# A transformed mental health system for Veterans and their families:

# brief implementation guide

Centre of Excellence - PTSD
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Phoenix AUSTRALIA | CENTRE FOR POSTTRAUMATIC MENTAL HEALTH

# Abbreviations

| | |
|---|---|
| CoE | Centre of Excellence |
| EBP | Evidence-Based Practice |
| EDI | Equity, Diversity and Inclusion |
| IS | Implementation Science |
| IT | Information Technology |
| MBC | Measurement Based Care |
| PTSD | Post-Traumatic Stress Disorder |
| SDM | Shared Decision Making |
| SGBA+ | Sex, Gender and Equity Based Analysis |
| TIP | Trauma Informed Practice |

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# 1 Introduction to this Brief Guide

*Phoenix Australia and the Centre of Excellence on PTSD and Related Mental Health Conditions in Canada share a common goal of improving mental health and wellbeing among current and former Defence members. These two organisations have entered into a formal collaboration to promote opportunities for sharing relevant information, as well as for joint initiatives in areas such as policy development, service improvement, training and research.*

Many systems that support Veterans with their mental health needs emphasise high quality and accessible treatment as a high priority in their reform effort, and are working towards this goal. Whilst progress has been made in many areas, it remains a significant challenge for many systems globally. One of the first deliverables from the collaboration has been to help address this challenge and deliver a *Conceptual Framework to guide the implementation of best and next practice in services and supports for Veterans and their families* (Conceptual Framework).

The Conceptual Framework is intended to progress the conversation around high quality and accessible treatment for Veterans and their families and drive further reform work to provide them with the best possible support and care.

Written as a technical document, it:

1. Provides an overarching design and 'scaffold' around which to build an effective system of services and supports that better meet the needs of Veterans and their families;
2. Provides a structure around which current and planned initiatives in service development can be considered;
3. Helps determine where different systems are in relation to best and next practice services and supports;
4. Outlines the best approach and path to get there, recognising the differing start points of various systems.

The technical document provides comprehensive, evidenced-based reference material on the needs of Veterans and their families; the current system they face; and a vision for the future that includes a stepped / matched model of care aimed at promoting wellbeing and effective recovery in Veterans and their families. This model provides an approach to service provision that prioritises best practice interventions and matching a person's needs with the right level of care at the right time in a timely manner.

This Brief Guide should be read in conjunction with the technical document.

## 1.1 Purpose of this Brief Guide

This Brief Guide is a short, practical document intended to support Veterans mental health systems to commence and / or enhance their own journey towards implementing the new system design, and ensuring high quality and accessible mental health treatment for Veterans and their families.

## This Brief Guide should be read in conjunction with the technical document.


*Brief guide version (this document)*


*Technical document version*

It is intended to:

- Be an actionable guide to the full Conceptual Framework and 'make meaning' of the wealth of information within it.
- Provide a resource and practical steps on where to start or further enhance implementation work in Veterans mental health systems at the local, regional or national levels.
- Provide a structure and menu for a range of future 'how to' guides and toolkits that could be developed.
- Be able to be applied internationally (i.e., be meaningful in a number of national Veterans mental health systems, each with their own unique environment and set of circumstances).
- Support providing rigor to implementation work (i.e., a framework to study and measure uptake and impact of the Conceptual Framework from now and into the future).

The Conceptual Framework is intended to progress the conversation around high quality and accessible treatment for Veterans and their families and drive further reform.

## 1.2 Scope

The scope of this Brief Guide is largely dictated by the scope of the Conceptual Framework. Therefore it:

- Is set within a vision for a future system, which is outlined later and described in full detail in the technical document;
- Focusses on practical steps to implement the macro model of care (described under section 2.2) and a set of evidence-based programs and treatments, which is a corner stone of the future system vision;
- Builds on key concepts around knowledge mobilisation and implementation; and
- Expands on specific objectives under each of the necessary building blocks for effective knowledge mobilisation and implementation.

It is predominantly intended for use by Intermediary Organisations. A more detailed definition of these organisations is included later in this Brief Guide, but essentially these are organisations that sit outside of both government and the service system and play a role in building the capacity of other system entities to improve outcomes for specific population groups.

However, it is hopefully helpful to anyone with an ability to influence outcomes for Veterans and their families – funders, insurers, policy makers, system managers, regulators, service providers, support organisations, practitioners as well as Veterans and their families themselves.

## 1.3 How to use this document

Building on the detail in the technical document, this Brief Guide should be used by intermediary organisations (and anyone else it is helpful to) to:

- Understand the scope and boundaries of the system – local, regional, national – in focus.
- Assess where that specific system is in relation to the future vision and macro model of care outlined in the technical document.
- Identify a program of knowledge mobilisation and Implementation work – a roadmap of activity and initiatives – and plan immediate next steps.
- Help develop additional collateral e.g., 'How to' guides to further enhance implementation work.
- Provide a structure through which to evaluate implementation work.
- Provide a framework for collaboration across stakeholders and the integration between different implementation components and activity.

**Where there is additional information provided in the technical document, links to the relevant section are indicated as follows: [Section X.X].**

# 2 A high-performing posttraumatic mental health system: Future design

*The Conceptual Framework details a future system of services and support for Veterans and their families [Section 4.3].*

A fundamental premise is that Veterans and their families face a complex array of services and supports and, however disconnected the elements may be, from their perspective it constitutes a service system and should be acknowledged and approached as such by those that can influence it. Some elements of the current system are high quality but taken as a whole, existing systems of care do not adequately meet the needs of Veterans and their families.

The technical document details the mental health needs of Veterans and their families [section 3.2, 3.3 and 3.4], the barriers they currently face in accessing support [section 4.1] and the impact – health, social and economic – that building an efficient and effective Veterans' posttraumatic mental health system can have [section 4.2]. A system like the one outlined on the following page has the potential to reduce domestic violence, family breakdown, suicide rates, unemployment, homelessness, and disability adjusted life years (healthy years lost), as well as making longer term savings in health and psychosocial care costs.

