Australian Government

Open Arms - Veterans & Families Counselling

NATIONAL ADVISORY COMMITTEE MEETING
29 & 30 April 2021

ATTENDEES	
Members	**Representing**
Professor Jane Burns	Chair
Dr Andrew Khoo	Psychiatrists
Dr Brad Murphy	General Practitioners
Ms Talissa Papamau	Contemporary Veterans
Mr Adrian Sutter	Contemporary Veterans
Mr Darryl Shipp	On behalf of Ken Foster, Vietnam Veterans
Ex-Officio	
Dr Stephanie Hodson CSC	National Manager, Open Arms
WO Grant McFarlane	Warrant Officer, Army
WOFF-AF Fiona Grasby	Warrant Officer, RAAF
WO-N Deb Butterworth	Warrant Officer, Navy
Dominique French	On behalf of Surgeon General ADF, JHC
MAJGEN Stuart Smith	Commissioner for Defence Engagement, DVA
Ms Gwen Cherne	Veteran Family Advocate, DVA
Secretariat	
Miss Laura Thompson	NAC Secretariat, Open Arms
Invited Guests	
Philippa Weiland	Regional Director, South Queensland
Tara Hatzismalis	Deputy Commissioner QLD
Leonie Everett	Director, Community and Peer Program, Open Arms
Liz Cosson	Secretary, DVA
Apologies	
Mrs Anne Pahl	Peacekeepers
Mr Don Spinks AM	Repatriation Commissioner, DVA
Professor David Forbes	Director, Phoenix Australia
Major Benjamin Flink	Reservists
Mr Paul Way	Director General, DCO
Ken Foster	Vietnam Veterans

Items 1: Welcome, Introductions and Apologies

The Chair welcomed the Committee and invited guests.

The Chair acknowledged the Traditional Owners of Country through Australia and recognised their continuing connection to land, waters and culture. Respects were paid to their Elders past, present and emerging. The Chair also acknowledged the service of all current and former Australian Defence Force members and their families. In particular, Australia's Vietnam veterans – Open Arms is their legacy. They have ensured that future generations of serving men and women will have access to specialised mental health and wellbeing support.

Apologies were accepted from Anne Pahl, MAJ Benjamin Flink, Ken Foster, Don Spinks, Prof Forbes, Paul Way and WOFF-AF Fiona Grasby. Darryl Shipp was in attendance on behalf of Ken

Foster and Dominque French on behalf of RADM Sarah Sharkey. Conflicts of Interests were declared via the Conflict of Interest form.

Item 2: Matters from Previous Meeting

The Chair advised the Committee that Open Arms have approached Partners of Veterans (PVA), the Australian War Widows Inc, the Australian Veterans' Children Assistance Trust (AVCAT) and Legacy Australia's Development Opportunities Section for nominations for current member vacancies.

Item 3: Open Arms National Manager's Report

Presenter: Dr Stephanie Hodson

Business Model

Dr Hodson provided the Committee with an overview of the Open Arms Business Model, highlighting client demand, staff, service delivery and enabling functions see **Attachment A**.

Meeting Demand

Dr Hodson informed the Committee that Open Arms have recruited a workforce modelling team who will be working to overcome Open Arm's challenges to meet demand, including the workforce being overworked; and the unavailability of professionals to recruit in particular areas.

Regarding wait times, the Committee were informed that often the wait times are blown out when a client has a preferred clinician, or requires a specialist service. There is often a mentality that individuals are 'happy to cope' while awaiting availability of their preferred clinician. It was noted that the Community and Peer Workers have been extremely beneficial in this area, as they continue connections to ensure if circumstances change, these individuals can be prioritised.

Client Assist Contact Centre (Client Assist)

The Open Arms internal call centre continues to receive more calls each week. This team also has the capacity to proactively reach out to individuals the Department holds concerns for, as well as the ability to work closely with the region and provide after-hours support to clients where needed.

As such, Open Arms has proposed a second location of the Client Assist team, in Western Australia. This will provide assurance of business continuity and also has desirable office hours with the time difference.

Workforce

The Committee queried the possibility of increasing the number of Australian Public Service (APS) staff within Open Arms. Dr Hodson informed the Committee that Open Arms are delegated a number of Average Staffing Level (ASL) which we have to ensure we stay within. Further to this Dr Hodson noted:

- the backbone of the service is made up of APS positions that form the leadership team and the positions requiring financial delegation;
- Open Arms aim to retain staff for continuity - as such, labour hire staff are typically offered a four year contract; and
- Open Arms offer the same professional development to all staff including labour hire employees.

There are opportunities for Open Arms to better support our labour hire workforce, in particular the Community and Peer roles, this was a theme identified in the Peer Program post implementation review.

Royal Commission

Dr Hodson noted the planning underway to determine additional resources required for the recently announced Royal Commission. It was noted that this is an opportunity for Open Arms to demonstrate our worth as a service.

Item 4: Regional Update

Led by: Philippa Wieland and South Queensland Team

The local South Queensland team were represented by the Regional Director, Assistant Director Clinical Coordination, Community Engagement Coordinator, Clinical Care Coordinator, Regional Peer Coordinator and two of the Community and Peer Advisors. The team presented to the Committee on the local trends, priorities and limitations of the South Queensland region.

Complex Needs

The South Queensland region saw an increase of 22 per cent in total clients supported from 2019 to 2020. This region have the highest number of complex cases, with the most widespread client population. These trends are being utilised to plan for the future organisational team structure.

Priorities

The team's current priorities include:

- Mending Military Minds Acquired Brain Injury Pilot (previously referred to as the Neurocognitive Health Program);
- Mates4Mates referral pathway;
- 'Go Beyond' pilot with Gallipoli Medical Research Foundation;
- establishing a satellite office in Maryborough for Community and Peer Team; and
- forward planning of property and recruitment based on demand trends.

Community and Peer Program

The Committee were provided with an overview of the local Peer Team and what experience they bring to the program. The Peer described themselves as 'an extra dimension of a completely holistic wrap around service' and outlined their value to clients, the community and Open Arms.

It was noted that demand for peer support is currently predominately in the ex-serving community in South Queensland. The team also highlighted the importance of the multidisciplinary Peer Team, and that Peers never work in isolation.

Community Engagement

The Community and Peer Teams have provided Open Arms with the capacity to have a proactive and focused approach to community engagement. Prior to this, engagement with the community was only possible when clinicians had the capacity to do so. In the first four months of 2021 the team attended 38 awareness events with a reach of approximately 3,000 people.

The team noted the South Queensland and the largest and most diverse region with individuals in rural and remote areas as well as city areas. Their biggest challenge is how to reach the entire region.

Health System

As there are over 300 hospitals in the region, Open Arms has developed a tier system to determine the frequency of engagement. Tier one includes hospitals with veteran only or veteran inclusive programs and engagement occurs bi-monthly.

Open Arms engage with health systems through Primary Health Networks, veteran focused General Practitioners and pre and post hospital services.

Item 5: Debrief from Staff Consultation
Led by: Chair

The Committee noted the significant impact resources were having on the local team, using the example of Peer Worker travel as an example. The Committee were concerned about the safety for staff and impracticalities of not having a fleet resources for the Peer Workforce. The Chair requested resources and staff wellbeing be a key focus for agenda item 7 discussion.

Item 6: 2021 Priorities: Challenges Meeting Demand
Covered in National Managers Report.

Item 7: Future Direction of Open Arms
Led by: Chair

The Chair took this time for members to share their 'pain points' and for the Committee to determine practical solutions. The below recommendations were proposed.

Recommendation 1: Propose to DVA & Defence that the question 'Are you a current or former Australian Defence Force Member?' is included on all official forms, specifically medical forms. The question should include a three tick boxes below for current, former and N/A, consistent with the format currently used to identify if an individual is Aboriginal or Torres Strait Islander. This will provide assist in the early identification of veterans and awareness for professionals. Additionally, this will prompt professionals from initial contact to utilise Defence or DVA systems as required.

Recommendation 2: Continue to leverage from partnerships, and expand on opportunities to partnership with expects in specific mental health fields including relationship counselling and counselling for children and youth.

Recommendation 3: Add the Open Arms logo and telephone number to all DVA white and gold cards. This will act as a tangible reminder of entitlement to mental health support for the individual and their family.

Recommendation 4: Request DVA consult on the potential to have medical professionals 'verified' as veteran specific or friendly. This could be utilised as a branding opportunity for the professionals as well as inform DVA. An example of how this could look is similar to an APHRA verification with a symbol to use on their website, signature block etc. This could be promoted through medical professional networks and newsletters.

Recommendation 5: Propose DVA hold a forum with representatives from veteran tech to workshop the development of a portal to bring together the veteran eco-system. A tech solution will bring together all Ex-Service Organisations (ESOs), veteran-friendly General Practitioners (GPs), advocates, resources, crisis hotlines etc. The portal should be developed based on the needs of end users. Tech experts and ESOs should be invited to determine what can be developed to meet the needs. In the saturated ESO market, it is important all participants are focused on collaboration and not pushing their own agenda. It is proposed for the portal to utilise Biofeedback, a machine learning model that will provide customised resources to individuals that are relevant to them specifically.

Recommendation 6: Open Arms to continue strengthening online resources including videos and podcasts that can be replayed. It is often difficult to retain information following a clinical session, trusted resources and content on the Open Arms website can be provided by the clinician to individuals as a recap on tools, and aids to discuss with family members.

Recommendation 7: Open Arms send an SMS to all clients upon the completion of their intake assessment with a link to online resources. This will ensure clients are aware of the resources available and will assist with only wait periods.

Recommendation 8: Continue to explore solutions for aging veterans, including how to better educate aged care workers on veteran needs.

