IMPLEMENTATION MANUAL

for Posttraumatic Stress Disorder Trauma Recovery Programs

Effective 1 July 2025

Version 1.0

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# **HOW TO USE THIS DOCUMENT**

Section 1 of this document outlines the Department of Veterans’ Affairs (DVA) minimum program requirements for the delivery of Trauma Recovery Programs (TRPs) and provides information on how to meet these requirements, including a checklist against each requirement.

Section 2 of this document highlights best-practice guidance for improving the quality of TRP services and provides advice on how best-practice can be obtained.

If you have any questions about the TRP, please contact the DVA TRP Program Managers at [Mental.Health.Programs@dva.gov.au](mailto:Mental.Health.Programs@dva.gov.au).

# **INTRODUCTION**

TRAUMA RECOVERY PROGRAM

DVA engages private and public hospitals throughout Australia to provide evidence-based TRPs for entitled persons experiencing Posttraumatic Stress Disorder (PTSD).

The TRPs are not intended to be stand-alone services, nor will they meet all the treatment needs of entitled persons. Rather, they aim to provide highly specialised, time-limited, evidence-based treatment for PTSD and its common comorbidities and form only part of a person’s treatment needs.

TREATMENT POPULATION

DVA funds TRPs for entitled persons who hold a current Veteran Gold Card or White Card and have a clinical diagnosis of PTSD. An entitled person includes veterans, ex-serving Australian Defence Force (ADF) personnel and current serving ADF personnel if their treatment is paid for by DVA. For the purpose of this Manual, ‘veteran’ includes ex-serving ADF personnel.

# **CHANGES TO ACCREDITATION**

Previously, hospitals were required to meet the:

* *National Safety and Quality Health Service* (NSQHS) Standards;
* DVA’s *National Accreditation Standards for Trauma Recovery Programmes (2015);* and
* *National Standards for Mental Health Services* *(2010)*.

Since December 2022, hospitals delivering TRPs are now only required to be accredited against the NSQHS Standards. Any requirements from DVA’s *National Accreditation Standards for Trauma Recovery Programmes – PTSD (2015)* that are not adequately covered by the NSQHS Standards have been included as a DVA minimum requirement, outlined in Section 1 of this document.

Hospitals can still follow the *National Standards for Mental Health Services (2010)*, however, accreditation to the standards is not mandatory for providers of mental health services as determined by the state and territory Health Departments.

# **PROGRAM EVALUATION**

WHAT IS THE CLINICAL DATA USED FOR?

The clinical effectiveness of the TRPs is evaluated using clinical outcome data from consenting participants. This data is collected by an independent research organisation – Phoenix Australia - Centre for Posttraumatic Mental Health. TRP clinical data collection has two main aims:

1. to describe the population characteristics of participants entering the programs; and
2. to measure change across time of an individual’s clinical, social and functional profile that the program is targeting.

All participant data is de-identified and aggregated by Phoenix Australia before it is provided to DVA.

Data is collected through:

* a clinician-administered assessment interview before the group program starts;
* a brief clinician-completed questionnaire at the end of group treatment; and
* a veteran self-report questionnaire at four time points (see Section 3.7 for further details):
  + before the group treatment starts
  + after the group treatment ends
  + 3 months after discharge
  + 9 months after discharge

At a national level, this can assist DVA to better understand:

1. the types of participants utilising these programs;
2. how effective TRPs are in reducing the severity of PTSD and its comorbid conditions;
3. emerging issues or barriers to effectiveness; and
4. potential program improvements.

At a hospital level, TRP providers can review data for their program in the annual *Hospital Outcome Reports* provided by Phoenix Australia, for quality assurance and continuous improvement purposes.

At a clinician level, participant intake data can be used to develop an individual’s case formulation and treatment plan, as well as help develop an understanding of the needs of each TRP cohort as a whole. Discharge and follow-up data can be used to help understand the participant’s progress, and remaining clinical or referral needs after they have been discharged from the group component of the program.

The DVA/Defence Human Research Ethics Committee has approved the monitoring of TRP outcomes, including collecting outcome data from TRP participants (i.e. veterans and current serving ADF personnel) (Protocol 828-16 & E096/002).

WHAT CLINICAL DATA IS COLLECTED?

The outcomes being measured through the data analysis are referred to as key indicators. These include:

1. Clinical indicators; and
2. Social and functional indicators.

The measures are selected based on considerations including their consistency with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA 2013), comparability with other datasets for benchmarking purposes and psychometric strength.

Demographic and other descriptive information, such as gender, current employment status, military service history and health service usage are also collected.

| **Clinical Indicators** | **Measure** |
| --- | --- |
| PTSD | Posttraumatic Stress Checklist (PCL-5) |
| Anxiety | Generalised Anxiety Disorder Assessment (GAD-7) |
| Depression | Patient Health Questionnaire – Depression (PHQ-9) |
| General distress | Kessler Psychological Distress Scale (K10) |
| Alcohol use | Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) |
| Anger | Dimensions of Anger Reactions-5 (DAR-5) |
| Aggression | Two-item measure of violence used in the Transition and Wellbeing Research Program |
| Jellinek Inventory for Assessing Partner Violence (J-IPV) |
| Sleep | Insomnia Severity Index (ISI) |

|  |  |
| --- | --- |
| **Social and Functional Indicators** | **Measure** |
| Quality of life | Assessment of Quality of Life instrument – 4 Dimensions version (AQoL-4D) |
| Potentially traumatic events exposure | Life Events Checklist (LEC-5) |
| Wellbeing | Personal Wellbeing Index (PWI) preceded by a global life satisfaction question routinely used in Australia and other countries |
| Relationship functioning | Abbreviated Dyadic Adjustment Scale (DAS-4) – will be completed by veterans who have a current partner |
| Family functioning | Family Assessment Device (FAD-12) |
| Disturbances in Self-Organisation (DSO) symptoms of Complex PTSD | International Trauma Questionnaire, disturbances in self-organisation subscale |
| Combat experiences | Deployment Risk and Resilience Inventory (DDRI-2): Section D. Combat Experiences |
| Guilt and Moral injury | Moral Injury Outcome Scale (MIOS) |
| Other addictive behaviours | Gambling - Problem Gambling Severity Index (PGSI) short form |
| Licit and illicit drug use (Smith et al., 2010) |
| Tobacco use - single item asking if ever or currently use tobacco |

ACCESSING THE DATA

To access your own hospital’s data, TRP providers can submit a request to Phoenix Australia at [phoenix-data@unimelb.edu.au](mailto:phoenix-data@unimelb.edu.au). Note that Phoenix Australia only holds de-identified participant information.