The Veteran and their family stand at the centre of the system – the focal point. The diversity within the population is consistently recognised and all services and supports are accessible and acceptable to them.

The system is then designed based on seven principles of 1) respect and dignity, 2) engagement and involvement, 3) equity of access, 4) breadth of support, 5) high quality treatment and care, 6) holistic outcomes and 7) economic responsibility [section 4.3]. These are highlighted around the edge of the diagram, with further detail included in the appendices to this Brief Guide. It is important to note that, although there is a loose association, each of the principles influence all of the vision not just the 'segment' on which they are labelled. The segments are not intended to create 'silos', rather integration and connection is vital as the bridges and overlaps between each indicate.

Each icon or label on the diagram then represents an entity, concept, initiative, activity, service or support. The status of each will vary between different systems. Each could, for example, be a) in place and active in the system already, b) in place but in need of evolution, or c) to be established and implemented.

This vision for the system is not intended to be exhaustive or exclusive, particularly for the entities and stakeholders it highlights. It does set out fundamental features that are required, but the intention is to:

- Provide a start point for understanding and evolving local, regional or national systems;
- Help guide conversations with all stakeholders;
- Provide a resource to understand the current system; and
- Help plan for future reform work.

The vision can be updated and tailored for each unique system (a system at any level).

## 2.1 A future posttraumatic mental health system


*Figure 1: A Veteran-centric high-performing posttraumatic mental health system*[1]

1. This diagram concept has been adapted from the Redbridge Health and Well-being services diagram presented in Ham & Smith (2020) Removing the policy barriers to integrated care in England

## 2.2 A next generation stepped / matched macro model of care

The corner stone of the future system design is a macro model of care – a next generation stepped / matched model [section 5.1, 5.2 and 5.3]. The proposed model, above, pushes past the boundaries of current models and adopts a holistic wellbeing approach, shifting the primary focus of the model (and the people working at all levels within it) towards Veteran and family wellbeing:

The model outlined here has a number of key features including:

- A comprehensive multimodal individual and family assessment at the point of entry.
- Shared decision making (SDM) to give the Veteran and their family an opportunity for input into the treatment planning process.
- The availability of acute assessment and intervention across all tiers of the service system.
- An ability to enter the stepped / matched model at any tier and move easily between tiers, all supported by 'service navigators' who are not only familiar with all components of the system and related services, but who also know the Veteran and family well.
- The best possible care coordination models in place to facilitate communication between providers, Veterans, and their families.
- The engagement and close collaboration with other organisations providing supports and services, including digital supports.
- Well understood and embedded evidence-based practice (EBP) across all tiers in the model. The technical document includes a menu of current EBP within each tier [section 5.3].
- Enhanced outcome monitoring, a commitment to measurement based care and continuous improvement and refinement of the model.
- A commitment to gender and equity informed outcomes and sex, gender and equity analysis (SGBA+)
- A commitment to building trauma-informed practice (TIP) capacity in organisations.