Recommendation 9: Prioritise staff wellbeing to prevent burnout including:

- provide appropriate training including how to manage difficult situations;
- ensuring teams are resourced appropriately to perform their jobs;
- value clinical and non-clinical supervision;
- address recruitment needs via early connection with student interns and provisional psychologists, as well as exploring how mental health nurses and occupational therapists can be utilised;
- revise Key Performance Indicators to provide achievable standards for clinicians; and
- provide strong leadership, and support from the top.

Recommendation 10: Plan five years ahead based on predicted demand trends.

ACTION: Provide recommendations to the appropriate areas for consideration/action.

Closed Session: Royal Commission Terms of Reference
Ex-officio members and invited guests were dismissed. Members only discussion to draft feedback on the themes proposed for the Royal Commission.

Day one meeting close.

Item 9: Set focus for day two
Led by: Chair

Item 10: Department of Veterans' Affairs Secretary's Address
Led by: Liz Cosson

The Chair welcomed Liz Cosson, Secretary of the Department of Veterans' Affairs (DVA) to address the Committee.

The Secretary advised the Committee of the themes proposed for the Royal Commission into Defence and Veteran Suicide (refer **Attachment B**) currently out for consultation. The Secretary highlighted the importance of seeking feedback and consultation of the terms of reference for the Royal Commission.

General themes proposed included:

- transition process;
- national public health system, particularly hospital discharge;
- lack of trauma informed psychiatrists;
- accountability for decisions and lack of response;
- impact on children and families;
- stigma surrounding mental health; and
- how to identify a veteran, specifically in public health care and with authorities.

The Secretary informed the Committee that the Department will not be waiting for the Royal Commission to commence before taking action. She advised Mindframe would be coming on-board to ensure media reporting is responsible, particularly during this time.

It was noted a major challenge for Open Arms continues to be the increase in demand with a need for more resources. There is a limited employment pool for all mental health providers (Open Arms, DVA, Defence, BUPA, Beyond Blue, etc.).

Item 11: Peer Program Post Implementation Review
Led by: Leonie Everett

The Chair welcomed invited guest Leonie Everett, as the National Director of the Community and Peer Program to present on the post-implementation review of the national program refer **Attachment C**.

Ms Everett acknowledged that the Community and Peer Program has reconnected Open Arms with the origins of the service, which commenced in South Australia led by Vietnam Veteran peers. It was noted that the program did not follow a model, and was developed organically to allow the service to respond to our client's needs.

Ms Everett highlighted the post-implementation review was an opportunity for the program of 52 Community and Peer Workers (Peers) across 20 locations to reflect, and to celebrate their achievements so far.

The Review comprised 23 consultations, with 77 participants and identified 16 recommendations for future management and continuous improvement of the program. All 16 recommendations were accepted and are informing ongoing organisational change and workforce development to reinforce the continued success and value of the program to both clients and staff.

The feedback from consultations identified the strengths of the program including, shared goals; investments in team building and integration; leadership approaches; valued aspect of the Peer role; and communities of practice. Additionally, participants identified the value of the program as: bridging the gap between clinical approaches and client experiences; connecting Open Arms with regional services and the veteran community; providing clinicians with a greater understanding of military service and culture, the impacts of transition to civilian life, and lived experience of mental health challenges; and aligning Open Arms with the Firth National Mental Health and Suicide Prevention Plan.

A key factor to the success of the program has been imbedding the Peers with the clinicians. Ms Everett described the Peer Teams as flourishing once they took off their 'clinician hat' and allowed themselves to be Peers, and the clinicians to be their safety net. This has also had a positive impact on the way Open Arms clinicians are thinking and working.

From the 16 recommendations, six key themes were identified for future focus continuous improvement:

- Continuous Program Improvement needs to consider principles of lived experience and Peer practice, and balance local adaptation with national consistency to address evolving community priorities. Stakeholder feedback, engagement and co-design should be embedded in practice improvement, policy development, strategic planning and evaluation.
- Community and Organisational Change activities will energise staff to embrace the program through reinforcing its value and aligning program objectives with Open Arms strategic priorities. Leadership for change requires consistent communications about the national vision and practicalities of effectively integrating a lived experience Peer workforce.
- Collaboration and Team-Work are integral to achieving positive outcomes. Strong working relationships founded on shared understanding foster cultural exchange, and develop trust

and mutual professional respect. Opportunity exists for work with all stakeholders to capture and refine activities supporting integration of clinical and Peer practices, and to ensure shared investment in the goals and vision of the program.

- Organisational Development activities were necessitated by the introduction of Peer into the existing Open Arms clinical model. Clarifying roles, responsibilities, boundaries, policies and processes will facilitate integrated multi-disciplinary approaches to care.
- Workforce Development for the wider Open Arms staff group will clarify scope of practice and expectations of how clinicians and leaders should be working with Peers. Provision of professional supervision, wellbeing support and ongoing learning will enable career growth for the Peer workforce, and ensure workforce diversity and flexibility.
- Resourcing and Logistics must support Peers and regional teams to meet increasing demand.

Dr Hodson thanked the Committee for their participation in the recent #Check5 grassroots campaign that was led by the Peers. Dr Hodson advised the success of the campaign was due to the lived experience voice of the Peers.

The Committee discussed the success of the program so far and how Peer led initiatives can be utilised. The Committee recommended a serious media campaign be led by Open Arms to showcase successful veterans. The Committee noted the positive impact the Peer have in conveying messages of success following transition from military service, and how lived experience can be utilised to overcome the 'broken veteran' narrative. Key points the campaign should promote include:

- veterans are valuable assets for employers;
- stories of success post-military service (i.e. success in employment post transition, veteran led business/organisation success, success in families); and
- mental health recovery stories and what veterans have gone on to achieve.

It was noted that Defence should be looking at recruits as lifelong, and could utilise positive success stories in the same way as recruitment videos.

ACTION: Recommend the development and promotion of an Open Arms led media campaign showcasing successful veterans.

The Committee discussed the future opportunities of the program including how Defence and DVA could collaborate with the Peer Program to connect Peers with individuals earlier. Points for consideration were how this could be achieved, what would it look like to have Peers on sites, and how would this be funded.

Item 12: Veteran Family Advocate Role & Consultation Trends

Led by: Gwen Cherne

The Chair invited Ms Gwen Cherne, the DVA Veteran Family Advocate to present on her role and recent consultations trends.

Ms Cherne outlined her position as a part of the Repatriation Commission that reports directly to the Minister for Veterans' Affairs. As the Veteran Family Advocate, Ms Cherne looks at all DVA systems from a family lens ensuring that families are included in approaches and influencing from the top down. Ms Cherne has described her lived-experience in changing the way the executives think, and ensuring the family is included in all conversations and decisions.

The priorities of the Veteran Family Advocate include building community awareness; suicide prevention and postvention; family policy; transition; and increasing the data and research as an evidence base on families.

Ms Cherne noted the cohorts that are not currently being addressed: parents and siblings; carers; ageing carers; disabled children of veterans; and elderly parents of veterans.

Ms Cherne highlighted that parents are entitled to the least amount of support. The Department is working on improving postvention support to provide grief, loss and trauma support. Ms Cherne posed the question to the Committee, why do we wait for the veteran to pass away before providing support services to their parents. In many circumstances an individual's parent is their primary carer when they are unwilling to accept support. Extending eligibility would provide support up front to stabilize the family unit.

ACTION: Open Arms to propose extension of eligibility for services to include parents, and siblings.

A consistent, trusted clinician has a positive impact on the grief journey following the loss of a veteran child. It was noted education of grief journeys would be beneficial, potentially through the Peer Program.

Finally, the Committee noted the importance of getting ensuring information reaches the families of current serving members. Serving members are currently the gatekeepers to their families, and without their trust information does not flow through to their families.

Day two meeting close.

Action Items after NAC Meeting 2021/2

Action Item	Description	Status
2020-05	Open Arms to provide an update to the NAC on what the increase in fees paid by DVA means for Open Arms' Outreach Program Counsellor (OPC) network.	Closed.
2020-09	DVA Claims to present at 2021 meeting.	Open.
2020-10	Include workforce wellbeing as 2021 agenda item.	Closed.
2021-01	Secretariat to request nominations for vacancies form AVCAT, Legacy Australia, PVA and War Widows Inc.	Closed.
2021-02	Circulate revised 2021 meeting schedule.	Closed.
2021-03	Provide recommendations to the appropriate areas for consideration/action.	Open.
2021-04	Recommend the development and promotion of an Open Arms led media campaign showcasing successful veterans.	Open.
2021-05	Propose extension of eligibility for services to include parents, and siblings.	Open.

Attachments:

Attachment A – Open Arms Business Model 2021
Attachment B – Royal Commission into Defence and Veteran Suicide - Themes for Consultation
Attachment C – Open Arms Community and Peer Post Implementation Review Report

OPEN ARMS BUSINESS MODEL

OPEN ARMS
Veterans & Families Counselling

1800 011 046
OpenArms.gov.au

Attachment A

NATIONAL SUPPORT

CLIENT SAFETY & QUALITY
» 23 Staff Members
Responsible for the clinical quality and practice improvement of Open Arms service delivery.

COMMUNITY & PEER PROGRAM
» 7 Staff Members
National implementation, review and oversight of the Community and Peer Program.

CLINICAL INNOVATION
» 12 Staff Members
Clinical service innovations to improve services available for veterans and their families.

CLIENT ASSIST OPERATIONS
» 9 Staff Members
24/7 call centre. Providing counselling services, customer service support, social media monitoring, and assertive reach out.