Data cannot be used by TRP providers for research or publication purposes unless ethics approval has been sought from and approved by DVA. TRP providers requiring access to the database for purposes other than quality assurance and clinical purposes should contact DVA’s TRP Program Managers at [Mental.Health.Programs@dva.gov.au](mailto:Mental.Health.Programs@dva.gov.au).

# **SECTION 1: MINIMUM REQUIREMENTS FOR TRPs**

This section outlines DVA’s minimum requirements for the delivery of TRPs. It provides explanatory support, information and a checklist to help hospitals ensure the requirements are met.

DVA will be requesting information from hospitals through the annual **Program Report** to ensure the programs continue to meet the minimum requirements for TRPs. The report will also support DVA’s ongoing work with hospitals to ensure the TRPs continue to benefit participants and that the hospital staff who are developing and facilitating the TRPs are supported. The report template (pages 18-21) is sent to hospitals in the last quarter of each year for completion.

## Accreditation against NSQHS Standards

*Hospitals providing Trauma Recovery Programs must be accredited against the current National Safety and Quality Health Service Standards (NSQHS Standards, second edition), or working towards achieving accreditation.*

**IMPLEMENTATION SUPPORT**

The [NSQHS Standards](https://www.safetyandquality.gov.au/standards/nsqhs-standards) outline the level of care that is required to be provided by health services and the systems that are needed to deliver care.

For TRPs, the hospital’s compliance with the NSQHS Standards will continue to be monitored as part of its usual accreditation processes.

The NSQHS Standards Guide for hospitals ([www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-guide-hospitals](http://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-guide-hospitals)) has been developed to assist health service organisations to align their patient safety and quality improvement programs using the framework of the NSQHS Standards.

If you have any questions about the NSQHS standards, you can contact the [Australian Commission on Safety and Quality in Health Care](https://www.safetyandquality.gov.au/) at [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au) or your accreditation agency.

## Provide evidence-based treatment for PTSD

*Trauma Recovery Programs to be delivered to Entitled Persons must provide evidence-based treatment for PTSD and its common comorbidities, consistent with the current ‘Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD’ (Phoenix Australia, 2020)[[1]](#footnote-1) (the Guidelines), as amended from time to time.*

*Please complete the implementation checklist below to assess if the group program is consistent with the Guidelines.*

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| --- | --- |
| **Implementation Checklist** | **(Y/N)** |
| Review the Guidelines that are available from [www.phoenixaustralia.org/australian-guidelines-for-ptsd/](http://www.phoenixaustralia.org/australian-guidelines-for-ptsd/) to ensure access to the current version |  |
| Individual treatment is consistent with the current Guidelines, and includes:   * engagement and preparatory work, as required * evidence-based PTSD treatment * relapse prevention, as required |  |
| All, or the majority of, treatment offered in the group program is consistent with the current Guidelines and is evidence-based |  |
| The TRP service has clear policies and procedures around what evidence-based treatment and adjunct therapies can be provided to participants |  |
| The TRP service keeps a record of the treatments their clinicians provide to participants in their individual therapy sessions |  |
| The TRP service has clinician and participant manuals to guide the treatment program. These manuals should be reviewed regularly to reflect best practice for PTSD and associated symptoms[[2]](#footnote-2) |  |
| The TRP group sessions run for a minimum of 20 days (or equivalent). This ensures there is sufficient time to cover the program content. Please refer to ‘*Section 2, During Treatment’* for best-practice guidance on program content |  |
| The TRP service offers the requisite number of individual therapy sessions in the program (i.e. 8 to 12 individual sessions) with at least one session offered weekly1 |  |
| Ideally, a TRP cohort is a minimum of 5 and maximum of 9 total participants[[3]](#footnote-3) (which includes veterans, current ADF personnel and first responders)   * The suggested minimum and maximum cohort size is intended as a guide to the number of participants that are required for viable group treatment, allowing for a potential late withdrawal after the cohort has been established |  |
| Adjunct therapies are not offered as a first-line treatment and should only be a minor component of the program[[4]](#footnote-4) [[5]](#footnote-5) (no more than 30% of program content) |  |

## Minimum program requirements

*Trauma Recovery Programs must meet DVA’s minimum program requirements as outlined below.*

* 1. Entitled persons must have a clinical diagnosis of PTSD in order to enter the program.

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| **Implementation Checklist** | **(Y/N)** |
| Before obtaining consent and conducting the clinical assessments, TRP services consider the inclusion and exclusion criteria that may impact on whether an entitled person is accepted into the program |  |
| The following **inclusion criterion** has been considered:   * a diagnosis of PTSD according to DSM-5 criteria A–H. Where an assessment of an individual with a history of PTSD falls short of the full diagnostic criteria and the clinician believes they will benefit from the program (based on their PTSD-related symptoms, level of distress and/or impairment), they can be considered for inclusion |  |
| The following **exclusion criteria** have been considered:   * acute alcohol or other substance intoxication * strong tendencies to dissociate without adequate strategies for management * acute suicidality or violence * current uncontrolled psychosis * lack of ongoing, repeated symptoms * inability to tolerate or manage high levels of arousal * history of difficulties engaging in group treatment * major current life crises |  |

* 1. Provision of assessment and treatment of Entitled Persons in Trauma Recovery Programs is to be delivered by a clinical workforce that has completed clinical training in evidence-based treatments (as specified by the current Guidelines) and meets DVA requirements to provide mental health services.