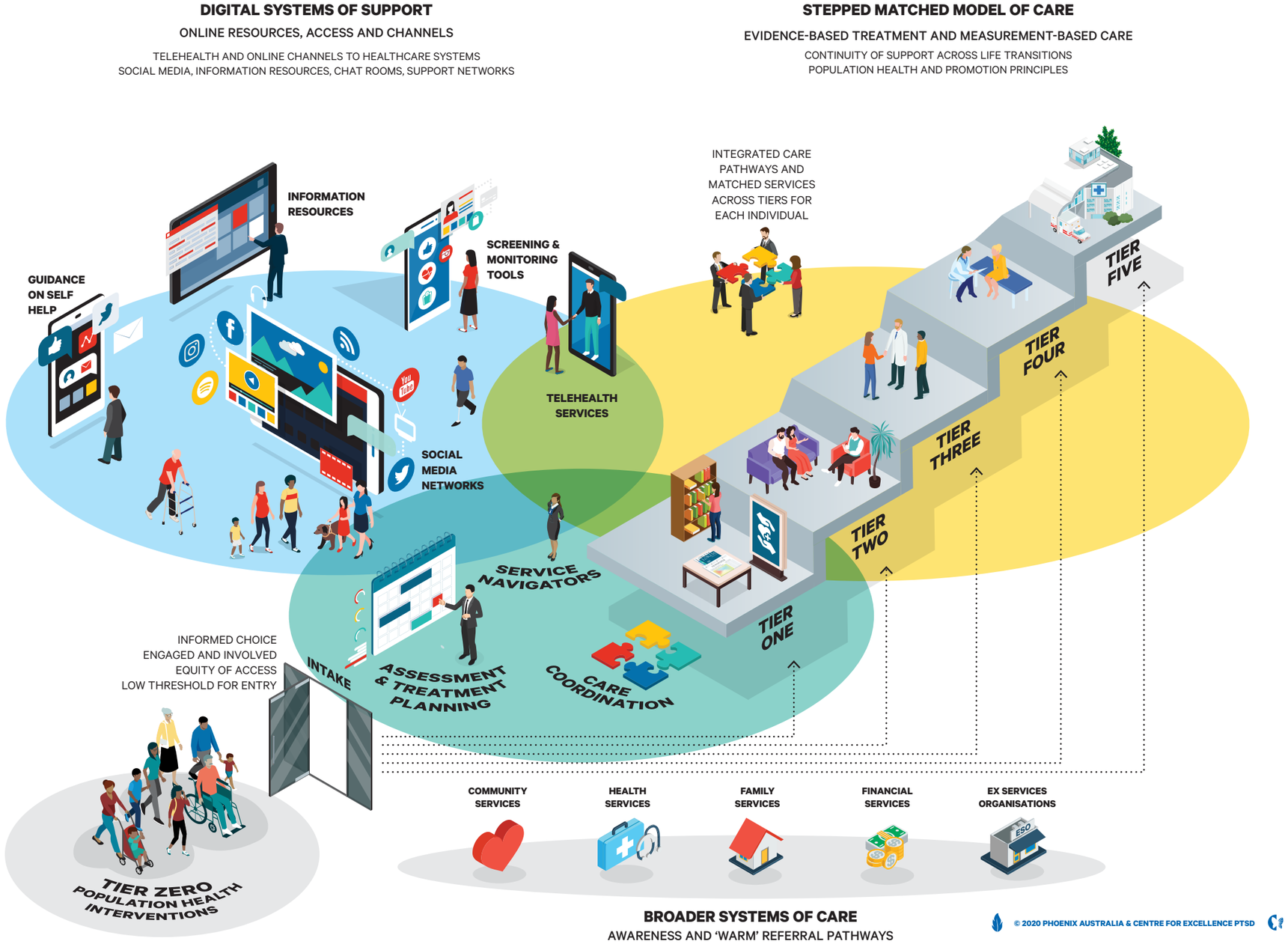



*Figure 2: Next generation stepped / matched model*

# 3 Implementation: Key stakeholders

*A broad range of stakeholders are able to influence the design of the system, the way in which it operates and the outcomes achieved for Veterans and their families.*

## 3.1 Stakeholders

The active involvement of all stakeholder groups in developing and operating a revised posttraumatic mental health system is crucial. No single organisation can deliver this new, integrated system design alone. The roles and responsibilities that each stakeholder group will take within different systems will vary, but key stakeholders include:


*Figure 3: Key Stakeholders in the Posttraumatic Mental Health System*

These stakeholders include Veterans and their families, placed firmly in the centre of the system. They are supported and guided through the system by the broader Veteran community, notably formal and informal pThese stakeholders include Veterans and their families, placed firmly in the centre of the system. They are supported and guided through the system by the broader Veteran community, notably formal and informal peer supporters, as well as the health professionals providing assessment services, treatment planning and mental health care to the individual and the family.

Integral to the system is the close collaboration of, and integration with, agencies providing support and interventions in other areas essential for Veteran wellbeing. An overarching Veteran wellbeing framework is included in the appendices, but key domains where these supports and

interventions will occur include health (physical and mental including posttraumatic), life skills and preparedness, social integration, housing & physical environment, cultural & social environment, employment or meaningful activity and finances.

Lastly, providing the overarching architecture within which the system are, for example, the funding bodies and insurers, policy makers, regulators, administrators and system managers.

The role of the intermediary organisation in this landscape is included in the next sub-section.

## 3.2 Intermediary organisations

As outlined previously, intermediary organisations typically sit outside of both government and the service system, playing a role in building the capacity of others and consistently focusing on Veterans and their families and enhancing the system around them to improve outcomes.

Intermediary organisations can take different forms and provide different functions depending on the system [section 6.4.1.2]. Typically though they:

- Act as a bridge between researchers, government decision makers, clinical leaders and the community;
- Provide technical expertise and support structures that are not typically built into service systems or are not part of a policy or system manager stakeholders' role;
- Play a pivotal role in advocating for and supporting system change i.e., is in a position where they can influence key decision makers and/or processes;
- Provide direction and continuity for service improvements;
- Have an ability to form and lead partnerships and collaborations amongst stakeholder groups;
- Have highly skilled staff with a comprehensive understanding of both government and service delivery environments and the ability to work between them.

Intermediary organisations take one of two main forms - treatment developers (purveyors), which are narrowly focused on disseminating their EBPs, and centres of excellence (CoEs), which have a broader focus across the research, policy and service divide to improve knowledge and practice in specialist areas. Depending on funding systems, in some jurisdictions, large NGOs or government agencies can take on many of the roles of intermediary agencies.

In this context intermediary organisations require expertise in quality improvement, implementation science and/or knowledge translation as well as a range of core competencies. [section 6.4.1.2]

It is important to note that intermediary organisations typically have to secure their own funding to deliver on their mission and support their own set of functions. The availability of funding can, obviously, constrain their role, function and reach within any system. The technical document outlines the importance of ensuring funding to foster partnerships, networks and other activities that are not purely project / deliverables-based. Without an ability to develop and maintain this kind of work, an intermediary organisation's efficacy in changing systems and improving outcomes can be severely hampered.

In this context, a key assumption to the following section is that funding is available to an intermediary organisation seeking to deliver on the proposed roadmap. The process of securing funding is not considered as part of the roadmap.

# 4 Implementation: A roadmap for Intermediary organisations

*This section sets out a roadmap for intermediary organisations, in the context of their role, to support the implementation of the overall future system design and next generation stepped / matched model of care, and also EBPs across the tiers within the model, their sustained use and continuous improvement systems and processes.*

The roadmap is designed based on the critical building blocks for delivering effective knowledge mobilisation and implementation within a system, which are described in detail in the technical document [section 6.4] and illustrated in the figure below:


*Figure 4: Effective knowledge mobilisation and implementation within a system*

The roadmap involves delivering change within a complex adaptive system, engaging with multiple stakeholders, sectors and systems of care and also taking into account how they will change over time. The overarching aims of the roadmap, and therefore themes for all activity, are to:

- Place the needs of all Veterans and their families at the centre of this work;
- Foster equity-informed and gender sensitive responses through training and skill development;
- Build an inclusive approach across all stakeholders to knowledge sharing and system improvement;
- Increase the availability of effective care, with greater number of Veterans and families accessing EBPs when they need it and at the right level of intensity;
- Sustain the use and effectiveness of evidence-based treatments and the systems that support them; and
- Build effective systems to identify emerging needs and knowledge amongst the Veteran community and their formal and informal support systems to inform policy and research in a timely manner.