COMMUNICATIONS & OPERATIONS
» 13 Staff Members
Online digital mental health resources, service promotion and client engagement. Procurement and contract management

CLINICAL SYSTEMS & MONITORING
» 15 Staff Members
Maintenance and availability of clinical software, data and information systems to ensure service continuity in a 24/7 environment.

SERVICE DELIVERY SUPPORT
» 5 Staff Members
Provides enabling services unique to Open Arms' clinical workforce needs

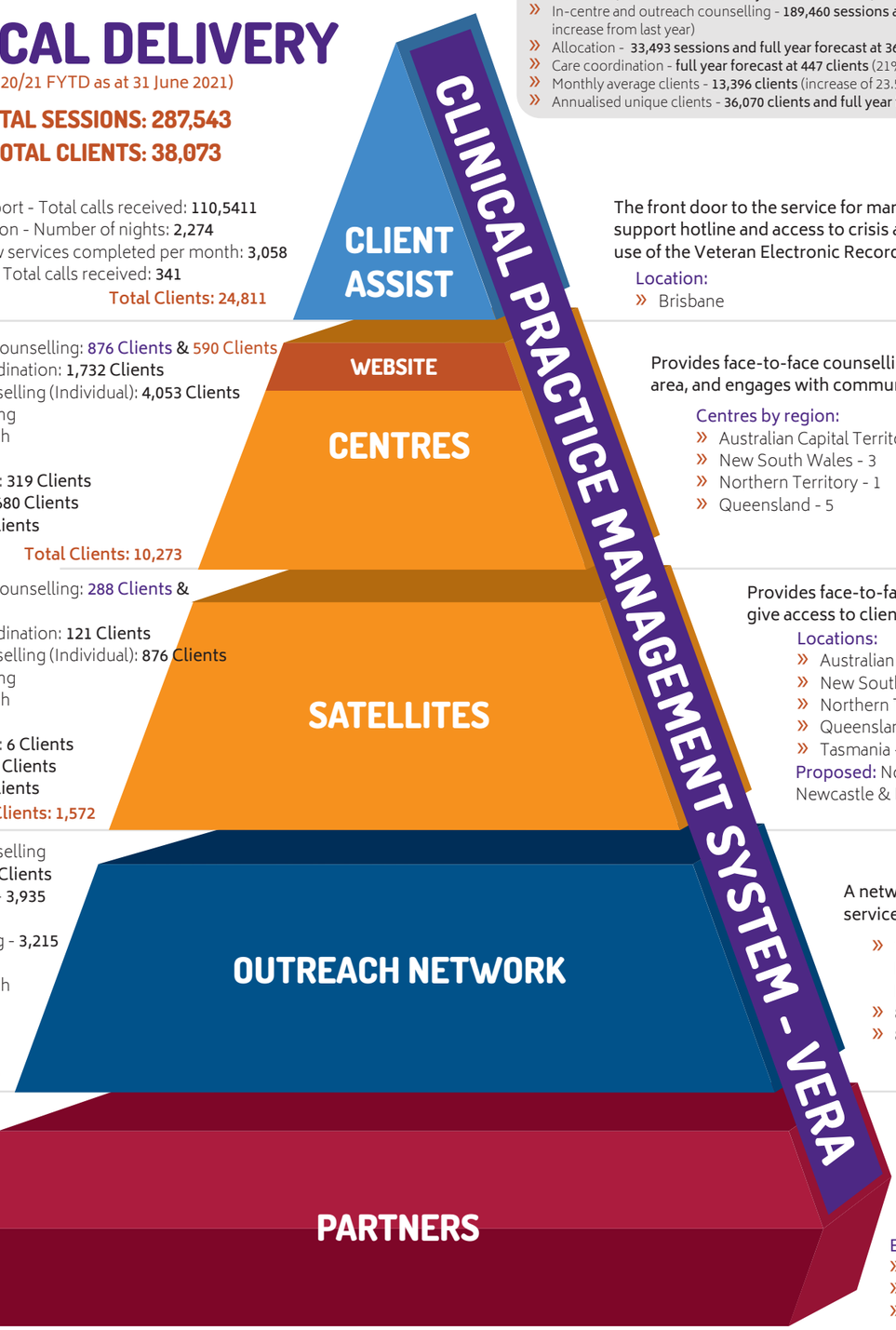
OPEN ARMS POLICY HUB
» Governance Policy
» Clinical Governance Policy
» Organisational Risk Management
» Mental Health Workforce
» Administration

CLINICAL DELIVERY

(2020/21 FYTD as at 31 June 2021)

TOTAL SESSIONS: 287,543
TOTAL CLIENTS: 38,073

» Intake - **38,634 sessions and full year forecast at 42,146 sessions** (5% over full year budget and about 33.3% increase from last year)
» In-centre and outreach counselling - **189,460 sessions and full year forecast at 206.683 sessions** (6% below full year budget and 21% increase from last year)
» Allocation - **33,493 sessions and full year forecast at 36,498 sessions** (in line with the full year budget and 28% increase from last year)
» Care coordination - **full year forecast at 447 clients** (21% over full year budget and 54% increase from last year)
» Monthly average clients - **13,396 clients** (increase of 23.5% from last year)
» Annualised unique clients - **36,070 clients and full year forecast at 38,478 clients** (inline with budget and increase of 23.5% from last year)



CLIENT ASSIST DELIVERY

The front door to the service for many clients provides the national intake service 24 hour crisis support hotline and access to crisis accommodation. Supports Open Arms staff and OPCs with the use of the Veteran Electronic Record Application (VERA) system.

Location:
» Brisbane

Total Staff: 63

» 24/7 telephone support - Total calls received: **110,5411**
» Crisis Accommodation - Number of nights: **2,274**
» Intake - Average new services completed per month: **3,058**
» Safe Zone Support - Total calls received: **341**

Total Clients: 24,811

CENTRES DELIVERY

Provides face-to-face counselling and other mental health support services within a regional area, and engages with community and ESO's for local supports and clinical care coordination.

Centres by region:
» Australian Capital Territory - 1
» New South Wales - 3
» Northern Territory - 1
» Queensland - 5
» South Australia - 2
» Tasmania - 1
» Victoria - 3
» Western Australia - 2

Total Staff: 339

» Family & Couples Counselling: **876 Clients** & **590 Clients**
» Complex Care Coordination: **1,732 Clients**
» Mental Health Counselling (Individual): **4,053 Clients**
» Mental Health Training
» Community Outreach
» Trauma Counselling
» Psychiatric Referrals: **319 Clients**
» Group Programs: **2,680 Clients**
» Peer Support: **946 Clients**

Total Clients: 10,273

SATELLITES DELIVERY

Provides face-to-face counselling services in a non-Open Arms centre to give access to clients who do not live within reach of a regional centre.

Locations:
» Australian Capital Territory - 1
» New South Wales - 5
» Northern Territory - 2
» Queensland - 3
» Tasmania - 2
» Victoria - 2
» Western Australia - 2
» South Australia - 2

Wellbeing Centres:
» Perth

Proposed: Noarlunga, Joondalup, Newcastle & Lismore
Proposed: Darwin, Townsville, Perth, Nowra & Wodonga.

Total Staff: 8

» Family & Couples Counselling: **288 Clients** & **57 Clients**
» Complex Care Coordination: **121 Clients**
» Mental Health Counselling (Individual): **876 Clients**
» Mental Health Training
» Community Outreach
» Trauma Counselling
» Psychiatric Referrals: **6 Clients**
» Group Programs: **74 Clients**
» Peer Support: **121 Clients**

Total Clients: 1,572

OUTREACH NETWORK DELIVERY

A network of clinicians in private practice who provide counselling services to Open Arms clients for an agreed fee.

» **1,076 Outreach Program Counsellors** - **281 (26%)** Clinical Psychologists, **552 (51%)** Psychologists, **243 (23%)** Mental Health Social workers.
» **88** Group Program Facilitators
» **86** Clinical Supervisors

Total Providers: 1,250

» Mental Health Counselling (Individual) - **16,164 Clients**
» Family Counselling - **3,935 Clients**
» Couples Counselling - **3,215 Clients**
» Community Outreach
» Trauma Counselling
» Complex Needs: **20 Clients**

Total Clients: 22,152

PARTNERS DELIVERY

Internal Partners:
» Relationships Australia - Psychologists, Social Workers, Counsellors

External Partners:
» Pop Up Health - Community Mental Health Nurses
» Centra-core - Psychologists
» Bupa - Any professional. E.g. Psychologist, Neuro Psychologist

» Specialist Services
» Overflow
» Family Counselling: **200 Clients**
» Couples Counselling: **289 Clients**
» Child
» Individual Counselling: **262 Clients**

Total Clients: 733

ENABLING FUNCTIONS

» Technology & IT Equipment
» Recruitment & Workforce Management
» Procurement
» Legal Support
» Telephony (Genesys Phone System & ALCATEL Mobile Kit)
» Property

» Technology & IT Equipment
» Recruitment & Workforce Management
» Procurement
» Legal Support
» Telephony (Genesys Phone System & ALCATEL Mobile Kit)
» Property
» Connectivity (WIFI)
» Property
» Vehicle

» Technology & IT Equipment
» Recruitment & Workforce Management
» Procurement
» Legal Support
» Property
» Vehicle

» Procurement

A service founded by Vietnam veterans, now for all veterans and families

Information if you're affected by coronavirus (COVID-19).