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| **Implementation Checklist** | **(Y/N)** |
| All clinical staff are trained to deliver evidence-based treatment consistent with the current Guidelines[[6]](#footnote-6) |  |
| Clinical staff are supervised by senior clinicians with training in evidence-based, trauma-focussed mental health treatments consistent with the current Guidelines7 |  |
| Clinical staff can demonstrate an understanding of the unique nature of military service and the impact it can have on the health and wellbeing of participants[[7]](#footnote-7) |  |
| Clinical staff work within a trauma-informed care framework[[8]](#footnote-8) |  |

* 1. Trauma Recovery Programs must have appropriate staffing to adequately deliver the various components of group programs including individual trauma-focussed therapy, facilitation and co-facilitation of therapy groups, program coordination, clinical oversight, and administrative tasks.

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| **Implementation Checklist** | **(Y/N)** |
| The TRP service ensures that:   * there is a nominated Psychiatrist or Clinical Psychologist as a Clinical Director to oversee the program * there is a multidisciplinary team supporting the program * there are administrative staff to support the program * there is a nominated program coordinator * there is a minimum of one clinician facilitating the program for every six participants at any given time, with an additional facilitator to be in attendance for groups over six participants |  |
| Individual trauma-focussed therapy is provided by a Psychiatrist, Clinical Psychologist, Psychologist, Social Worker (mental health) or Occupational Therapist (mental health) that:   * has the relevant experience including competency in trauma-focussed therapy; * has the relevant qualifications, accreditation and national registration with relevant professional organisations; and * has competency in the evidence-based treatment/therapy type provided |  |
| Group facilitators must be either a Psychiatrist, Clinical Psychologist, Psychologist, Social Worker (mental health), Occupational Therapist (mental health) or Mental Health Nurse that:   * has the relevant experience including competency in trauma-focussed therapy; * has the relevant qualifications, accreditation and national registration with relevant professional organisations; * has experience in facilitating group programs[[9]](#footnote-9); and * demonstrates competency in delivering the content/modules comprising the group sessions |  |

* 1. As part of the discharge process, a comprehensive discharge plan is provided to the Entitled Person’s external treatment providers/referrers and includes:
* clinical assessment and treatment outcomes;
* risk assessment;
* ongoing treatment requirements; and
* referral to support services.

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| **Implementation Checklist** | **(Y/N)** |
| Participants are assisted with recovery plans and actively linked with ongoing clinical support, including accessing Open Arms Veterans and Families Counselling (Open Arms) if required at discharge |  |
| The discharge plan includes clinical assessment and treatment outcomes, risk assessment, ongoing treatment requirements, and referral to support services |  |
| The TRP service provides direct clinical contact with the referring agency on the participant’s treatment outcomes and the discharge plan |  |

* 1. Trauma Recovery Programs must implement processes and systems to manage the Entitled Person’s care journey, from referral into the service to post-discharge, including the opportunity to attend a group relapse prevention session 1 to 3 months post-discharge.

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| **Implementation Checklist** | **(Y/N)** |
| The TRP service responds to and prioritises all referrals according to risk, urgency, distress, dysfunction and disability |  |
| The participant must provide informed consent to participate in the program, noting that they are able to withdraw their consent at any time |  |
| The TRP service conducts regular clinical case reviews to monitor treatment progress, and to review treatment outcomes and modify treatment plans |  |
| Adverse events are reported to the appropriate authorities within the prescribed timeline. An adverse event includes:   * death of a participant while undertaking the TRP; * patient assault during TRP delivery requiring external involvement e.g. police, external emergency services; * an actual or near miss incident/complaint related to the TRP delivery with serious identified system issues; and/or * incidents related to the TRP which may result in media interest, internal or external investigation, mediation, penalties or compensation.   Further information is available in the Incident Management Guide at [www.safetyandquality.gov.au/sites/default/files/2021-12/incident\_management\_guide\_november\_2021.pdf](http://www.safetyandquality.gov.au/sites/default/files/2021-12/incident_management_guide_november_2021.pdf) |  |
| The TRP service offers a group relapse prevention session 1 to 3 months post-discharge that includes an opportunity for consolidation of key information from the program, and discussion of relapse prevention approaches |  |

* 1. Trauma Recovery Programs must offer appropriate information/resources and support to families and carers of Entitled Persons as part of the program (e.g. referral to external psycho-educational services; carer and or veteran co-joint groups; linkages to other agencies as necessary e.g. Housing, Open Arms).

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| **Implementation Checklist** | **(Y/N)** |
| Program information/resources explicitly identify how the program includes families and/or carers, and what the purposes and benefits of inclusion are |  |
| The TRP service actively invites families and/or carers to engage in the TRP |  |
| The TRP service helps families and/or carers to access external psycho-educational services that can help optimise their wellbeing |  |

* 1. Trauma Recovery Programs must implement systems to ensure compliance with DVA’s TRP data collection protocols at assessment and intake, discharge, and 3 and 9 months post-discharge follow-up (as amended from time to time).