The roadmap outlines the key activities for an intermediary organisation to consider according to each building block and their corresponding action areas.

## 4.1 Building Block 1: Nurturing leadership

Leadership, both formal and informal is an important element of effective knowledge mobilisation and implementation. The effective implementation of the overall future system design and next generation stepped / matched model of care involves working with multiple sectors and service systems and their leadership structures. In the absence of a single point of influence or decision-making, the following objectives and activities seek to influence and foster collaboration as well as build facilitation and knowledge brokerage models [section 6.4.1].

### Objective 1.1

**1.1 Engage with government decision makers** to encourage policy directions and resourcing that are consistent with and support the implementation of best practice.

Engagement needs to involve discussions about the improvements or interventions that require implementation but more importantly, required resources and guidance for effective and sustained knowledge mobilisation and implementation efforts.

Key activities are intended to position the intermediary organisation as not just a trusted advisor and/or advocate for uptake of evidence, but also as a facilitator that brings together policy makers, researchers, clinicians and the Veteran community through co-design.

Key activities

**1.1.1** Establish and / or develop relationships with key government stakeholders including Minister(s) and opposition spokes-people, their advisors and bureaucrats at all levels.

**1.1.2** Develop a surveillance capability and provide policy-relevant advice to government, keeping them abreast of the litera-ture. This surveillance capability should also track the barri-ers and influencers that policy makers face in staying abreast of the literature and subsequently using it.

**1.1.3** Host and / or participate in regular meetings and workshops with policy makers to influence their thinking and planning including co-design and co-production workshops on key policy issues around service delivery/system change that engage a range of stakeholders.

**1.1.4** Develop policy guidance and support tools around sus-tained knowledge mobilisation and implementation science.

**1.1.5** Build guidance and support tools for policy decision makers to enable their own meaningful and sustained engagement with other important stakeholder groups.

## Objective 1.2

**1.2 Support intermediary organisations and knowledge brokers** to provide implementation leadership and facilitation.

The type of leadership provided should be based on an organisation's place in the service system. Intermediary organisations should be resourced to foster partnerships between health providers, researchers and the community in a sustainable manner.

### Key activities

**N/A** This is largely a government function and therefore out of scope for intermediary organisations except for activity and processes around sourcing funding.

## Objective 1.3

**1.3 Support implementation efforts across all levels of leadership** and across all types of stakeholders.

This includes centralised leadership to support a shared vision and provide program continuity, as well as effective resourcing and local leadership to provide day-to-day guidance.

In complex systems, top-down approaches to implementation are not recommended. Local leadership needs to be resourced and supported to ensure that interventions are adapted to local needs.

The role of intermediary organisations is facilitative i.e., through the provision of tools, brokering, implementation support services and facilitation of leadership networks across disciplines/sectors.

### Key activities

**1.3.1** Engage with organisations and service systems to learn about their leadership culture and support requirements, based wherever possible on a sound understanding of key leadership attributes and processes that support implementation [section 6.3.2.3].

**1.3.2** Work with all levels of leadership of organisations implementing EBPs to plan their implementation and consolidation including adaptation of interventions to suit local needs. Facilitate ongoing implementation through facilitation/brokering services.

## Objective 1.4

**1.4 Engage both formal and informal leaders** in mobilising knowledge and changing practice.

Informal leaders such as opinion leaders or community leaders should be, wherever possible, engaged in supporting change and quality improvements.

Organisational leaders need to be resourced to support implementation efforts from the start so that they can foster organisational readiness and early adoption, and over time to champion EBP sustainment.

An intermediary organisation's role is also to understand who has influence on improving outcomes. Any form of leadership support and development needs to both target organisational leadership and potential champions in amongst service providers and community.

### Key activities

**1.4.1** Establish and maintain leadership networks across disciplines/sectors around key areas of change/implementation programs to improve care for the Veteran community. This includes consideration of designing and hosting formal leadership development programs that reflect equity, diversity and inclusion (EDI) principles.

**1.4.2** Provide advice and guidance to organisations and relevant information to opinion leaders on what is required for effective system change and implementation.

**1.4.3** Support community leadership programs around accessing and supporting best practice/effective early engagement in the service system.

**1.4.4** Work with and support community-based champions through regular access to information, training, and networks i.e., an ongoing program of support that provides consistent messaging around EPBs, and effective care systems etc.

**1.4.5** Develop a change/implementation readiness assessment to be deployed as part of implementation efforts. This helps identify early adopters and champions so that they can be more effectively engaged.

## Objective 1.5

**1.5 Foster leadership capability** for promoting practice improvement and the implementation of innovations.

More research needs to be done to address this critical aspect of system change and implementation support.

### Key activities

**1.5.1** Engage in research activity in relation to implementation leadership and how to most effectively foster diverse leadership capability.

**1.5.2** Develop and publish specific tools and guidance, for example, online implementation leadership checklists, readiness assessment questionnaires etc.

**1.5.3** Support the design and promotion of mentoring programs for formal and informal leaders that reflect equity, diversity and inclusion (EDI) principles.

**1.5.4** Ensure the incorporation of leadership capability in workforce competency frameworks as well as formal training pathways and programs.

## 4.2 Building Block 2: Maximising collaboration

The artificial divide between knowledge producer and knowledge recipient has led to many years passing before research evidence is embedded into practice, but more importantly, disconnection between knowledge creation and use has often resulted in interventions being developed without an understanding of the context in which they will be delivered. The following objectives and activities seek to address these concerns. [section 6.4.2]

### Objective 2.1

**2.1 Actively involve practitioners and clients** in the planning and design of efficacy and implementation research in order to facilitate effective dissemination and implementation of new approaches.

#### Key activities

**2.1.1** Develop and disseminate a specific co-design and co-production framework or strategy for the system.

**2.1.2** Ensure the incorporation of co-design work into each project or funding proposal.

**2.1.3** Establish and maintain a consumer engagement strategy and plan for the organisation incorporating regular communication and outreach activity.