Australian Government
Department of Veterans' Affairs

Royal Commission into Defence and Veteran Suicide – Themes for consultation

Last updated: 19 April 2021

The Royal Commission into Defence and Veteran Suicide Terms of Reference will be determined in consultation with the defence and veteran community and states and territories. We expect that it will cover the following themes:

- Systemic issues and analysis of the contributing risk factors relevant to defence and veteran death by suicide, including:
  - Contribution of pre-service, service (including training), transition and post-service issues
  - The relevance of issues such as service, posting history and rank of the defence member or veteran
  - The manner of the recruitment of the person into the Australian Defence Force
  - The manner in which a person transitioned from the Australian Defence Force
  - The availability, quality and effectiveness of health, wellbeing and support services
  - How information about individuals is shared by and within the government.
  - How matters of individuals' mental and physical health are captured during enlistment and during and after service.
  - The quality and availability of support services for families, friends and colleagues affected by a defence and veteran death by suicide.
  - The risk factors of defence members and veterans who have attempted or contemplated suicide or have other lived experiences of suicide.

- The protective and rehabilitative factors for defence members and veterans who have attempted or contemplated suicide or have other lived experiences of suicide.
- The engagement of defence members and veterans with Commonwealth, State or Territory Governments about support services, claims or entitlements.

The Royal Commission will be asked to make any recommendations, including recommendations about any policy, legislative, administrative or structural reforms.

The Royal Commission will be asked to have regard to:

- Previous relevant reports and inquiries.
- The work of the interim National Commissioner for Defence and Veteran Suicide Prevention.
- The support available to members and veterans of other defence forces, particularly in Canada, New Zealand, the United Kingdom and the United States.
- The role of government and non-government organisations
- Support services for families and others impacted by defence and veteran death by suicide
- Opportunities to promote the understanding of suicide risks and protective factors in the defence and general community.

The Royal Commission will not be required to inquire into matters that it is satisfied have been dealt with by other inquiries, investigations or criminal or civil proceedings. Further, it will not be required to make findings of civil or criminal wrongdoing or findings about individual defence and veteran deaths by suicide.

The Royal Commission will be asked to focus on systemic issues, recognising that they will be informed by individual experiences and may need to make referrals to appropriate authorities.

The Royal Commission will be asked to recognise that its inquiries, including its findings and recommendations, will provide a foundation for the future work of the National Commissioner for Defence and Veteran Suicide Prevention.

Attachment C

2020

Open Arms Community and Peer Program: National Implementation Review

SUMMARY REPORT PREPARED FOR OPEN ARMS BY DVA HEALTH PROMOTION AND EVALUATION ADVISORS

DR DIMITRI BATRAS, MS EMILY FOENANDER & DR JOANNA SCHWARZMAN

ATTAINED SUCCESS PTY LTD
ACN No 159 249 911
ABN No 14 159 249 911

Acknowledgements and more information

Open Arms extends gratitude and appreciation for the Community and Peer Advisors, clinicians, program managers, senior leaders and other associated staff who collectively contributed to this Program, and ultimately made it possible. The completion of this implementation review is crucial to informing the continuous quality improvement of this Program, and in informing purposeful future direction.

For further enquiries about the management of the Community and Peer Program and the implementation review please contact Ms Leonie Everett - Open Arms Assistant Director Community Engagement, E: leonie.everett@dva.gov.au, T: (02) 6276 4579.

Please direct any enquiries about this summary report to Dr Dimitri Batras - Review project lead and Director of Attained Success Pty Ltd, E: dimitri.batras@dva.gov.au / dbatras@attainedsuccess.com.au, T: 0403 596 457.

Contents

Executive Summary

Following the success of the Community Engagement Pilot, national implementation of the Community and Peer Program commenced in November 2019. Community Engagement Teams have now been established in 13 Open Arms locations. The roll out of these teams saw the introduction of Veteran and Family Community and Peer Advisors working in partnership with clinicians.

In June 2020 Open Arms engaged Attained Success Consulting to undertake a program implementation review through consultation with 77 key internal stakeholders. The review aimed to increase Open Arms' understanding of the Community and Peer Program implementation to date, including strengths and opportunities for improvement, from the perspectives of key internal stakeholders. The review is intended to inform future implementation priorities and processes, as well as continual improvement of the Program.

Findings from the consultations showed that the Program has broad support and is valued within Open Arms. The Program was noted to have a promising infrastructure, albeit with opportunities to refine and improve. Benefits of the Program have been observed for Open Arms as an organisation, its staff and clients, and for the broader Veteran community. These benefits include improvement in client outcomes, services that are more responsive to client needs, and evidence of Open Arms' valuing of the lived experience of both military service and mental health recovery. The service model of Peers and clinicians collaborating has been powerful:

> *"I would say that some of our most outstanding outcomes have come from collaborative relationships between the Peers and the Clinical Care Coordinators."*

Themes arising from the interviews can be contextualised through organisational capacity building frameworks, specifically: Organisational development, Workforce development, Resourcing and logistics, and Collaboration and teamwork. Within each of these domains, participants identified significant strengths of the Program and examples of successful implementation within regions. Participant feedback also highlighted several priority areas they thought could be addressed to further enhance implementation of the Program. Opportunities to strengthen organisational change processes through ongoing communication, leadership and engagement of stakeholders was also identified. A common theme arising across consultations was the need to strike a balance between national consistency and regional flexibility. Further, participants highly valued the opportunity to provide input into this review, and emphasised the importance of ongoing consultation and engagement in future changes and Program implementation.

Findings from the stakeholder consultations were used to derive the following recommendations that can be used by Open Arms as part of their ongoing improvement processes.

Recommendations

Cross-cutting recommendations

Several findings about future improvements to the Program spanned across the organisational capacity domains selected for grouping themes in this report. These cross-cutting factors highlighted values, espoused beliefs and principles of practice for the Community and Peer Program and have impacts for the way in which ongoing implementation activities are conducted to enable strong buy-in and promote impactful program outcomes. Themes raised included the need for process and outcome measures for the Program, use of co-design in quality improvement processes and enablement of regional approaches under a nationally consistent framework.

Recommendations:

1. Identify opportunities to simultaneously strengthen national consistency and support regional flexibility in implementing the Community and Peer Program.
2. Embed opportunities for stakeholder feedback, engagement and co-design in policy development, and for Program implementation and quality improvement activities.
3. Develop a monitoring and evaluation plan for the Program to facilitate ongoing collection of feedback and to inform continuous Program improvement.

Communication and organisational change

The addition of a new capability for Open Arms through establishment of the Community and Peer Program involves significant cultural change, service change and workforce integration**.** There was recognition among stakeholders that leadership for change will continue to require consistent communication about the national vision for integrating a peer workforce. Open Arms is well positioned to develop an effective change strategy and key messages in partnership with Peers and clinicians.

Recommendation:

4. Prioritise communication for change management, including planned communication from senior managers, and with a focus on the alignment of the Community and Peer Programs' aims and objectives with Open Arms' strategic vision.

Collaboration and teamwork

Collaboration and teamwork were reported to be integral for achieving positive outcomes and those who reported stronger relationships with their co-workers also reported greater workplace satisfaction and viewed the Program in a positive light. Successful teamwork involved Peers and clinical staff building rapport with each other, working on projects of mutual interest and jointly contributing to the assessment of client needs. Consultations with stakeholders indicate that ongoing dialogue and collaborative approaches to goal setting and direction for the Program would be well received, would energise staff and would encourage stakeholders to embrace this new Program.

Recommendation:

5. Continue to identify successful team building approaches, facilitate the sharing of these activities across regions and continue to invest in team building.

Organisational development

The national rollout of the Community and Peer Program in November 2019 has significantly contributed to Open Arms' capacity to support clients and added diversity to the organisation's service offering. The introduction and integration of Peers into the existing Open Arms clinical model necessitated changes to organisational structures and processes and intentional ongoing efforts to support the integration of clinical and peer models of engaging with clients and community. A deliberate focus on clarifying strategic directions, policies and procedures, roles and responsibilities, structures and processes in the next phase of implementation will support ongoing integration of the Program and workforce.

Recommendations:

6. Use co-design processes with stakeholders to develop a strategic plan for the Community and Peer Program that builds on existing regional strengths, captures shared goals, and aligns with Open Arms' strategic direction.

7. Engage operational staff and managers to identify the need for additional policy and procedures concerning risk management and safety relating to client support and client contact.
8. Clarify roles, responsibilities, reporting lines and organisational processes with a focus on both Program governance and decision-making workflows at regional and national levels.
9. Strengthen processes and documentation that support client referrals and clarify screening and allocation of clients to Peers and clinical staff.
10. Continue to identify, share and support the implementation of activities that promote the integration of the lived experience workforce into clinical environments, for example information sharing and two-way learning within regions.

Workforce development

Factors highlighted in consultations that would enable ongoing workforce development included clarifying roles, responsibilities, scope of practice and expectations, provision of professional supervision and support structures that facilitate ongoing practice development and that support wellbeing, and identification of opportunities for ongoing learning to enable career growth, diversity and flexibility. While many of the opportunities for ongoing development focused on the Peer role, learning opportunities for clinical staff were also highlighted as valuable for enhancing awareness of the Program and Peer practices and facilitating collaborative service delivery.

Recommendations:

11. Capture a service delivery model that includes multidisciplinary team role definitions, scope and boundaries and with attention to both service integration and differentiation of practice between peer support, case management and complex case coordination.
12. Use co-design processes, and build on existing strengths, to capture, communicate, and continually refine the Peer model of practice, including what Peers do and how the Peer roles can be shaped and deployed to meet client needs.
13. Continue to identify ways to improve the mental health and wellbeing support available to Peers, especially proactive support.
14. Ensure existing Peer workforce professional supervision structures are known and available to all Peers.
15. Ensure professional development opportunities that relate to the Peer practice model and integration of the lived experience workforce are available and targeted to a range of Open Arms staff, not just Peers.