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| **Implementation Checklist** | **(Y/N)** |
| The TRP service has an effective administrative system to manage data collection at specified time points |  |
| An administrator or liaison person is a contact point for Phoenix Australia, with responsibility for compliance with the program outcome monitoring requirements  Refer to ‘ADMINISTRATIVE SYSTEM’ below |  |
| Data is collected through:   * a clinician-administered assessment interview before the group program starts; * a brief clinician-completed questionnaire at end of group treatment; and * a veteran self-report questionnaire at four time points:   + before the group treatment starts   + after the group treatment ends   + 3 months after discharge   + 9 months after discharge   Refer to ‘CLINICAL SYSTEM’ below |  |
| Consent forms are returned to Phoenix Australia for all participants for whom data is collected  Refer to ‘OBTAIN INFORMED CONSENT TO PARTICIPATE IN THE CLINICAL DATA COLLECTION’ below |  |
| Protocols for data collection at the four time points are met  Refer to the following sections below:  ‘DATA COLLECTION AT ASSESSMENT AND INTAKE’  ‘DATA COLLECTION AT DISCHARGE’  ‘DATA COLLECTION 3 MONTHS POST-DISCHARGE’  ‘DATA COLLECTION 9 MONTHS POST-DISCHARGE’ |  |
| The TRP service aims to meet the following optimal return rates for data collection:   * Clinical assessment questionnaire (CA-PTSD) – 100% * Veteran intake questionnaire (VI-PTSD) – 90% * Clinical discharge questionnaire (CD-PTSD) – 100% * Veteran discharge questionnaire (VD-PTSD) – 90% * Veteran 3-month follow-up questionnaire (V3-PTSD) – 70% * Veteran 9-month follow-up questionnaire (V9 – PTSD) – 40% |  |
| Protocols for the return of clinical questionnaires are met  Refer to ‘CLINICAL QUESTIONNAIRE RETURN PROTOCOLS’ below |  |

**ADMINISTRATIVE SYSTEM**

1. **IDENTIFY/APPOINT AN ADMINISTRATOR** (or liaison person) as a point of contact for Phoenix Australia, who will be responsible for:

* Setting and retaining login details for their TRP website account ([www.phoenixtrp.org.au](http://www.phoenixtrp.org.au)) provided by Phoenix Australia and requesting accounts for any other staff members that require one.
* Generating a unique consecutive cohort number and Phoenix Australia ID number for each person participating in the cohort (please contact Phoenix Australia if you need to confirm the number you are up to).
* Tracking data, including:
  + Keeping a record of exactly which completed consents and questionnaires have been sent to Phoenix Australia.
  + Following up on outstanding questionnaires and sending them to Phoenix Australia, and/or accounting for outstanding questionnaires (e.g. because a veteran withdrew from the program) so this can be reported to Phoenix Australia.
* Completing the clinical data collection return form each time data is returned to Phoenix Australia.
* Informing Phoenix Australia of changes to the administrator's or liaison person’s contact details, and other relevant program changes by emailing [phoenix-data@unimelb.edu.au](mailto:phoenix-data@unimelb.edu.au).

**Important: The unique ID number for each person participating in the cohort needs to be entered onto all hard copy clinical data collection completed questionnaires.** This allows Phoenix Australia to track each person’s progress over time without them being identified.

1. **ESTABLISH THE TRAUMA RECOVERY PROGRAM GROUP**
2. **Assign the cohort number:** the administrator is to assign a cohort number to each TRP cohort. Since October 2014, each hospital’s cohorts have been numbered consecutively from 001.
3. **Allocate a unique participant ID number:** the administrator is to assign a unique participant ID number for all persons eligible to participate in the TRP clinical data collection. Since February 2024, participant ID numbers have been allocated consecutively, irrespective of whether the participant has completed a TRP previously. Each hospital has been provided with a participant ID to start their consecutive numbering.
4. **Inform Phoenix Australia of new cohort details:** Email Phoenix Australia at [phoenix-data@unimelb.edu.au](mailto:phoenix-data@unimelb.edu.au) before the start of the group program, and include the cohort number, proposed dates that the group will meet and number of veterans, current serving ADF personnel and other participants in the new cohort. This helps with data management.

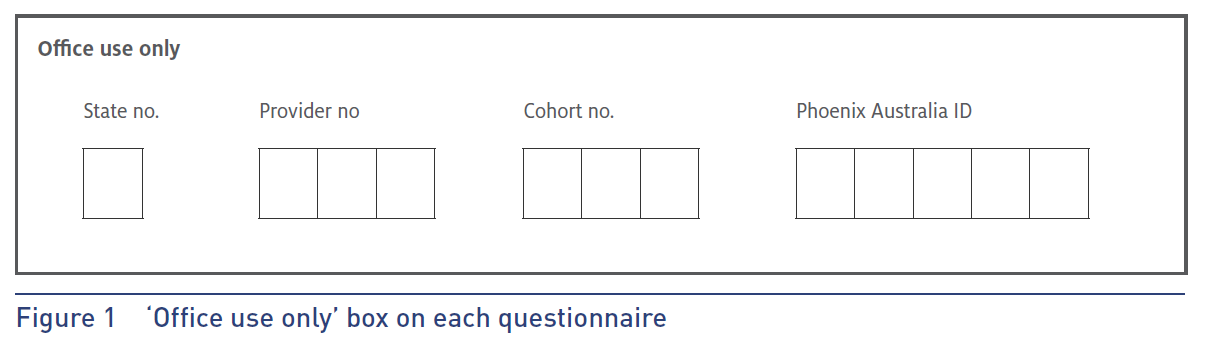
**CLINICAL SYSTEM**

TRP services and participants are to complete a series of participant and/or clinician questionnaires as part of the treatment protocols. Questionnaires can be printed and completed in hard copy.

All hard copy questionnaires have an ‘office use only’ box on the front page that must be completed (see Figure 1). This enables Phoenix Australia to link a participant’s responses across time in a way that does not identify them. Each TRP service is responsible for ensuring that participants and clinicians complete the relevant questionnaires at intake, at discharge, and at 3- and 9-months follow-up.