**2.1.4** Establish and maintain a Lived Experience reference group of Veterans and Veteran families, formed to help, for example, guide the design of implementation and knowledge mobilisation programs and set research priorities.

### Objective 2.2

**2.2 Include participatory research models and practice evaluation** in research priorities.

These types of research help identify how systems and service environments shape practitioner behaviour and the way in which communities' access and utilise support.

Whenever possible, they should be used as an opportunity to form partnerships for future dissemination and implementation efforts.

#### Key activities

**2.2.1** Prioritise practice-based research projects and support active engagement of practitioners through initiatives such as embedding practice-based researchers and facilitators in partner organisations or having practitioners rotate through the intermediary organisation.

**2.2.2** Support participatory research models by actively engaging Veterans and families and consistently partnering with Veteran community and service organisations to design, conduct and disseminate research.

**2.2.3** Prioritise and foster research-practice partnerships and promote the value of participatory research models to government and other research funders.

## Objective 2.3

**2.3 Foster collaboration between treatment developers, knowledge brokers and service leaders** to promote uptake and maintaining adoption.

Implementation programs need to include system designs and processes that encourage collaboration to adapt the delivery and implementation of EBPs to service needs, non-directive brokering of implementation by experts and/or trainers (organisations or individuals), and inter-agency partnerships.

### Key activities

**2.3.1** Establish and maintain specific learning communities between researchers, practitioners, service providers and funders. This may also include people with lived experience.

**2.3.2** Host regular collaboration and networking events.

**2.3.3** Provide regular advice and facilitation, via collaborative workshops, around system design and the quality assurance cycle to embed recommended practices.

## Objective 2.4

**2.4 Ensure that implementation programs and the design of information packages about service systems and EBPs are informed by the needs and knowledge of the Veterans' community.**

It is important that service-users be given a clear role in developing and reviewing knowledge products and/or service design.

Using process and outcome data collected from service users to inform this collaborative process, program evaluation and the science of implementation is also critical.

### Key activities

**2.4.1** Establish and maintain a Veterans and families advisory group(s) that acts as a source of advice and guidance on the needs of the Veteran community as well as a key input to co-design and co-production work.

Linked to objective 1.5 above, The role of the group(s) could also be to help foster leadership capability amongst members, for example, co-chair positions, speaking engagements etc.

**2.4.2** Promote and support the establishment of new data collections to assess the acceptability of programs / treatment and engagement / utilisation for the Veteran community.

## 4.3 Building Block 3: Addressing inequity

Knowledge mobilisation and implementation play a critical role in ensuring that research agendas, knowledge sharing and service improvements address health inequities experienced by some members of the Veteran community. The Veteran community is heterogeneous, however many models in knowledge mobilisation and implementation do not fully articulate how to improve access to care for Veterans who experience additional barriers because of their gender, culture, sexual orientation, ethnicity and religion, disability status or experiences of social disadvantage. The following objectives and activities seek to build a recognition of all perspectives, an inclusive approach, that is transparent, open and flexible, particularly in terms of prioritising the input of those most marginalised/unheard [section 6.4.3].

### Objective 3.1

**3.1 Incorporate drivers of inequities** when designing knowledge mobilisation and implementation strategies, including policy advocacy, research-practice partnerships, capacity building and evaluation of implementation programs.

It is important that the systemic drivers of inequity are also addressed. This goes beyond an intermediary organisation addressing them as a separate issue, but rather as an issue that is integrated into every aspect of their work. This might include working to ensure there is sufficient human resources, financial allocations, and time dedicated to addressing inequity across all areas of the sector's work.

In support of this, the development of sustainable systems that address inequity should be progressed alongside any opportunity to increase capacity across the sector for addressing systemic inequities.

#### Key activities

**3.1.1** Consult regularly with a broad range of stakeholders to ensure a contemporary understanding of local drivers of inequity. This should help ensure an understanding of their experience of drivers of inequity and on how they impact on their health and mental health. Understanding how this impacts on posttraumatic mental health is particularly important as experiences of trauma can be closely associated with disadvantage and their impact exacerbated by inequity.

**3.1.2** Actively seek out and engage with service providers who may represent, work with or be part of groups that are oppressed by systemic inequities in order to ensure that the feedback from service providers is diverse and a starting point to addressing inequities.

**3.1.3** Ensure that the Veterans advisory group represents diversity amongst Veterans, and is committed to ensuring that the group is safe for, inclusive of and takes seriously the experiences and perspectives of diverse people.

**3.1.4** Ensure that when design processes or outcome evaluations for implementation work, the engagement of disadvantaged groups as well as an analysis of the social determinants of health and their effects on differential population groups are included.

## Objective 3.2

**3.2 Establish specific data collection infrastructure and reporting** so that government decision makers, policy actors, researchers and services can set priorities that are informed by health inequities.

The focus here is on determinants of health being integrated in any data reporting or data infrastructure.

### Key activities

**3.2.1** Promote and support the establishment of new data collections (with input from funders, service providers and with reference to international literature) to improve the analysis and understanding of the determinants of Veteran mental health.

This should include ensuring that individuals with lived and living experience of systemic oppression are involved in the setting of the data collection systems and metrics, to ensure that all relevant data is being captured, analysed, and interpreted within a contextualised framework.

**3.2.2** Consider the need to establish additional data collection mechanisms and systems for the determinants of Veteran mental health and, where required, develop the investment case.

**3.2.3** Ensure that new or expanded data collections in this area are applied and utilised (e.g., through the development of evidence briefs, other resources and via the implementation of new programs/priorities that fill identified gaps).

## Objective 3.3

**3.3 Take an inclusive approach to defining knowledge and research priorities**, recognising and elevating non-traditional sources of knowledge.

