



DIRECTOR–GENERAL DEFENCE HEALTH SERVICE

HEALTH BULLETIN NO 12/2003

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19 AUGUST 2003

CRITICAL INCIDENT MENTAL HEALTH SUPPORT PROGRAM

INTRODUCTION

1. A crisis or traumatic event that has a stressful impact sufficient to overwhelm the usually effective coping skills of either an individual or a group is known as a 'critical incident' (CI) or 'potentially traumatising event' (PTE). These incidents are typically sudden and powerful events outside the range of ordinary human experiences, and can overwhelm even well trained and experienced people, either at the time or later on.

2. Due to the nature of Australian Defence Force (ADF) work and training, the likelihood of personnel being involved in a CI or PTE, both in peacetime and during operations, is greater than in most civilian occupations. The provision of Critical Incident Mental Health Support (CMS) is therefore a fundamental part of the ADF's recognition of, and response to, such incidents. CMS is also part of a broad suite of responses that can be provided in an operational area; Australian Defence Force Publication 714—*Operational Stress Management* provides a more complete description of the types of responses that can be provided in the operational environment.

3. CMS refers to a process of intervention with individuals who have been involved, either directly or indirectly, in a CI or PTE. CMS is a mental health initiative that sits within a broad framework that aims to promote strategies for individuals and groups to mitigate and alleviate possible psychological injuries following a CI or PTE. CMS is designed to bolster personal resources in order for personnel to maintain performance throughout incidents, or to return to duty and perform to their full capacity as quickly as possible.

4. Stress management is a command responsibility, but specialist assets are available to commanders to assist them in the maintenance of the mental health of their personnel. CMS is designed to augment existing personnel support services.

AIM

5. The aim of this Health Bulletin (HB) is to detail the ADF policy for the management of personnel involved in CI or PTE. In an operational context, this Bulletin should be read in conjunction with the HB—*Mental Health Support to Operationally Deployed Forces*. This HB will become a Defence Instruction (General).

DEFINITIONS

6. For the purpose of this HB, the following definitions apply:

- a. **Critical Incident (CI).** A CI is an incident that can both evoke unusually strong emotional reactions and have the potential to interfere with the ability of personnel to function appropriately. These incidents are outside the range of usual experience and may include, but are not restricted to, traumatic events. It is the unique context in which incidents occur, and the potential for strong negatively perceived emotional reactions by personnel involved, that determine whether incidents are critical. An example of a CI could be where a suicide has occurred and the workplace or deceased person's friends are strongly and negatively impacted by the death.

- b. **Potentially Traumatic Event (PTE).** A PTE usually involves personnel having experienced, witnessed, or being confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. An incident is only considered traumatic if the reactions of the personnel included intense fear, helplessness and horror. An example of a PTE could be where a person finds the body of someone who has suicided.
- c. **Mental Health Professional.** The term Mental Health Professional is applied to the following Defence employed or contracted personnel who provide mental health services to ADF personnel on behalf of the ADF:
 - (1) medical officers, including specialist psychiatrists;
 - (2) nursing officers;
 - (3) psychologists;
 - (4) social workers; and
 - (5) chaplains.
- d. **CMS Team.** A specifically trained and formed team that is capable of complementing local resources in the provision of specialist services following a CI or PTE. The CMS Team Leader will, in most cases, be a psychologist; however, in locations where a psychologist is unavailable, the Team Leader will be the most senior CMS provider available. Director Defence Force Psychology Organisation (DFPO), will nominate all Team Leaders.
- e. **Levels of service providers.** The CMS framework is multidisciplinary, and involves layers of CMS providers based on their professional background and level of CMS training. Descriptions of levels of service provision can be found in [annex A](#) to this HB.

MANAGEMENT OF CRITICAL INCIDENT MENTAL HEALTH SUPPORT IN THE AUSTRALIAN DEFENCE FORCE

- 7. Director DFPO is responsible for coordinating tri-Service CMS management, which includes:
 - a. policy;
 - b. training development, delivery and accreditation;
 - c. availability of trained personnel;
 - d. operations;
 - e. funding and resources allocation; and
 - f. quality assurance.