Resourcing and logistics

An ongoing investment in physical resources for regional teams and a sustained allocation of human resources were identified as priorities. As awareness and uptake of the Program increases, several participants reported that workloads had increased across both peer support and community engagement. Vacancies in non-peer roles were observed to contribute to local challenges in managing workloads. Participants identified a need for greater monitoring of workload and capacity and ensuring there were reporting channels to convey the need for additional resources to meet demand.

Recommendation:

16. Examine options to enhance resource allocation and support for Peers and regional teams, especially in relation to workload management, ensuring diversity in roles and preventing burnout.

1 Introduction

1.1 Community and Peer Program background

In 2017-2018 Open Arms undertook a two-year Community Engagement Pilot in Townsville. The key objective was to enhance the management and support of complex and/or high-risk clients, especially clients considered to be at risk of suicide. The Pilot also offered support to the Operation Compass national suicide prevention trial based in Townsville, with a specific focus on connection and early engagement with veterans and their families. The Pilot involved the implementation of a Community Engagement Team comprising an Open Arms clinician and two lived experience Community and Peer Advisors. Based on the early success of the Pilot in Townsville, the Program was expanded in 2018 to include Community and Peer Advisors at Open Arms locations in Sydney and Canberra. An independent evaluation of the Townsville Community Engagement Project was conducted by Gripfast Consulting in September and October 2018. The Pilot confirmed that Open Arms Peers facilitated the breaking down of barriers to care, improved relationships with key community groups, reduced the stigma around mental health and help seeking, and improved the holistic mental health and wellbeing outcomes for veterans and their families. The evaluation of the Townsville Pilot also supported the national implementation of the Community and Peer Program across all Open Arms locations.

In February 2019, Minister for Veterans and Defence Personnel, The Hon Darren Chester, attended the Defence Community Welcome Event in Townsville and announced the national implementation of the Program. The inaugural Community and Peer Program Induction Workshop was held in Canberra between 25 and 29 November 2019 for all newly recruited Program staff. This week-long workshop provided a comprehensive agenda of team based and role specific activities, orienting both Open Arms Peers and coordinators to Open Arms and establishing foundational practices for delivery of the Community and Peer Program.

On the 29th November, Minister Chester attended the National Induction and officially launched the Open Arms National Community and Peer Program. Community Engagement Teams have now been established at 13 Open Arms locations, with 46 Community and Peer Advisors operating across these locations. Under Open Arms' refined Community Engagement Team model, each regional team consists of a clinical Community Engagement Coordinator (CEC), up to three Veteran Peers, and a dedicated Family Peer. Veteran Peers are representatives of the Navy, Army and Air Force ex-service communities. They bring lived experience of ADF service and of mental health issues and recovery. Family Peers bring lived experience of being a part of the military family and experience of mental health, which may include as a family member of a Veteran affected by mental health issues. All Community and Peer Advisors are trained as Mental Health Peer Workers.

A Community Engagement Team, including the National Community and Peer Advisor, Assistant Director Community Engagement, and Five Community and Peer Advisors has been integrated into Open Arms National Operations, supporting the ongoing implementation and continuous improvement of the Community and Peer Program. The National Operations Peers also provide a lived experience advisory function across Open Arms National Operations and are contributing to the development of Open Arms services through portfolio projects focusing on areas including: homelessness, family support, bereavement support, and suicide prevention and postvention.

1.2 Aims and scope of review

In June 2020 Open Arms engaged Attained Success Consulting to undertake a program implementation review. This implementation review aimed to inform future implementation priorities and processes and support continuous development of the Open Arms' Community and Peer Program (hereafter the Program). Key internal Open Arms stakeholders were consulted with the view to strengthen Open Arms' understanding of how Program implementation has been experienced to date; perceptions of the Program; what has worked well; and the challenges and barriers. This review also aimed to enable clarification of gaps, ongoing needs, opportunities and priorities to inform future activities.

2 Methods

Key stakeholder groups were invited to participate in the review consultations. A total of 77 stakeholders participated in 23 consultations. Consultations included 9 one on one interviews, 11 group interviews, and written and telephone follow-up. Appendix A lists the stakeholder groups who were invited and participated in the consultations.

In consultation with DVA's Research Governance team, it was established that DVA ethical approval was not required for this project. The implementation review was conducted in accordance with ethical procedures for quality assurance projects.

2.1 Data collection and analysis

Data were collected through semi-structured interviews. An interview guide was developed based on the aims of the review, project documentation and with input from the National Community Engagement Team. The full interview guide is available in Appendix B.

Interviews were conducted via video conferencing (Zoom) with individuals or small groups of participants in similar roles. Participants were provided with an information sheet (Appendix C) outlining the purpose of the consultations and gave informed consent to participate.

Interview audio recordings and notes taken during the interviews were analysed to identify key themes. Feedback from the consultations indicated aspects of organisational change that may need to be considered, and priorities for ongoing organisational capacity building.

Given the themes align with known frameworks, we have selected key organisational capacity building factors from 'A Framework for Building Capacity to Improve Health' (NSW Health, 2001), diffusion of innovations (Rogers, 2003) and organisational readiness for change (Armenakis, Harris and Mossholder, 1993; Armenakis and Harris, 2002) to structure the themes and recommendations. We have also drawn on insights from Schein (2010) regarding organisational culture and Batras, Smith & Duff (2016) for lessons concerning health promoting organisations and organisational change.

3 Findings

The main findings of this review draw on factors relevant to organisational change and organisational capacity building. These domains were selected based on the primary themes arising from the review, and the potential of these findings to inform ongoing improvements to the implementation of the Program.

3.1 Value of the Program

There is overwhelming agreement among participants, except for a minority, that the Program brings value to the veteran community and Open Arms in a multitude of ways. The Program was noted to have a promising infrastructure, albeit with opportunities to refine and improve. Whilst this review was not intended to make an assessment of the effectiveness of the Program, feedback referred to some of the benefits that have been observed, including for Open Arms as an organisation, its staff and clients, and for the broader Veteran community.

Some of the benefits of the Program identified in the consultations include improvement in client outcomes, services that are more responsive to client needs, and evidence of Open Arms' valuing of the lived experience of both military service and mental health recovery. The service model of Peers and clinicians collaborating has been powerful:

> *"I would say that some of our most outstanding outcomes have come from collaborative relationships between the Peers and the Clinical Care Coordinators."*

Clinicians identified how they have developed a greater understanding of military service, and a greater appreciation for the impacts of culture and the context of veteran experience, behaviours and perspectives.

By bridging the gap between clinical approaches and client and consumer experiences and perspectives, Peers add "*an extra dimension of a completely holistic wraparound service*". In addition to providing a 'soft entry' to the Open Arms' services, Peers can help with the navigation of services and organisations. Peers can assist with a wide range of issues such as housing, food and accommodation. The Program is ensuring an additional level of service that other organisations are looking for from Open Arms.

The Program, particularly the community engagement component, has enabled Open Arms to develop and maintain stronger connections with the veteran community, and embed Open Arms within local veteran and mental health organisations and networks. The Program represents a real opportunity to recognise existing community capacity and to contribute to the growth and empowerment of veterans and their families.

3.2 Feedback in context

Over the past four years, Open Arms has undertaken significant service enhancement and expansion and has experienced significant growth in its staffing profile, client numbers, range of services and capacity to support clients. In 2019-20 alone Open Arms experienced a 24% increase in the number of clients who accessed the service.

Consultations occurred in July 2020, a time when many unanticipated disruptions affected Program implementation, community engagement and service delivery more broadly. The workforce was required to transition to working from home; remote from teams. This change happened as teams were still forming. The service has rapidly adopted new ways of working to be able to provide online services, resulting in new policies and procedures, adoption of new technology and resorting of

priorities. The unavoidable disruptions caused by the COVID-19 pandemic, bushfires, storms and floods are likely to have shaped some of the feedback provided in this review.

It is important to highlight that this review was conducted in mid-2020, approximately six months after the official national launch of the Program in November 2019. It was widely acknowledged in the consultations that the implementation of the Program remains a work in progress. Participants consistently expressed an understanding that the stage or timing of implementation in each region influenced the nature of the challenges being experienced. Further, the 13 locations where the Program is being implemented are diverse with respect to staffing profiles, community demographics, stakeholders and services, and rates of referral. Implementation has focused on resourcing and supporting the delivery of the Community and Peer Program across these diverse regional locations.

Additionally, implementation at both national and regional levels has focused on the cultural integration of a lived experience workforce and Peer ways of working into an established mental health service delivery environment.

Ultimately, the findings from the consultations present opportunities to improve and refine what is clearly a well conceptualised and well received Program.

A number of challenges identified by participants relate to implementation during the Program design stage and over the first few months. Some of these may have been addressed, or partially addressed in recent months. At Program design stage, there may have been opportunity for stronger engagement with regions. However, external influences on timelines were widely acknowledged as posing an initial barrier, impacting planning and delivery during the early stages of implementation.

Participants were appreciative of the opportunity to provide input into the evaluation and anticipated that improvements would result, both for the Program and more broadly across Open Arms. Feedback from some participants also highlighted that variable perspectives on the Program may exist across the broader Open Arms workforce. This range of perspectives will be important to consider when designing and delivering future implementation activities, in particular those targeting integration of the Program and Peer workforce into Open Arms.

3.3 Communication and organisational change

The addition of a new capability for Open Arms through establishment of the Community and Peer Program involves significant cultural change, service change and workforce integration**.** The Program enables Open Arms to align with a national movement in the mental health sector for Lived Experience Peers to be a critical component of mental health care models and service improvement activities. Stakeholders congratulated Open Arms for rolling out the Program and bringing on a Peer workforce, showing commitment to this agenda and the benefits for the service and community.