### Key activities

**3.3.1** Lead the design, through stakeholder engagement channels, publication and execution of a Veteran centric research program.

This should include the utilisation of data collected through activity in the previous objective, to inform the manner in which knowledge and research priorities are defined.

## Objective 3.4

**3.4 Include the voices of Veterans and their families**, including underrepresented groups among them in all aspects of research, program design and roll-out.

### Key activities

**N/A** Refer to activities 2.1.5 and 2.4.1.

## Objective 3.5

**3.5 Ensure that the design of stakeholder engagement across the Veteran community is inclusive, safe and representative of marginalised and vulnerable community members.**

This includes developing a strong understanding of barriers and facilitators to access to effective care for those in the Veteran community that experience more vulnerability or are underrepresented because of their minority status.

### Key activities

**3.5.1** Complete, periodically update and communicate a detailed stakeholder map and management for the system. This includes leveraging the Veterans advisory group and Lived experience group outlined previously.

Periodic updates should include analysis of barriers/facilitators for underrepresented groups, including processes for improving engagement and consultation with these groups.

## 4.4 Building Block 4: Building capacity and capability

Practitioners, providers, organisations and peer supporters at all levels of the service system need to have the capacity to conduct recommended assessments, make informed decisions about care planning and deliver evidence-based treatments in order for the stepped / matched model to be implemented. The following objectives and activities seek to address these needs. [section 6.4.4]

### Objective 4.1

**4.1 Deliver capacity building programs** for a range of stakeholders, with the context in which the program is delivered in mind.

The knowledge and skill needs of practitioners as well as available organisational resources, climate and culture need to be considered when developing training and support programs.

#### Key activities

**4.1.1** Complete, communicate and periodically refresh a detailed a service map and analysis (directory of services) for the system in scope and in relation to the next generation stepped / matched model.

**4.1.2** Continually work with stakeholders – government, profes-sional colleges, service providers etc. - to improve communication, co-design and implement new components of the system (e.g., intake, service navigation, enhanced care co-ordination, 'warm transitions in care etc.).

**4.1.3** Design and deliver a training needs analysis to guide capacity building programs.

**4.1.4** Develop a clinical and cultural competency framework for practitioners and organisations, based on analysis of training needs, leadership and organisational climate.

**4.1.5** Design and publish integrated education and training pathways and programs and, where relevant, support the delivery of such programs. These pathways and programs should be integrated with multifaceted implementation strategies as outlined under 4.2.

**4.1.6** Influence the ongoing refinement of tertiary curricula through advocacy and collaboration with professional colleges, peak bodies, professional associations and unions.

**4.1.7** Establish and facilitate interdisciplinary practitioner support networks, including practice-to-practice partnerships across Tiers.

**4.1.8** Provide education material for those working with high risk, complex needs clients.

**4.1.9** Engage with and provide capacity development support to other types of stakeholder who should also be involved in implementation efforts. For example, building capacity for the understanding of implementation within academic and research institutions to enhance the incentivisation of im-plementation-focused research.

**4.1.10** Develop and offer a robust training program on sex, gender and equity-based analysis (SGBA+) to support programming

**4.1.11** Develop and offer a robust trauma-informed practice (TIP) curriculum to guide development of services, systems and organisations

## Objective 4.2

**4.2 Integrate capacity building activities in to multifaceted implementation programs.**

Standalone capacity building programs need to be supplemented by other implementation strategies that address contextual barriers and facilitators of implementation.

Programs should not solely rely on strategies aimed at individual practitioners to embed learning (e.g., combining training with ongoing consultation and supervision (for complex clinical interventions), or clinical reminders (used primarily for less complex interventions such as medication prescription).

### Key activities

**4.2.1** Support organisations to ensure that any training is not offered in isolation. Rather, seek to help embed training in systems that support sustainability and application of new learning.

**4.2.2** Work with organisations to consolidate learning through, for example, supervision or consulting work i.e., embedding in organisational quality monitoring processes and supported by leadership.

## Objective 4.3

**4.3 Establish learning collaboratives and networks of excellence** that will continue to identify learning needs, monitor quality and improve practice.

These practitioner networks need to be supported and resourced to continuously collect and use data to improve practice.

Members of the network should prioritise working with Veterans and their families and commit to ensuring providers and practitioners in the network build and maintain skills and competencies required of a multi-disciplinary workforce (clinical and cultural competence; sex, gender and equity-based analysis (SGBA+); trauma-informed practice (TIP)).

### Key activities

**4.3.1** Identify and co-design the form and function of the networks to ensure they meet the learning and development needs of members and the broader system.

**4.3.2** Support the establishment and maintenance of networks through facilitation, education, training, competency development, quality improvement, the use of data and the integration of research agenda(s). See objectives 4.1 and 4.2 above.

**4.3.3** Work with funders and professional / peak / accreditation bodies on the incentives for participation in networks and help facilitate this with service providers and funders.

## 4.5 Building Block 5: Integrating adaptability

Effective implementation needs to take into account how service systems as well as policy and funding environments change over time. An implementation process also needs to be able to respond to the inevitable adaptations to EBPs made by service providers over time. The following objectives and activities seek to integrate this required adaptability [section 6.4.5].

### Objective 5.1

**5.1 Focus on harnessing emergent solutions rather than pushing a standardised program** onto a service system when implementing or scaling up innovative programs.

This means that engagement with service system stakeholders needs to extend beyond consultation to forming partnerships where stakeholders have a shared and equal stake in changing practice.

Key activities

**5.1.1** Establish and maintain surveillance mechanisms to identify and disseminate emergent and innovative programs, implementation solutions and approaches.

**5.1.2** Support interpretation and co-design processes with service providers.

**5.1.3** Develop and disseminate an implementation / knowledge mobilisation / research translation model that has a strong focus on partnership development as well as monitoring and facilitating practice base adaptations and solutions.