OVERVIEW OF CRITICAL INCIDENT MENTAL HEALTH SUPPORT FRAMEWORK

- 8. The major elements of the ADF CMS framework are:
 - a. preincident education and preparation for personnel management aspects of CI or PTE;
 - b. assessment of the potential impact of a CI or PTE upon the effectiveness and efficiency of individuals and military units;
 - c. psychological first aid for those with acute psychological injuries;
 - d. mental health surveillance and case identification of those considered at risk of developing chronic psychological injuries;
 - e. appropriate treatment or referral for those displaying early signs of potential chronic psychological injuries, with the aim of preventing development into chronic conditions;

- f. education aimed at:
 - (1) improving self-management, both at unit and individual levels, following a CI or PTE;
 - (2) assisting self-identification and self-referral for personnel at risk of developing psychological injuries; and
 - (3) maximising treatment/management acceptance, compliance and effectiveness.
 - g. awareness programs on stress and psychological injuries following CI or PTE;
 - h. provision of formally trained CMS Teams to supplement local resources; and
 - i. support for spouses and families.
9. The major principles of ADF CMS are:
- a. strong engagement and consultancy with command at all levels during all stages of CMS delivery;
 - b. recognition that unit members have a significant part to play in the successful management of a CI or PTE, and that individual service members are responsible for making a positive contribution to their own mental health;
 - c. provision of a flexible, multidisciplinary approach to mental health promotion and maintenance, and to deliver effective early mental health interventions following a CI or PTE;
 - d. effective management of chronic post-traumatic pathology (this involves early case identification and treatment of acute conditions); and
 - e. maximising resilience through effective social support and appropriately indicated and targeted prevention strategies.
10. Whilst CMS is based upon an assumption of normal recovery for the majority of individuals following the majority of events, CMS provides for immediate interventions based around containment of symptoms and support of the individual, as well as referral for psychological or psychiatric treatment when indicated.
11. CMS provides a flexible phased structure designed to allow the CMS provider (in conjunction with command) to select and implement CMS interventions according to the circumstances of the personnel, the unit and the event. A full description of each CMS phase is contained in [annex B](#).
12. Although CMS is an ADF framework, there will be potentially traumatising or critical incidents that include ADO civilians, families and the general community. The guidelines for such groups are contained in [annex B](#). Reservists should be included in all stages of CMS for any event that has occurred in relation to their military service.

CRITICAL INCIDENT MENTAL HEALTH SUPPORT TEAM MEMBERS

13. Although technical management of CMS is vested in the Director DFPO, any Defence employed personnel who has undertaken appropriate ADF CMS training can be employed in CMS activities according to subparagraph 5.e.
14. The aim is for each Defence area or unit to have access to an appropriately trained CMS Team. CMS support to establishments and bases will be coordinated by Regional Mental Health Teams (RMHT), and CMS support to deployed units will be coordinated from command specific CMS Teams. Each region has a RMHT, and a member of that RMHT is a regional CMS coordinator (appointed by Director DFPO). The CMS coordinator, with the remainder of the RMHT, facilitates delivery and integration of CMS services within their area of responsibility. It is recognised some areas will have limited personnel, and that some of those CMS trained personnel may be personally involved in an incident. When this is the case, DFPO staff can, through liaison with the local CMS provider and other areas of command, assist in allocating assets from other regions.

CRITICAL INCIDENT MENTAL HEALTH SUPPORT TEAM LEADER RESPONSIBILITIES

15. The CMS Team leader for each region is appointed by the Director DFPO, in consultation with other CMS stakeholders. The CMS Team leader has the following responsibilities:

- a. Development and coordination of a local CMS plan in conjunction with other regional mental health assets and command.
- b. Integrating and maintaining CMS planning in local area emergency planning.
- c. CMS plans are to be revised annually and staffed through Director DFPO for inclusion in the national plan.
- d. When approved by Director DFPO, plans are to be promulgated to all units within the local area.
- e. Developing, training and exercising CMS teams to maintain preparedness. There is to be an annual exercise of CMS procedures in each area.
- f. Establishing and maintaining local access, callout and operational arrangements (for working hours and out-of-hours).
- g. Promoting CMS and wider mental health education and awareness.

CRITICAL INCIDENT MENTAL HEALTH SUPPORT TEAM FUNCTIONS AND ROLES

16. The roles and functions of CMS teams are:

- a. to work in conjunction with RMHT to prepare Service personnel to manage their stress and understand the range of normal responses to a CI or PTE (this is part of mental health literacy); and
- b. to assist Service personnel who are experiencing the negative or debilitating effects of exposure to a CI or PTE. This includes liaison and consultancy with Command, the delivery of an appropriate CMS response and referral to other service providers as necessary.

ACTIVATION OF CRITICAL INCIDENT MENTAL HEALTH SUPPORT TEAM

17. The single Services are responsible for establishing call-out procedures appropriate to their single Service needs. However, in general, CMS teams will be activated following a request from a Commanding Officer (CO) or delegate, or on occasion by higher authority and on approval from the appropriate headquarters. Requests for CMS activation should be made directly to the regional CMS coordinator or their representative. Requests for CMS responses should be recognised as only one aspect of appropriate management of personnel in times of high demand on personal and personnel resources. Activation should normally occur as soon as practicable after the incident, usually in the first day following an incident. Where possible, notification of possible call-out should be considered to allow CMS personnel to be placed on standby, and to commence preliminary activity arrangements. The following incidents are offered as a guide to when activation should be considered:

- a. line of duty and non-duty death;
- b. rescue and casualty incidents involving exposure to gruesome sights, including body recovery etc;
- c. significant events where there is personal identification with victims and their circumstances;
- d. training accidents and 'near misses';
- e. prolonged involvement in incidents or activities with potential danger;

- f. overseas deployments which involve critical incidents, eg accidents/incidents in ships/units/formations on deployment;
- g. natural disasters; and
- h. any combination of the above or any incidents deemed by a CO, or delegate, to be critical or potentially traumatic, or to have a potentially significant negative effect on personnel.