Preparedness and communication for organisational change

Interview participants commonly reported that there is an opportunity for Open Arms to strengthen communication about this change agenda, to showcase their veteran centric approach and continue to garner support for the integration of a peer workforce. With changes to roles and organisational structures, alongside other improvements, participants noted the importance of nurturing this new Program through change management and communication activities. Positive staff preparedness activities were undertaken by some regional teams to ensure buy-in, understanding of roles and collaboration among teams. Participants indicated that continued effort in this vein could energise staff to embrace this new Program.

The diffusion of innovations literature suggests that a new product or program in an organisation requires a period of clarification and modification to enable it to fit within the organisational context and allow the organisation to adjust to accommodate the innovation. Regional and national teams alike were motivated to reach a shared vision for the Program, clarify roles and protocols, and foster openness and trust among a multidisciplinary workforce. Actions in support of this included Peers and clinicians being involved in Program establishment activities and planning, transition events and community engagement activities, consultations, team meetings and case conferencing. Other team integration activities and factors enabling organisational change included clinicians sharing positive experiences of managing Peer teams, mock debates, question and answer activities and discussions about expectations, barriers and strengths. These change management and communication activities appeared to facilitate the transition process within regional teams and integration of the workforce.

Leadership and organisational culture for change

Opportunities to share lessons across regions such as national forums and online communities of practice were viewed in a positive light as stakeholders valued inclusivity, open communication and visible demonstrations of leadership support, such as through resource allocation for the Program. The commonly reported aspects of supportive leaders included: demonstrating trust, providing structure and clarity, valuing of the complementary skills Peers bring by involving them in clinical meetings and allowing Peers to work to their strengths in/with the community.

Culture is formed in groups and is influenced by team experiences. While the culture of regional offices is influenced by their local leaders and team, there was recognition among stakeholders that leadership for change will continue to require consistent communication about the national vision for integrating a peer workforce. Findings from the interviews relating to cultural change and integration present an opportunity for Open Arms' change management and communication strategy to focus on the key areas that have particular interest and impact for the workforce. When considering a change strategy, the key areas for attention are: i) the need for change, ii) appropriateness of response, iii) ability to implement, iv) intrinsic and extrinsic gains, and v) genuine commitment to the change from respected peers and senior leaders. Given the large degree of goodwill in the program, stakeholders' endorsement of Open Arms' investment in a peer workforce, and the existence of both personal and team stories of success, the organisation is well positioned to develop an effective change strategy and key messages in partnership with Peers and clinicians.

3.4 Collaboration and teamwork

The consultations highlighted that collaboration and teamwork were critical to achieving positive outcomes for Open Arms and its workforce, and for clients, external stakeholders and the wider veteran community.

Shared goals and vision

During the consultations, feedback reflected shared goals for the Program. Participants from both regional and national consultation groups identified that improving access to mental health services and support for veterans was a top priority for Open Arms and the Program. The Program, and the inclusion of Peers in the Open Arms model of service was described as a crucial factor in improving service access for veterans and engaging with the veteran community more broadly. Participants also shared the perspective that by employing Peers in Open Arms, the voice of lived experience was able to inform strategic direction and service improvements, ultimately ensuring that Open Arms remains accountable to veterans and services can meet user needs. While there was broad agreement on the aims and goals of the Program, and the value of peer work, there is opportunity to work with all stakeholders to capture and refine the goals and vision of the Program. Consultations

with stakeholders indicate that ongoing dialogue and collaborative approaches to goal setting and direction for the Program would be well received.

Relationships and teamwork

Throughout the consultations, the importance of teamwork and collaboration between Peers, clinicians and coordinators was highlighted by participants. Across the consultations the status of teamwork varied with some regions reporting a cohesive team environment, whilst others described this as a work in progress or felt that team relationships were strained.

Clinicians reflected on how any initial uncertainty around having Peers join the team had been quickly dismissed, with Peers being highly valued team members who can enhance clinicians' understanding of veterans and are enabling clinicians to see more clients. Where Peers and clinical teams were able to work effectively together, participants noted improvements in outcomes for veterans, team culture and reported greater work satisfaction. Successful teamwork involved Peers and clinical staff building rapport with each other; working on projects of interest to both Peers and clinicians (such as a two-way referral process); and jointly contributing to the assessment of client needs. Additional factors that promoted strong working relationships in the team included team members having an opportunity to openly discuss their roles, share experiences and spend time developing trust and mutual respect for each other's unique skills. Within the organisation, trust and mutual respect could be further strengthened through expanding language of the clinical environment to include Peers, Peer work practices and lived experience perspectives.

The facilitation of Communities of Practice and opportunities for people in similar roles to network were identified as positive supports in the ongoing development of practice for both Peers and for individuals in Coordination positions. They are also seen to assist continuous improvement of the Community and Peer Program. Both Peers and CECs had established connections within their role-based groups throughout the induction week and these supportive networks had continued to provide benefit.

3.5 Organisational development

Organisational development processes are critical to support organisational change management. Clarity around strategic directions, and policies and procedures, structures and management support that underpin this direction can contribute to the adoption of new ways of working.

Strategic directions

Participants reflected that proactive community engagement and increased input from veterans and veterans' families was a positive addition to the clinical services offered by Open Arms. While the perceived benefits and value of the Program were consistently conveyed, participants also expressed a desire for clarity of the vision and future direction for Open Arms and for the Program.

Consultations highlighted that priorities for peer work varied across each region, and that the strategic direction for the Program and Open Arms should accommodate the need for local adaptation of the Program, changes over time and Peer engagement with a range of community priorities. It was suggested that national level KPIs could be used to align regional and local plans, and encourage regions to make locally relevant decisions, while remaining consistent with national priorities.

Organisational structures and processes, and management support

The introduction and integration of Peers into the existing Open Arms clinical model necessitated changes to organisational structures and processes. Many participants described successful integration of Peers with the clinical workforce that was facilitated by information sharing, two-way

learning, debate and role shaping at the regional level. However, not all regions or participants perceived the integration of Peers into Open Arms as straightforward.

Participants highlighted differences between the clinical model and the Peer model. Clinicians have progressively increased referrals to Peers, although there has been some hesitation from clinicians. A number expressed their interest in learning from 'best practice' examples of how to integrate the Peer workforce, and some indicated a preference for standardised delivery of the model. From the perspective of Peers, it could also be challenging entering the unfamiliar clinical environment.

A small number of specific areas were identified where the integration of Peers in organisational structures and processes may need some greater attention. The need to clarify and communicate the scope and nature of peer work practices was expressed, in particular to address uncertainty around expectations of privacy, confidentiality and record keeping. Clinicians recognised that psychologists and social workers are trained in these aspects of practice at university and/or through professional registration and indicated an appetite to better understand how these practices were supported for the Peer workforce.

Lack of clear understanding of reporting lines and responsibilities was also reported as a challenge at several levels from Program governance to client referral management. The desire for clear chain of command may be stronger from within the Peer workforce based on their military experience. Complications in chain of command may diminish trust and rapport with Peer staff. Despite the potential for difference in expectations between the Peer and non-Peer workforce, some consistent areas for improvement were identified, including: increase Peer representation at leadership meetings and in decision-making forums; strengthen client referral pathways, screening and allocation and escalations; clarify the role of national Peers; and encourage regular communication.

Policies and procedures

The development and dissemination of policies and procedures for the Program was raised as a high priority by several participants, particularly those in regions where the Program had launched more recently. Stakeholders engaged at the national level were more likely to indicate that several documents were available to guide regional implementation. Several regional participants found that reports from the Townsville Pilot to be useful in setting up the Program in their own location, while others found the Townsville experience was not similar enough in context to apply locally. It was not always clear whether the policies and procedures mentioned had not been developed, if the participant was not aware of the document, or whether the existing documentation was perceived as inadequate. Regardless of the reason for limited use of a document, the interview findings point to several opportunities to improve the development, dissemination, and use of policies, procedures and other materials to guide the delivery of the Program.

Participants highlighted the need to strike a balance between national consistency and regional flexibility in decision-making tools, policies and procedures relevant to Program implementation. Participants consistently expressed that the development of documentation should occur with stakeholder input. Participants highlighted a number of priorities that had the potential to be addressed through ongoing development and dissemination of policies and procedures including addressing a desire for consistent record keeping among Program staff; and issues of safety and risk management related to client support and engagement work, including home visits.

3.6 Workforce development

Workforce development is an important factor in building organisational capacity to meet the strategic priorities and needs of the Program and organisation. Factors highlighted in consultations that would progress workforce development included role clarity and expectations, professional supervision and support structures and opportunities for learning.

Role clarity and expectations

Participants frequently conveyed a desire for greater clarity of the Peer role. Defining boundaries with existing clinical roles and the Community Engagement Coordinator (CEC) roles were also an important consideration. Many aspects of the Peer role were highly valued and had support. Positive aspects of the Peer role with clients included: acting as a bridge or 'step-up and step-down' to therapy; bringing lived experience to create positive change; educating the wider Open Arms workforce; the ability to tailor the role to reflect Peers' individual skills, interests and experience; and being able to be responsive, compassionate and flexible when working with clients. Similarly, the role of Peers in community engagement was also highly valued in building networks that may have previously been unknown to Open Arms; establishing partnerships and strengthening of referral pathways; promoting the value of Open Arms; and bringing ex-service organisations together and collaborating rather than duplicating community engagement activities.

Despite the many positive aspects of the Peer role identified in the consultations, stakeholders also provided feedback on the need to further clarify and define the Peer role, including how it interfaces with other roles within Open Arms. Both Peers and CECs indicated balancing the community engagement and client aspects of their roles was demanding and could lead to burnout. Many found efforts to better understand each other's roles, and to negotiate and clarify expectations and boundaries within the newly integrated teams were well received and had strengthened working relationships locally.