### Objective 5.2

**5.2 Establish processes and partnerships to foster co-production and collaboration** across organisations and/or teams when fostering emerging solutions.

Co-production and collaboration allow for ongoing problem-solving and learning from what has been trialled at different sites or by different teams.

Key activities

**5.2.1** Building on 2.1.2, design and publish specific co-design and co-production toolkits to support this work across organisations and work with stakeholders to help build the capacity for co-production.

**5.2.2** Develop best practice alliancing and memorandums of understanding to help facilitate partnerships working within the system.

## Objective 5.3

**5.3 Optimise the way in which EBPs are delivered** throughout the implementation process.

Robust data collection and feedback processes need to inform how EBPs are being adjusted to fit the practice context. Use continuous quality improvement, including a robust data collection, analysis and feedback process to plan and assess improvements.

### Key activities

**5.3.1** Engage service providers in understanding the importance of data collection and continuous improvement. Share data in network meetings with a focus on continual improvement.

**5.3.2** Work with learning collaboratives and networks of excellence to embed and enhance continuous improvement processes through the application of data, information and analysis.

## Objective 5.4

**5.4 Establish a process to understand what core elements of practice lead to good clinical outcomes,** given that practitioners will adapt EBPs protocols.

This includes taking a planned approach to flexing treatment programs that target both clinical decision making and practical barriers.

### Key activities

**5.4.1** Develop and implement a program logic evaluation framework(s) including for the next generation stepped / matched model and the implementation of the EBP menu [section 5.1].

**5.4.2** Develop and publish a minimum data set capturing the core elements of recommended practice.

**5.4.3** Work with stakeholders to continually embed and enhance a consistent outcome monitoring and measurement based practice environment.

**5.4.4** Work with stakeholders to understand and address barriers to implementing and maintaining data collection mechanisms in practice settings. This includes facilitating processes that result in the establishment of minimum data sets across diverse settings.

**5.4.5** Ensure connections between tracking how people flex / adapt to treatment (linked to outcomes) and quality improvement processes within learning collaboratives or networks of excellence.

## 4.6 Building Block 6: Using data and feedback to sustain change

Successful long-term implementation of EBPs is supported by the systematic collection and analysis of data to plan and adjust implementation efforts. The following objectives and activities seek to meet this need [section 6.4.6].

### Objective 6.1

**6.1 Establish and maintain systematic data collection and analysis** to assist in advice, policy work and the planning and ongoing adjustment of implementation efforts.

Key activities

**6.1.1** Complete and periodically refresh a mapping exercise of current data collections with a view to identifying gaps and new data collections to support an understanding of Veteran and their family's wellbeing [section 3.1].

**6.1.2** Promote and support the establishment of new data collections (with input from funders, service providers, reference groups, and with reference to international literature).

**6.1.3** Work with learning collaboratives and networks of excellence to ensure that they have adequate data infrastructure, collection and reporting systems and processes. Enhance the clarity of reporting linked to incentives e.g., recognition, accreditation, funding etc.

**6.1.4** Work with government to support access to and transparency of data sets across the system (e.g., open data programs).

### Objective 6.2

**6.2 Conduct iterative assessments on implementation outcomes** of individual, organisational and system based barriers and facilitators to assist in:

- Planning implementation efforts;
- Adapting implementation strategies; and
- Understanding factors that led to EBP adoption and sustained use.

Key activities

**6.2.1** Implement the program logic evaluation framework (see 5.4.1) and promote and pursue opportunities for evaluation and translation of outcomes.

**6.2.2** Support assessment work at several points during implementation, including: 1) effectiveness and fidelity of delivery, 2) reach of interventions amongst service users, 3) penetration (i.e. integration of the practice within the health system or organisational processes), and 4) sustainability of EBP reach and quality.

## Objective 6.3

**6.3 Establish Measurement Based Care (MBC),** wherever possible to embed EBPs through individual feedback and data-driven system-wide quality improvement planning.

This includes ensuring that MBC implementation is supported by a well-resourced IT system, clear requirements and incentives for data collection and a sound reporting framework that is backed by a collaborative and supportive leadership.

The use of data and expectations of this are crucial to effective MBC implementation and therefore leadership buy in and capability in this area are key.

### Key activities

**6.3.1** Co-design and co-produce a MBC Framework and strategy, ideally for the whole Veteran mental health system, or at least for key support organisations within the system. This should include an implementation plan. Provide ongoing advice and guidance on implementation work.

**6.3.2** Co-design and co-produce a range of 'how to' guides, tools and techniques to support the implementation of MBC.

**6.3.3** Promote the development of research priorities that prioritise MBC related implementation efforts in research.

**6.3.4** Co-design and co-produce leadership capability building tools, in particular around the use of data - culture, reporting and clarity about use of data and expectations.

## Objective 6.4

**6.4 Ensure that a culture of quality assurance and improvement** is established, to support the use of data to improve practice and implement EPBs in a sustainable manner.

### Key activities

**6.4.1** Promote and communicate the benefits of quality assurance and improvement to help increase awareness and understanding within the system.

**6.4.2** Ensure that evaluation frameworks and any existing system-level performance indicators link to practice change / equitable outcomes / implementation science work.

# 5 What next?

## 5.1 For an intermediary organisation

In terms of intermediary organisations, the Brief Guide provides a number of key activities. An important first step will be, in the context of the unique nature of the intermediary organisation, to assess each activity for relevance and maturity. A work plan can then be developed to help guide this area of focus.