The questionnaires are available from the TRP website at [www.phoenixtrp.org.au](http://www.phoenixtrp.org.au)

* Clinical assessment questionnaire (CA-PTSD)
* Clinician-administered PTSD supplement (CAPS-5)
* Veteran intake questionnaire (VI-PTSD)
* Clinical discharge questionnaire (CD-PTSD)
* Veteran discharge questionnaire (VD-PTSD)
* Veteran 3-month follow-up questionnaire (V3-PTSD)
* Veteran 9-month follow-up questionnaire (V9-PTSD)



**OBTAIN INFORMED CONSENT TO PARTICIPATE IN THE CLINICAL DATA COLLECTION**

Before collecting data from the clinical assessments or related questionnaires, the clinician must obtain informed consent from the participant. This is a requirement of the DVA/Defence Human Research Ethics Committee approval (Protocol 828-16 & E096/002). **Please note, individuals who do not consent to participate in the clinical data collection are still able to participate in the TRP.**

When obtaining consent, be sure to emphasise the following to the participant:

* The information collected will be used to improve treatment for, and understanding of, mental health conditions in veterans, locally and nationally.
* Participation in the clinical data collection involves:
  + Completing questionnaires at the beginning of the program, at discharge and at the scheduled relapse prevention program at 3 months and 9 months post-discharge. These questionnaires include questions about quality of life, wellbeing, and health service use. Each will take approximately 20 minutes to complete.
  + Undergoing a clinical assessment including the clinician-administered PTSD scale (CAPS), alcohol use disorder identification test (AUDIT) and other questions about demographics and psychiatric and medical diagnoses with a clinician before starting the specialised PTSD treatment. This interview may take up to 90 minutes. The clinician will also provide information on the participant’s progress upon discharge from the program.
* The information will be kept in the strictest confidence by Phoenix Australia. Identifiable information will not be provided to DVA, and the participant’s results will not be used when determining pensions or any other compensation entitlement. Participants can withdraw their consent to provide clinical data at any time.
* Datasets maintained by Phoenix Australia will be kept in such a way that no individual can be identified.

Once participants have read and understood the consent form, and agreed to participate in the clinical data collection:

* Ask the participant to sign the consent form. The signed consent forms are returned to Phoenix Australia.
* Provide the participant with a copy of the consent form to keep.

**DATA COLLECTION AT ASSESSMENT AND INTAKE**

Before administering the CA-PTSD, clinicians should view the CAPS-5 demonstration videos and read the accompanying document, *Clinician-administered PTSD scale (CAPS-5) information booklet*. The videos and booklet are available online through the website ([www.phoenixtrp.org.au](http://www.phoenixtrp.org.au)).

The CA-PTSD must take place **within the 3 months** before the TRP starts[[10]](#footnote-10) [[11]](#footnote-11). If there is a delay of more than 3 months before the TRP starts, the CA-PTSD has to be completed again.

The CA-PTSD relates to diagnosis of PTSD and symptom severity and does not replace the need for a full clinical or intake assessment. A full clinical assessment will help identify any comorbid issues and assess the veteran’s suitability for the program.

The clinician administering the CA-PTSD will need:

* The CA-PTSD, which needs to be sent to Phoenix Australia once completed; and
* The CAPS-5, which is a supplement to the CA-PTSD and can be kept in the medical files for clinical purposes – **do not return it to Phoenix Australia**.

The clinician needs to:

* Administer the CA-PTSD (demographics, psychiatric and medical diagnoses and AUDIT)
* Administer the CAPS-5 CA-PTSD supplement
  + Score the CAPS-5 using the CAPS scoring sheet at the end of the CA-PTSD supplement, and transfer the summary scores and diagnoses to the CA-PTSD
* Return the hard copy CA-PTSD to Phoenix Australia once is has been completed with the CAPS scores
* Administer the VI-PTSD at the start of the TRP (e.g. at the first group session)

**DATA COLLECTION AT DISCHARGE**

The clinician must complete the CD-PTSD within 1 week of the end of the TRP. Do not complete this in the presence of the participant.

The participant must complete the VD-PTSD at the end of the TRP (e.g. at the end of the final group session).

Individual therapy may continue past the completion of the group program, and these changes in mental health and wellbeing will be picked up in the 3-month post-discharge assessment.

**DATA COLLECTION 3 MONTHS POST-DISCHARGE**

The 3-month follow-up questionnaire is to be administered 3 months post-discharge. This can be administered when the cohort is recalled for a group relapse prevention session if it occurs approximately 3 months post-discharge.

The TRP service may choose to (1) mail the questionnaire to the participants, so they can complete it and then return it on the follow-up day; or (2) administer the questionnaires during the follow-up day.

If a participant does not attend, they need to be sent the 3-month follow-up questionnaire (if they have not already), and any questionnaires that are not returned need to be followed-up.

**DATA COLLECTION 9 MONTHS POST-DISCHARGE**

A group session at 9 months post-discharge is not required.

Each TRP service is responsible for sending out the 9-month follow-up questionnaire to all participants in the cohort, and following up any questionnaires that are not completed and returned.

**CLINICAL QUESTIONNAIRE RETURN PROTOCOLS**

The clinical data collection returns form must be completed when sending hard copy consent forms and questionnaires at all required time points to Phoenix Australia. The TRP service is to use a separate form for each cohort.

The information required for the form is:

* Name of the service
* Date cohort started
* Number of veterans, serving ADF personnel and other participants, and the total number in the group
* Codes for state, provider and cohort number
* Each participant’s Phoenix Australia ID number, regardless of whether their questionnaire is included in the package
* Boxes ticked to indicate which questionnaires and/or consent forms are included in the package being sent to Phoenix Australia
* Reason for any missing assessments (e.g. did not consent to participate in the clinical data collection, treatment dropout due to ill health)

The postal address to return hard copy clinical data collection forms to Phoenix Australia is:

**Phoenix Australia**

**TRP Clinical Data Collection**

**PO Box 562**

**Mitcham Shopping Centre SA 5062**

This address is also listed on the clinical data collection return form.