This feedback highlighted the opportunity to further define the scope of Peer role, CEC role, and other associated Program roles. Some specific aspects that could be addressed in efforts to shape these roles include clearer work prioritisation guidelines and criteria that may assist in workload management; boundaries between peer and clinical roles relating to one-on-one client work especially case-management and counselling; scope of Peer work with clients with complex needs; differentiating counselling and peer support; creating and shaping team leader roles for Peers; and clarifying Peer management, supervision and support functions within clinical and CEC roles.

Open Arms Peers are unique in that the lived experience they bring is twofold; of both mental health and military life. Participants encouraged ongoing consideration of how to best utilise and support these two experiences and identities and in particular how this informs approaches to pairing a client with the most appropriate Peer.

Professional support and supervision

Consultation with stakeholders found that improving support for wellbeing and mental health of the lived experience workforce was a priority. While those in the Peer role enjoyed their work and found many benefits for their own wellbeing, they also identified risks to their mental health in the role. Specifically highlighted were workload pressures, the uncertainty of casual employment and being exposed to mental health triggers. Those in other roles also identified the potential for burnout. Many, not just Peers, identified the opportunity for more proactive wellbeing and mental health support, particularly for the Peer workforce. Feedback indicated that models of support should consider that small, tight-knit communities could add significant discomfort for those accessing mental health support at their own workplace.

Additionally, clinicians and Peers identified professional supervision as an area for ongoing improvement. An added challenge identified in the consultations was that supervision models for Peers were felt to be not fully conceptualised (compared to Social Work, for example). Local arrangements for supervision and support for Peers varied. One example of effective support was identified as Peers' ability to connect with each other to help and support each other (around the country, via information sharing). There may be an opportunity to formalise this through smaller groups than currently possible in the Community of Practice. Having access to mentorship from more experienced Peers, for example those involved in the Pilot, may be beneficial.

Workforce learning and professional development opportunities

While many of the opportunities for ongoing development focused on the Peer role, learning opportunities for clinical staff were also highlighted. Since the introduction of Peers to Open Arms, clinicians identified how they have developed a greater understanding of military service, and a greater appreciation for the impacts of culture and the context of veteran experience, behaviours and perspectives. These changes appear to be as a result of experiential learning - where clinicians have a visibility of the ways that Peers are working and supporting clients, dispelling negative perspectives that may have been held by clinicians based upon previous experiences of peer programs.

Structured opportunities for information sharing that have supported learning in the organisation included Communities of Practice, and other networking opportunities that were initiated during the National Induction week. These activities appear to have contributed to stronger engagement with clinicians, exploration of Program improvement opportunities, and discussion of service innovation.

The option to pursue professional development courses or accredited training while in the Peer role was also identified as a positive step to facilitate the development of the Peer workforce and peer practice. However, some participants felt that there was potential for overreliance on formal qualifications and certificates. When discussing professional development participants raised the need to ensure any training fit within the existing workload of Peers. Further, professional development for the wider Open Arms workforce was identified as an opportunity to clarify expectations of how others, such as clinicians and those in leadership positions, should be working alongside or supervising Peers.

3.7 Resourcing and logistics

Resourcing and resource allocation form a critical component of organisational capacity to deliver a program. Participants identified considerations regarding both human resources and physical resources when providing feedback on implementation of the Peer program to date and indicating priorities for future focus.

Program Staffing

It was the observation of some participants that the introduction of the Program has increased Open Arms capacity. The Program is also broadening the holistic nature of Open Arms services through adding to the stepped model of care, extending services beyond a medical model, offering an alternative way to engage with clients and provide clients visible models of recovery.

National managers described being focused on growing and strengthening the Peer workforce and Program. As awareness and uptake of the Program increases, several participants reported that the Peer workload had increased (although COVID-19 led to a temporary initial reduction in workload). Participants identified a need for greater monitoring of workload and capacity and ensuring there were reporting channels to convey the need for greater resources to meet demand. The potential for

burnout was flagged, particularly for those in regions where it was difficult to juggle community engagement and a heavy client support workload. Vacancies in other non-Peer roles, and where supervisors experience high volume workloads were observed to contribute to local challenges in managing workloads.

Peers provided feedback about how the nature of contracts and casual work impacted on their work and wellbeing, highlighting an experience of low job security and an impact on management of self-care and continuing recovery.

Physical resources

Some participants described adequate access to physical resources including desks, laptops and transport, however others identified resourcing as a top priority to address. Delays in access to a desk, computer or IT systems caused frustration and were most evident at commencement of the role or during the transition to remote working due to COVID. Several participants made specific requests for improved access to vehicles to undertake community engagement and client support visits. Using taxis were identified as time inefficient and could be perceived negatively by the community.

4 Conclusions and recommendations

This review aimed to increase Open Arms' understanding of the Community and Peer Program implementation to date from the perspectives of key internal stakeholders. The review is intended to inform future implementation priorities and processes, as well as continual improvement of the Program.

The Community and Peer Program is a visible artefact of a forward-thinking model where veterans with a lived experience of mental health issues and recovery provide an additional and complementary service to clinical interventions. As with any program at this stage of implementation, the findings of this review present several opportunities for Program-level improvement.

Findings from the consultations showed that the Program has broad support and is valued within Open Arms. Themes arising from the interviews aligned closely to elements of organisational capacity building frameworks, specifically: Organisational development, Workforce development, Resource and logistics, and Collaboration and teamwork. Within each of these domains, participants identified significant strengths of the program and examples of successful implementation within regions and teams. Participant feedback also highlighted several priority areas they felt could be addressed to further enhance implementation of the Program.

Opportunities to strengthen organisational change processes through ongoing communication, leadership and engagement of stakeholders was also identified. A common theme arising across consultations was the need to strike a balance between national consistency and regional flexibility. Further, participants highly valued the opportunity to provide input into this review and emphasised the importance of ongoing consultation and engagement for Program implementation and future improvement.

It is important to note that specific regional differences in implementation many have not been captured in this review. It is also important to consider that perspectives conveyed are those of individuals who volunteered to participate in this process. Further examination of strengths and opportunities relevant to specific regions may be warranted. Ongoing evaluation should continue to capture stakeholder views using a range of data collection methods.

4.1 Recommendations

Findings from the stakeholder consultations were used to derive the following recommendations that can be implemented by Open Arms as part of their ongoing Program and organisational improvement processes. The recommendations consider factors important for organisational change and are presented in alignment with domains of selected organisational capacity building frameworks.

Cross-cutting recommendations

Several findings about future improvements to the program spanned across the organisational capacity domains selected for grouping themes in this report. These cross-cutting factors highlighted values, espoused beliefs and principles of practice for the Community and Peer Program and have impacts for the way in which ongoing implementation activities are conducted to enable strong buy-in and promote impactful program outcomes. Themes raised included the need for process and outcome measures for the program, use of co-design in quality improvement processes and enablement of regional approaches under a nationally consistent framework.

Recommendations:

1. Identify opportunities to simultaneously strengthen national consistency and support regional flexibility in implementing the Community and Peer Program.
2. Embed opportunities for stakeholder feedback, engagement and co-design in policy development, and for Program implementation and quality improvement activities.
3. Develop a monitoring and evaluation plan for the Program to facilitate ongoing collection of feedback and to inform continuous Program improvement.

Communication and organisational change

The addition of a new capability for Open Arms through establishment of the Community and Peer Program involves significant cultural change, service change and workforce integration**.** There was recognition among stakeholders that leadership for change will continue to require consistent communication about the national vision for integrating a peer workforce. Open Arms is well positioned to develop an effective change strategy and key messages in partnership with Peers and clinicians.

Recommendation:

4. Prioritise communication for change management, including planned communication from senior managers, and with a focus on the alignment of the Community and Peer Programs' aims and objectives with Open Arms' strategic vision.

Collaboration and teamwork

Collaboration and teamwork were reported to be integral for achieving positive outcomes and those who reported stronger relationships with their co-workers also reported greater workplace satisfaction and viewed the Program in a positive light. Successful teamwork involved Peers and clinical staff building rapport with each other, working on projects of mutual interest and jointly contributing to the assessment of client needs. Consultations with stakeholders indicate that ongoing dialogue and collaborative approaches to goal setting and direction for the Program would be well received, would energise staff and would encourage stakeholders to embrace this new Program.

Recommendation:

5. Continue to identify successful team building approaches, facilitate the sharing of these activities across regions and continue to invest in team building.

Organisational development

The national rollout of the Community and Peer Program in November 2019 has significantly contributed to Open Arms' capacity to support clients and added diversity to the organisation's service offering. The introduction and integration of Peers into the existing Open Arms clinical model necessitated changes to organisational structures and processes and intentional ongoing efforts to support the integration of clinical and peer models of engaging with clients and community. A deliberate focus on clarifying strategic directions, policies and procedures, roles and responsibilities, structures and processes in the next phase of implementation will support ongoing integration of the Program and workforce.

Recommendations:

6. Use co-design processes with stakeholders to develop a strategic plan for the Community and Peer Program that builds on existing regional strengths, captures shared goals, and aligns with Open Arms' strategic direction.
7. Engage operational staff and managers to identify the need for additional policy and procedures concerning risk management and safety relating to client support and client contact.
8. Clarify roles, responsibilities, reporting lines and organisational processes with a focus on both Program governance and decision-making workflows at regional and national levels.
9. Strengthen processes and documentation that support client referrals and clarify screening and allocation of clients to Peers and clinical staff.
10. Continue to identify, share and support the implementation of activities that promote the integration of the lived experience workforce into clinical environments, for example information sharing and two-way learning within regions.