In terms of system facing work, an important set of first steps might include:

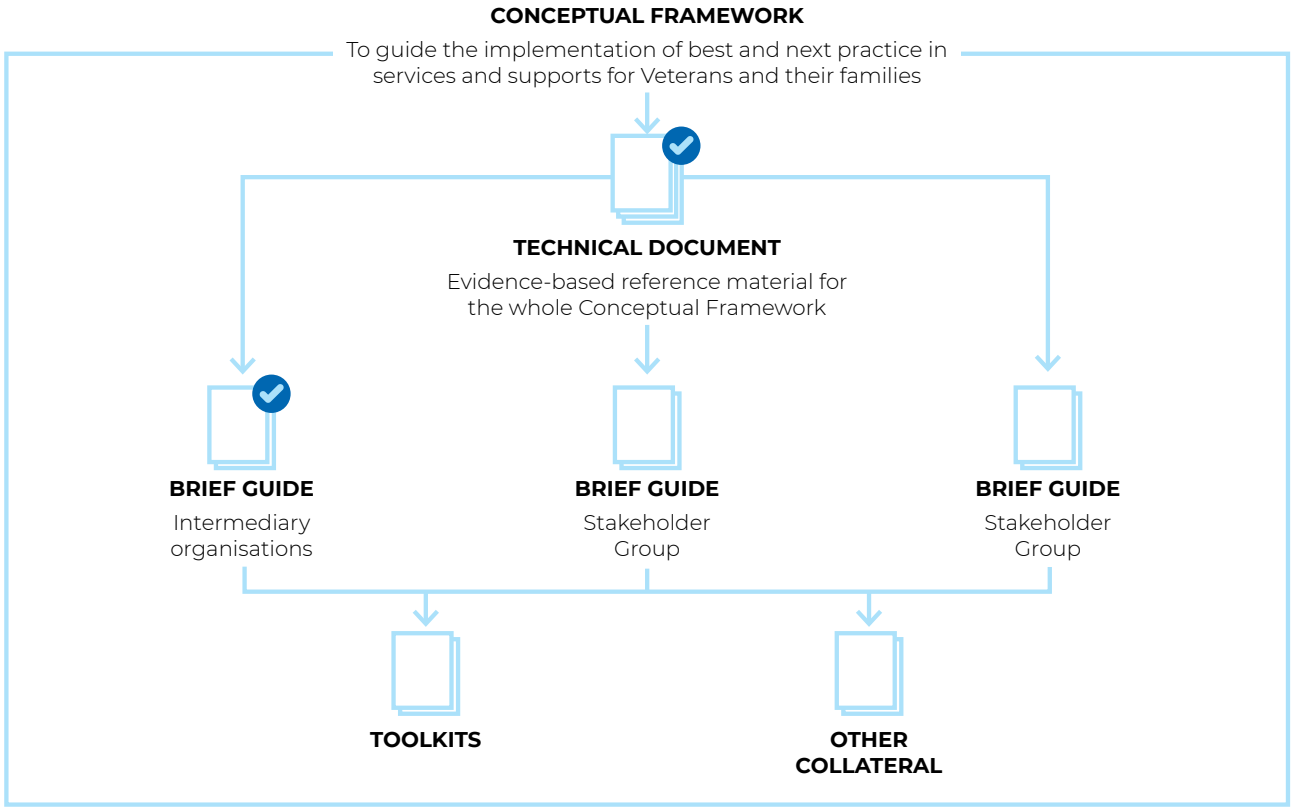
- Setting the boundary of the Veteran mental health system they are keen to work with e.g., a local system, a regional system, or a national system.
- Completing an initial stakeholder map for that system (who to include and involve) as well as completing a service mapping and analysis (directory of services) for the system in scope.

It could then consider how to build a 'coalition of the willing' within that system boundary. Some ideas here may include hosting a 'Summit' type event for all stakeholders, an event that helps:

- Discuss the future vision for the system (using the one in this Brief Guide as a start);
- Collectively assess the current system against the vision;
- Review the service mapping;
- Commit to the vision and an equitable model of care;
- Consider collaboration mechanisms such as alliancing principles / agreements, memorandums of understanding etc.;
- Co-design and tailor their own system design, model of care, and roadmap;
- Agree upon a governance mechanism (however informal) to monitor progress.

## 5.2 For the Conceptual Framework

This Brief Guide is intended to provide a resource and practical steps on where to start or further enhance implementation work in Veterans mental health systems at the local, regional or national levels. It hopefully provides a structure and menu for a range of future 'how to' guides, toolkits and other collateral that could be developed. In addition it provides a format upon which to develop additional brief guides targeted at other system stakeholders:




Developing additional brief guides and toolkits will require effort across international networks. Many may already exist and could be shared.

Establishing an international network of implementing organisations / stakeholders, would be a positive step in moving towards a future system as outlined in this Brief Guide.

# 6 Appendices

## 6.1 Overview of the collaboration

**Phoenix Australia - Centre for Posttraumatic Mental Health** is Australia's national centre of excellence in posttraumatic mental health. Its mission *Understanding Trauma. Renewing Lives* drives its focus and it has a vision to be:

- A world renowned leader in building the capability of individuals, organisations and the community to understand, prevent and recover from the adverse mental health effects of trauma.
- At the forefront of world's best practice in military, Veteran, national security and first responder mental health and wellbeing.

Established by the Department of Veteran's Affairs as the National Centre for War-Related PTSD in 1995, it now has over 25 years of expertise supporting Defence Force personnel and Veterans.

**The Centre of Excellence on Post-Traumatic Stress Disorder (PTSD) and Related Mental Health Conditions / Centre d'excellence sur le trouble de stress post traumatique (TSPT)** is the recently established Canadian Centre of Excellence. It has been created to provide better access to information, research, tools and expertise on posttraumatic stress disorder and related mental health conditions.

The organisations outlined above share a common goal of improving mental health and wellbeing among current and former Defence members and have entered into a formal collaboration to promote opportunities for sharing relevant information, as well as for joint initiatives in areas such as policy development, service improvement, training and research. The collaboration is intended to drive benefits for their respective governments, as well as other national governments, and most critically for the Veteran communities they seek to assist.

## Acknowledgements

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