**Ensure that:**

* **Participants’ consent forms are not posted in the same envelope as their questionnaires**

## Reporting requirements

*Hospitals delivering Trauma Recovery Programs must submit an annual Program Report to DVA and comply with Phoenix Australia’s annual data audit (This is separate to the ‘Private Hospital Quality Report’ requesting information on each hospital’s contract and accreditation status).*

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| --- | --- |
| **Examples for implementation** | **Checklist (Y/N)** |
| The TRP is reviewed regularly and a Program Report is submitted to DVA annually. The ‘Program Report’ template is available on the next page |  |
| Program improvements/adjustments to better meet the needs of participants, should consider participant feedback and/or data analysis reports provided by Phoenix Australia |  |
| The TRP service complies with Phoenix Australia’s annual data audit  Refer to ‘ANNUAL DATA AUDIT’ below |  |

**ANNUAL DATA AUDIT**

The TRP service is required to comply with Phoenix Australia’s audit by completing and sending the TRP-PTSD clinical data collection data audit form to [phoenix-data@unimelb.edu.au](mailto:phoenix-data@unimelb.edu.au) when requested. Details include:

* Cohort number
* Total number of group participants
* Number of veterans and serving ADF personnel
* Number of questionnaires sent
* Reason for missing data

Where there are any discrepancies in the data, Phoenix Australia will notify and work with the administrator so that the issues can be resolved.

|  |  |
| --- | --- |
| **Trauma Recovery Program (TRP) – Program Report** | |
| **Name of Hospital:** | |
| **Reporting Period: 20xx** | |
| **Program information (Information can be included as an attachment)** | |
| 1. **Title of TRP** |  |
| 1. **Target population** |  |
| 1. **Target cohort numbers**   [Noting research evidence that optimal group size is 5-9, please provide clinical justification for larger group sizes and specify whether additional facilitator/s will be present] | \_\_\_\_  OR  \_\_\_\_ to ­­­­\_\_\_\_ (range) |
| 1. **Number of group programs per year** |  |
| 1. **Specify the aims and expected outcomes of the TRP** |  |
| 1. **Program format**  |  |  | | --- | --- | | **Mode of treatment** | Face-to-face  Online  Combination/Hybrid | | Total number of days  Total number of weeks  Number of days per week  Number of treatment hours per treatment day  Total number of treatment hours | \_\_\_\_\_ days  \_\_\_\_\_ weeks  \_\_\_\_\_ days per week  \_\_\_\_\_ treatment hours per treatment day  = \_\_\_\_\_ total treatment hours[[12]](#footnote-12) |   The above totals:  Include individual treatment  OR  Exclude individual treatment | |
| 1. **Program design: Individual component** | **Individual treatment is offered to participants:**  More than once per week  Weekly  Fortnightly  Monthly  Once during the program  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **The following treatments are used in the individual component:**  Trauma-focused cognitive behavioural therapy (with prolonged exposure)  Trauma-focused cognitive behavioural therapy (without prolonged exposure)  Cognitive processing therapy  Eye movement desensitisation and reprocessing  Cognitive behavioural therapy  Interpersonal therapy  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **Program design: Group component** | **The group component includes:**  Cognitive behavioural therapy  Interpersonal therapy  Psychoeducation  Symptom management  Skills acquisition  Skills practice  Relapse prevention  Family / partner day(s)  Group excursions  Linkages to other services  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **The group sessions cover:**  PTSD  Anxiety  Depression  Anger  Addictions / substance use  Sleep  Relationships / interpersonal skills  Vocational rehabilitation  Physical health and lifestyle  Moral injury  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **Timetable** | *Please provide a timetable, detailing the topic/focus of each session and the facilitator/s for each session* |
| 1. **Clinical Processes**   Please include information on:   * Intake and assessment procedures * The discharge process including provision of a discharge plan:  1. clinical assessment and treatment outcomes; 2. risk assessment; 3. ongoing treatment requirements; and 4. referral to support services  * Whether processes and systems are in place to ensure Entitled Persons have the opportunity to attend a group relapse prevention session 1 to 3 months post-discharge |  |
| **Workforce** | |
| 1. **Clinical workforce** **and staffing capacity**   Please provide a list of all staff involved in program delivery (including Clinical Director, lead facilitator, co-facilitator/s, individual trauma-focussed therapist/s) in the table below   |  |  |  |  | | --- | --- | --- | --- | | **Name** | **Clinical Role (e.g. Clinical Psychologist)** | **Mental Health and other Qualifications [including qualifications in evidence-based treatment] (e.g. Master of Applied Psychology, Dip Ed TF-CBT)** | **Role in Program** | |  |  |  | Clinical Director | |  |  |  | Lead facilitator | |  |  |  | Co-facilitator | |  |  |  | Individual trauma-focussed therapist |  * All clinical staff are trained to deliver evidence-based treatment consistent with the *Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD (Phoenix Australia, 2020)),* [www.phoenixaustralia.org/australian-guidelines-for-ptsd/](http://www.phoenixaustralia.org/australian-guidelines-for-ptsd/) * The Clinical Director of the TRP must be a Psychiatrist or Clinical Psychologist * Individual trauma-focussed therapy is provided by a Psychiatrist, Clinical Psychologist, Psychologist, Social Worker (mental health) or Occupational Therapist (mental health) that:   + has the relevant experience including competency in trauma-focussed therapy;   + has the relevant qualifications, accreditation and national registration with relevant professional organisations; and   + has competency in the evidence-based treatment/therapy type provided * Group facilitators must be either a Psychiatrist, Clinical Psychologist, Psychologist, Social Worker (mental health), Occupational Therapist (mental health) or Mental Health Nurse that:   + has the relevant experience including competency in trauma-focussed therapy;   + has the relevant qualifications, accreditation and national registration with relevant professional organisations;   + has experience in facilitating group programs; and   + demonstrates competency in delivering the content/modules comprising the group sessions | |
| 1. **Staffing changes**   Have there been any staffing changes this reporting period? If so, please provide processes for handover of TRP knowledge following staff turnover | Yes – Please advise of changes  No |
| **Quality Assurance** | |
| 1. **Program improvements**   During this reporting period, have any improvements/adjustments been made to the TRP to better meet the needs of participants?  *These can be based on participant feedback and/or the annual data analysis reports provided by Phoenix Australia.* | Yes – Please list  No |
| **Complaints and Feedback** | |
| 1. Have you received any feedback from participants in relation to the TRP this reporting period? | Yes – Please list  No |
| 1. Have you received any complaints from participants in relation to the TRP this reporting period? | Yes – Please list  No |
| 1. Please include any feedback or issues that you would like to raise with DVA |  |
| **Contact Details** | |
| Contact person 1  Name:  Title:  Phone number:  Email:  Contact person 2  Name:  Title:  Phone number:  Email: | |
| **Signature of authorised representative**  Name and position: ………………………………………………………………………………………………………………………………  Signature: ………………………………………….…………………. Date: ………/………../………… | |

