent underlying capacity has been developed. In particular:

- The Daw Park Repatriation Hospital with Ward 17 continues to provide a quality PTSD program and outpatient services for some veterans however the geographic separation between the Hospital and the Edinburgh Army and Air Force Base has meant the needs for community based services for the ADF are not readily available;

- Significant expertise in veterans mental health has also been developed by due **to the interest and/or service backgrounds** of some private psychiatrists and assisted by the provision of PTSD programs in the private sector at the Adelaide Clinic;

- The VVCS is well established and provides excellent programs but these are often not well integrated with other services;

- South Australia through the University of Adelaide is a major centre for research and education on veterans' mental health through its Centre for Traumatic Stress Studies (formerly the Adelaide node of the CMVH) and delivery of the ADF's Master of Clinical Psychology program.

- Professor McFarlane AO who is involved with all the above is also the ADF's senior uniformed adviser on mental health and a key advisor to DVA.

The SA Government recognizes the need to ensure that ADF and Veterans' Affairs derived policies are effectively implemented at a State level. It has established a ministry for Veterans Affairs and a Veterans' Health Advisory Council to advise the Minister. The Mental Health Sub Committee of the Council has been asked to review and determine priorities for the provision of mental health services for veterans in South Australia. This is to inform the broader initiatives for the provision of health for the veterans' community in South Australia.

A key recommendation is the need to improve local coordination of care and the development of a network of interested mental health professionals. Whilst the ADF Regional Mental Health teams have provided some opportunities in the past, the lack of funding and clear service delivery models has not led to any sustained coordination at this level. Equally, the lack of integration between the Repat Ward 17 staff and the private sector and VVCS has created at times

differing and conflicting aims and models of service delivery. Coordination of care is best driven at the service interface by clinicians both across and within the existing stove piped organizational frameworks.

The Proposal

Two key actions are recommended:

1. Assessment Procedure: Develop an agreed assessment procedure between the ADF South Australian based Regional Mental Health teams and Veterans' Health Services, whether these services are in the private or public sector. This would:

- Include the identification of ex-serving members who do not have DVA entitlements by improving the record keeping and notification of ADF service;
- Establish a single managed point of contact/entry, co-ordination, delivery and follow up;
- Improve clinical efficiency with a process for measuring outcomes; and
- Provide a vehicle for a coordinated approach with all recognised providers managing delivery of treatment programs

2. Establish a Clinical Network: Development of a coordinated network of service providers who are known to provide evidence based care should be created. The network would supplement rather than replace existing organizational frameworks. It would:

- Develop and/or drive the implementation of the Assessment Procedure into both the public and private sectors;
- Facilitate professional development through regular meetings for clinical presentations and quality assurance activities;
- Focus both on psychotherapeutic/CBT interventions, as well as optimal psychopharmacology;
- Develop active links to rehabilitation providers, coordinated by the treating clinicians;
- Educate clinicians and relevant ESO stakeholders on the services provided and the related policies, procedures, and initiatives being funded centrally by the ADF and DVA
- Provide linkages into the wider established clinical networks with the potential for integration with the GP network or "Gateways"; and

establish a mechanism to provide clinical feedback to funders and policy makers particularly DVA and the SA Department of Health; and

- This initiative be monitored with a quality assurance program to document the effectiveness

This network should have components that address those who have first presentation and acute illnesses, as well as the need to establish long term coordinated rehabilitation services. These services need to be grafted onto the existing clinical and service structures that already have relationships with the ADF and ex-serving community in South Australia.

The network is not intended to be an organizational entity but a loosely coupled and largely self managing professional association. It would however require some financial or in-kind support for administrative overheads and selected clinicians time

Summary of the Potential Benefits

The actions above would be supported by the Department of Health in South Australia, recognising the particular needs and interests of veterans and the value from the provision of evidence based care.

Funding stakeholders are also likely to be incentivised from a budgetary perspective. DVA reduces long term costs through early and better intervention whilst the SA Government optimizes the federal funding available for services they would otherwise have to meet.

In summary there will be a more effective and efficient delivery system better able to manage demand. The evidence indicates that interventions are more effective if they are provided early in the course of a disorder. Services also are required to address the diverse needs of mixed genders and families. There is an obvious need for future Mental Health Delivery system to be more robust, flexible but coordinated.

Treatment outcomes will be more effective if these occur before significant disability and employment disadvantage have emerged.