Workforce development

Factors highlighted in consultations that would enable ongoing workforce development included clarifying roles, responsibilities, scope of practice and expectations, provision of professional supervision and support structures that facilitate ongoing practice development and that support wellbeing, and identification of opportunities for ongoing learning to enable career growth, diversity and flexibility. While many of the opportunities for ongoing development focused on the Peer role, learning opportunities for clinical staff were also highlighted as valuable for enhancing awareness of the Program and Peer practices and facilitating collaborative service delivery.

Recommendations:

11. Capture a service delivery model that includes multidisciplinary team role definitions, scope and boundaries and with attention to both service integration and differentiation of practice between peer support, case management and complex case coordination.
12. Use co-design processes, and build on existing strengths, to capture, communicate, and continually refine the Peer model of practice, including what Peers do and how the Peer roles can be shaped and deployed to meet client needs.
13. Continue to identify ways to improve the mental health and wellbeing support available to Peers, especially proactive support.

14. Ensure existing Peer workforce professional supervision structures are known and available to all Peers.
15. Ensure professional development opportunities that relate to the Peer practice model and integration of the lived experience workforce are available and targeted to a range of Open Arms staff, not just Peers.

Resourcing and logistics

An ongoing investment in physical resources for regional teams and a sustained allocation of human resources were identified as priorities. As awareness and uptake of the Program increases, several participants reported that workloads had increased across both peer support and community engagement. Vacancies in non-peer roles were observed to contribute to local challenges in managing workloads. Participants identified a need for greater monitoring of workload and capacity and ensuring there were reporting channels to convey the need for additional resources to meet demand.

Recommendation:

16. Examine options to enhance resource allocation and support for Peers and regional teams, especially in relation to workload management, ensuring diversity in roles and preventing burnout.

References

Armenakis, A. A., Harris, S. G., & Mossholder, K. W. (1993). Creating Readiness for Organizational-Change. *Human Relations, 46*(6), 681-703. doi: 10.1177/001872679304600601

Armenakis, A. A., & Harris, S. G. (2002). Crafting a change message to create transformational readiness. *Journal of Organizational Change Management, 15*(2), 169-183. doi: 10.1108/09534810210423080

Batras, D., Duff, C., & Smith, B.J. (2016). Organizational change theory: implications for health promotion practice, *Health Promotion International*, 31(1), 231–241. doi: https://doi.org/10.1093/heapro/dau098

NSW Health Department. (2001). A Framework for Building Capacity to Improve Health. Sydney: NSW Health Department.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: Free Press.

Schein, E. H. (2010). *Organizational culture and leadership*. San Francisco: Jossey-Bass.

Appendix A

Summary of stakeholders invited and participated in consultations

Stakeholder group	Invited	Participated	Consultation format
Regional Directors	6	6	1 group interview
Assistant Directors Clinical Coordination	9	9	1 group interview 1 written response
Community Engagement Coordinators	9	11	1 group interview 1 individual interview
Community and Peer Advisors	33	26 (capped at 24)	4 group interviews 1 follow up conversation
In-centre clinicians	78	13 (capped at 20)	2 group interviews 1 written response
National Operations (Including National Peers)	5	5	1 group interview
Open Arms National Operations program managers and organisational leaders	7	7	5 individual interviews 1 small group interview 2 follow-up interviews

Appendix B

Semi-structured interview guide

1. **How would you describe the value of the Community and Peer Program?**
    - Value for Open Arms?
    - The community?
2. **What is your role in the Community and Peer Program?**
    - How does your work in this role contribute to the implementation (or operation) of the program?
    - What have you focussed your attention on?
        - For example: integration of the program in Open Arms, support to Peers, direction, structure
3. **How would you describe your experience of the Community and Peer Program?**
    - What have you observed? Can you describe some of the actions taken to establish the program? For example, Org. Dev/ Integration of program and Peers, Resources, Workforce development, Partnerships, Leadership
    - In terms of implementing or establishing the Community and Peer Program, where is it up to?
4. **How has the organisation supported the program /the peer workforce?**
    - And where is that support coming from?
    - Peers: how has the organisation supported the wellbeing of Peers? To what extent do you think Peers feel supported?)
    - Do you have what you need (or 'have in place') to make the Community and Peer Program Implementation successful?
5. **Thinking about all stages of the program up until now, what do you think has worked well?**
    - Why do you think that is?
    - What are the main gains?
6. **What are the current challenges?**
    - What is contributing to those challenges?
7. **Thinking about where we are up to with implementation of the program, what are your main priorities and needs?**
    - Priorities/Needs for supporting you in your role?
    - Priorities / needs for supporting the workforce?
    - Priorities for the continuous development of the program?
8. **What are your recommendations for the Community and Peer Program?**
    - Would that address your needs/priorities?
    - Are there any specific actions, structures or supports that you would recommend for the next phase of the program?
    - How could this be achieved? Who is involved?
9. **Do you have any other feedback you would like to provide?**

Appendix C

Participant information sheet

Information Sheet – Community and Peer Program Implementation Review – One on One and Group Consultations

June and July 2020

Title: 'Open Arms Community and Peer Program Implementation Review'

Thank you for taking the time to read this information sheet which is for you to keep.

My name is Dimitri Batras, I am a contractor for the Department of Veterans' Affairs (DVA) working on the 'Open Arms Community and Peer Program Post Implementation Review' along with my colleagues Emily Foenander and Joanna Schwarzman.

Open Arms has progressively been undertaking the national rollout of the Community and Peer Program. The core objectives of the Community and Peer Program are to enhance the identification of and response to vulnerable Veterans and their families.

The national rollout of the Community and Peer Program commenced with the recruitment of Community and Peer Advisors and Community Engagement Coordinators and was launched in November 2019 at the National Induction.

What is the Post Implementation Review about?

You are invited to take part in the Community and Peer Program Post Implementation Review being undertaken by Open Arms.

Please read this Information Sheet in full before deciding to participate.

The Post Implementation Review aims to consult with key internal staff to:

- increase Open Arms' understanding of how the Community and Peer Program implementation has been experienced to date;
- increase Open Arms' understanding of perceptions of the Community and Peer Program;
- increase Open Arms' understanding of what has worked well;
- increase Open Arms' understanding of the challenges and barriers;
- enable clarification of gaps, ongoing needs and priorities to inform future activities;
- enable clarification of opportunities and seek recommendations.

Why have I been invited to take part in the Post Implementation Review?

You have been invited to participate in this study because you have been identified as an internal stakeholder participating in or contributing to the rollout of the Community and Peer Program.

The following internal stakeholders have been identified to participate in the Post Implementation Review:

Open Arms Regions:

Regional Directors
Assistant Directors Clinical Coordination
Community Engagement Coordinators
Community and Peer Advisors
In-Centre Clinicians

National Operations:
National Manager
Deputy National Manager
Assistant National Manager
Former A/g Director Clinical Services
National Operations Community and Peer Team

Possible benefits of the Post Implementation Review

Feedback received through the Post Implementation Review will inform future Community and Peer Program implementation activities and priorities, including the resourcing and support provided to the workforce and opportunities for continuous improvement of the Program.

What does the Post Implementation Review involve and what impacts are there?

Depending on your role, the Post Implementation Review will involve either one on one or role-based group consultations using an online video conferencing platform.

Interview questions will specifically focus on Community and Peer Program implementation. However, depending upon your experience of the Community and Peer Program, the interview could lead to you thinking of (and possibly verbalising) experiences that may have been stressful. Should this occur we will ask you if you would like to continue the interview and if not, we will ask you if there is something that we can do to support you such as connecting in with your Line Manager or the support person of your choice. All participants are free to cease participation at any time.

How much time will participation take?
One on one consultations will take up to 60 minutes and will be conducted at a time of your convenience. Group consultations will take up to 90 minutes and will be scheduled at either a time identified to be most available for most individuals in your role, or through a registration process that enables your identification of convenient dates and times. With your consent I would like to audio record the conversation to ensure accuracy. This will assist with the preparation of transcripts and summaries for data analysis.

You can withdraw from the study
Participation in this study is voluntary and you are under no obligation to consent to take part. If you do consent to participate, you may withdraw from further participation at any stage. Acceptance of calendar invitations and completion of registration surveys are an

indication of interest to participate. Your verbal consent to participate will be gained at the commencement of the consultation session.

How will the feedback you provide be presented to Open Arms?
A Summary Report will be provided to Open Arms. This report will contain identified themes that emerged through consultations. Anonymous sample quotes will be included where these reinforce the theme. Non-identifiable high-level summary personas will be included demonstrating common characteristics of stakeholders.

How will the information you give be kept private?

Only the evaluators will have access to the information that you provide.

Your answers will be completely confidential and any personal details, which may identify you in any way, will not be passed to Open Arms.

How will this information be stored and protected?
The evaluators are bound by the *Privacy Act 1988, Privacy Amendment (Enhancing Privacy Protection) Act 2012* (Privacy Amendment Act) and the *Archives Act 1983.* Information collected will be stored indefinitely for a minimum of 5 years in password protected computer files, independent of Open Arms/Department of Veterans' Affairs. Evaluation findings will be published as aggregate data. These reports will not identify you in any way.

If you would like to contact the evaluators about any aspect of this review, please contact the Principal Evaluator:

Dimitri Batras
DVA Health Promotion and Evaluation Adviser
Email: Dimitri.Batras@dva.gov.au
Tel: 03 9284 6453 or 0403 596 457
Post: PO Box 9998, 300 Latrobe Street, Melbourne Victoria 3001, Australia

Thank you.

Dimitri Batras
Principal Evaluator