# **SECTION 2: BEST-PRACTICE GUIDANCE**

This section highlights best-practice guidance for improving the quality of services to participants and provides advice on how best-practice can be obtained. TRP services are not contractually required to implement or report on compliance with these guidelines to DVA (noting this is independent of any requirements associated with TRP service accreditation).

**PROGRAM GOVERNANCE**

* A well-documented and consistently implemented risk assessment and risk management protocol is available
* The TRP service has clinical and administrative processes that are clearly spelt out for staff and, where appropriate, for participants
* Regular audit of clinical records by the TRP service indicates the use of evidence-based treatments
* Regular audit of treatment plans by the TRP service indicates that veterans are provided with information to make decisions based on the best available evidence
* The TRP service has documented records of referrals, and ongoing communication with external services
* The TRP service conducts thorough handover processes regarding all aspects of TRP delivery when there are staff changes
* The TRP service engages in activities that support links with key external services (i.e. attendance at external provider meetings, agency orientations, shared professional development activities)
* The TRP service engages in the DVA/Phoenix Australia Community of Practice

**INFORMATION PROVISION**

* Participants, their families and/or carers can access information that clearly describes the program and addresses frequently asked questions
* Program information that clearly articulates any options that participants have for accessing flexible treatment times is provided, including any after-hours or weekend access
* Information is provided to participants about self-care resources, programs or interventions at appropriate stages of the program
* The TRP service ensures the program information/manual is up to date, accurate and accessible (hard copy and online)
* Online information can be accessed from a variety of browsers and across different operating system platforms and meets relevant online accessibility requirements (i.e. they are compliant with current Web Content Accessibility Guidelines [WCAG])

**PROGRAM ACCESSIBILITY**

* The entry process to the program is clearly documented, including the inclusion and exclusion criteria, and is available to referrers and participants
* The TRP service actively engages with potential referrers to the program and with organisations that cater to DVA’s target TRP population, which is entitled persons with diagnosed PTSD
* The TRP service has an understanding of the wait time for access to the program (average and maximum), and communicates this to potential participants
* Systems are in place to meet expected and unexpected spikes in demand, and ensure timely access to the program
* Systems are in place to ensure that individuals on wait lists are monitored and provided with suitable advice about their enrolment in the TRP (i.e. contact records, provision of preparatory individual therapy and referral to an alternative TRP)
* Individuals are informed about alternative treatment options, and are assisted in making decisions about program suitability
* If alternative treatments will be sought, a system is in place to effect referrals to other TRP services, hospital facilities, or community-based providers

**PROGRAM PROCEDURES**

* Systems are in place to ensure that any preparatory individual therapy is consistent with the individual’s presenting needs and consistent with the TRP goals and content
* Consideration is given to flexible program delivery e.g. providing programs or program components on weekends, or condensing them into shorter blocks to account for participants with work or care commitments
* If the TRP service does not provide access to 24-hour acute care, information on how to access 24-hour, non-TRP acute care services is provided to the participant and their carer(s)

**SERVICE IMPROVEMENTS**

* Quality improvement activities and program evaluation activities are in place. This includes, but is not restricted to, participation in the TRP Clinical Data Collection processes
* A system is in place for documenting the effectiveness of the program, including clinical outcomes
* The TRP service uses clinical outcome data, to improve performance in delivering care and services
* Regular reports are provided to management/clinical workforce on the qualitative and quantitative outcomes of the program, including recommendations for quality improvement
* Improvement activities have been implemented and evaluated to maximise quality of care

**STAFFING**

* The TRP service has a documented staff induction/orientation policy and/or manual
* Regular clinical case meetings and clinical supervision is available to staff, on either an individual or a group basis
* A process is in place for regularly reviewing the performance and professional development goals of each clinician
* Staff are provided with opportunities for engaging in professional development activities and maintaining currency with best-practice approaches

**OBTAIN INFORMED CONSENT TO PARTICIPATE IN THE TRP**

* Potential participants and their carer(s) can attend information sessions before the program starts
* Processes are in place to ensure that the reasons for involvement of a carer(s) are made clear to all parties before obtaining consent for inclusion or participation
* Clinical records have copies of signed consent forms from participants and carer(s), including consent to participate in the clinical data collection

**INTAKE AND ASSESSMENT**

* The TRP service has clinical records that show nominated next of kin or carer details and their involvement in treatment
* Participants and their carer(s) (if applicable) understand their rights and responsibilities (e.g. through the intake process/interviews)
* The TRP service ensures that a coordinating clinician is allocated to each participant at intake, which is documented and made known to the participant and their carer(s) (if applicable)
* The TRP service facilitates access to alternative care for individuals not accepted by the service
* Participants and their carer(s) (if applicable) are involved in the development of their treatment, care and recovery plans
* The treatment plan assesses the participant’s current level of self-care and identifies specific skills for development
* The participant and their carer(s) (if applicable) have received a copy of the current treatment plan, and steps have been taken to ensure that the content of the treatment plan is understood by them
* The TRP service routinely includes carers (if applicable) and external treatment providers in the participant’s treatment

**DURING TREATMENT**

* Action is taken to reduce safety risks and improve the quality of care for participants, including conducting regular risk assessments throughout the program
* Treatment plans are updated to indicate interventions offered in response to changes in clinical need
* Individual therapy sessions are provided during the program at times agreed with the participant
* Group sessions should comprise at a minimum:
  + psycho-education
  + symptom management and skills training (including practice exercises and reinforcement of learning)
  + information and links to community-based support services, including Open Arms
* As a guide, the number of sessions for ‘symptom management and skills training’ in relation to PTSD and common comorbid problems:
  + PTSD (8 sessions)
  + anxiety (8 sessions)
  + depression (8 sessions)
  + anger (8 sessions)
  + addictions, including alcohol and other drugs (6 sessions)
  + sleep (4 sessions)
* As a guide, the number of group sessions for ‘information and links’:
  + one group session on the importance of support following discharge from the TRP and links to community-based support. This could include inviting representatives from Open Arms and community services to present at the TRP and/or organise a site visit
* As a minimum, group sessions should ensure that participants understand:
  + what the symptoms are
  + the frequency of their symptoms and triggers
  + symptom management
* The TRP service reviews the participant’s treatment plan when the participant:
  + requests a review
  + declines treatment and support
  + is at significant risk of injury to themselves or another person
  + is going to exit the program
  + is observed to be deteriorating in mental state or functioning
* The TRP service engages with relevant clinicians or services at critical points throughout the program, to ensure continuity of care
* The TRP service actively engages with participants in accessing vocational, educational and training opportunities, and a vocational, education and training officer is available to provide this service as requested
* The TRP service engages with key defence and veteran services (ADF mental health, Open Arms), and Ex-Service Organisations at key stages in the participants' involvement in the program
* The TRP service evaluates effectiveness of the intervention and outcomes with the participant before discharge

**POST TREATMENT**

* The TRP service facilitates and documents referral and ongoing communication with external services
* The TRP service facilitates access to recovery-focused services, vocational support systems, and education and employment programs post-discharge
* Referral to relevant programs or interventions, with follow-up if indicated, is in clinical records

1. https://www.phoenixaustralia.org/australian-guidelines-for-ptsd/ [↑](#footnote-ref-1)
2. Cosio (2015). Replication of a cognitive behavioral therapy for chronic pain group protocol by therapists in training. Postgraduate Medicine, 127(2), 242–250. [↑](#footnote-ref-2)
3. Burlingame, G. M., McClendon, D. T., & Yang, C. (2018). Cohesion in group therapy: A meta-analysis. *Psychotherapy*, *55*(4), 384. [↑](#footnote-ref-3)
4. Phelps, A. J., Lethbridge, R., Brennan, S., Bryant, R. A., Burns, P., Cooper, J. A., Forbes, D., Gardiner, J., Gee, G., Jones, K., Kenardy, J., Kulkarni, J., McDermott, B., McFarlane, A. C., Newman, L., Varker, T., Worth, C., & Silove, D. (2022). Australian guidelines for the prevention and treatment of posttraumatic stress disorder: Updates in the third edition. *Australian & New Zealand Journal of Psychiatry*, *56*(3), 230–247. <https://doi.org/10.1177/00048674211041917> [↑](#footnote-ref-4)
5. Haagen, J. F. G., Smid, G. E., Knipscheer, J. W., & Kleber, R. J. (2015). The efficacy of recommended treatments for veterans with PTSD: A metaregression analysis. *Clinical Psychology Review*, *40*, 184–194. <https://doi.org/10.1016/j.cpr.2015.06.008> [↑](#footnote-ref-5)
6. https://www.phoenixaustralia.org/australian-guidelines-for-ptsd/ [↑](#footnote-ref-6)
7. Treichler et al 2023 Military culture and collaborative decision-making in mental healthcare: cultural, communication and policy considerations. BJPsych Open. 2023 Aug 14;9(5):e154. doi: 10.1192/bjo.2023.516. PMID: 37578050; PMCID: PMC10486237. [↑](#footnote-ref-7)
8. Herzog, J. R., Whitworth, J. D., & Scott, D. L. (2019). Trauma informed care with military populations. *Journal of Human Behavior in the Social Environment*, *30*(3), 265–278. https://doi.org/10.1080/10911359.2019.1679693 [↑](#footnote-ref-8)
9. Finch et al 2020 A systematic review of the clinician related barriers and facilitators to the use of evidence-informed interventions for post traumatic stress, Journal of Affective Disorders, Volume 263, 2020, Pages 175-186,ISSN 0165-0327, <https://doi.org/10.1016/j.jad.2019.11.143>. [↑](#footnote-ref-9)
10. The CAPS-5 assessment is considered current for one month. However, for practical reasons when used within the TRP CA-PTSD assessment, the acceptable time period has been extended to “within 3-months” noting that the reliability of the assessment decreases as time passes. [↑](#footnote-ref-10)
11. Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013). The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). [Assessment] Available from www.ptsd.va.gov. [↑](#footnote-ref-11)
12. DVA must be advised of any proposed change to total number of contact hours [↑](#footnote-ref-12)