Where doubt exists as to the requirement of a CMS intervention, consultancy with CMS providers is strongly recommended.

18. Documentation to be completed for call out is in [annex C](#).

CRITICAL INCIDENT MENTAL HEALTH SUPPORT EDUCATION AND TRAINING

19. **Training sponsor.** The training sponsor for all CMS training is Director DFPO. All CMS training is to be undertaken according to DFPO training guidelines, with only DFPO accredited trainers delivering such training. Director DFPO is therefore responsible for both training and accreditation.

20. **General.** There are three types of training relevant to the CMS program:

- a. enhanced general mental health literacy for the ADF population;
- b. CMS awareness training; and
- c. specialist CMS program training.

21. **Enhanced mental health literacy.** This is a primary aim of the ADF Mental Health Strategy and encompasses ongoing awareness training for all members. Education can include:

- a. stress identification and management education;
- b. the nature of a CI or PTE, and its potential impact on family and/or friends;
- c. substance misuse education;
- d. general health promotion education; and
- e. suicide awareness and risk education.

22. **CMS awareness training.** CMS awareness training will be provided to all ADF members throughout their Service career. This training will be conducted by suitably CMS qualified and trained ADO mental health professionals. It is to cover a summary of CMS policy, principles and procedures and will be provided to the following courses:

- a. all initial entry officer training courses;
- b. promotion courses for Leading Seaman (E) and above;
- c. single Service command and precommand courses;
- d. tri-Service Command and Staff training;
- e. medical assistant and psychological examiner courses; and
- f. other courses and ad hoc training as requested.

23. **Specialist CMS program training.** Specialist CMS training is provided under the auspices of Directorate of Mental Health (DMH), with course content and administration under the technical control of Director DFPO. Training will be delivered by suitably qualified and trained ADO mental health professionals and will cover two distinct areas:

- a. **CMS Skills Course.** This course will develop the skills necessary for selected ADF personnel to operate as members of a CMS team (that is, Level 2/3 CMS providers). This includes Critical Incident Stress Management Advisors, and other selected military personnel (Advanced Medical Assistants, experienced Psychological Examiners).
- b. **CMS Provider Training.** This course of three days duration is provided for mental health professionals to qualify them as Level 4 CMS providers. Train the Trainer Courses are sponsored by DMH and aim at increasing the pool of CMS trainers, such that regions can be responsible for identifying and managing their own training needs. Update training will also be available for CMS providers.

24. The **Traumatic Stress Syndromes Course** is a course of advanced training and will be provided to selected mental health professionals. This course is run in conjunction with the Australian Centre for Post-traumatic Mental Health.

25. Ongoing individual skills enhancement is also encouraged, as is attendance at selected conferences and workshops facilitated.

26. All chaplains should undertake at least the Level 2/3 CMS Skills Course, and are encouraged to also complete the Level 4 CMS Provider Course.

BOARDS OF INQUIRY

27. Critical incidents often result in the requirement for a formal investigation or Board of Inquiry (BOI). CMS providers should take active steps to control any discussion in interventions that could obviously jeopardise the quality of information available to an investigation or BOI, and display flexibility in timing and choice of interventions, to avoid or minimise any potential for contamination of evidence. However, CMS activities may alleviate distress for personnel and therefore appropriate mental health management of personnel should not be unduly delayed by the requirements of investigations.

REPORTING AND RECORDING

28. Whenever a CMS intervention has been applied, formal reporting/recording must take effect. The content, dispersal and management of these reports is covered in CMS provider training.

FAMILY SUPPORT

29. The ADF recognises that critical incidents will often impact family members of those involved. Therefore, the ADF is committed to providing support services to families. This response will normally be undertaken and coordinated by the Defence Community Organisation, but should include close liaison with CMS providers.

CONCLUSION

30. This HB outlines a framework that is considered to be consistent with current best practice guidelines within the management of psychological trauma. The CMS framework also provides a mechanism whereby standardised training and interventions can be conducted to assist in enhancing the effectiveness of the ADF response to critical incidents and potentially traumatising events.



T.K. AUSTIN
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Director-General Defence Health Service

Annexes:

- A. [Levels of Critical Incident Mental Health Support Service Providers](#)
- B. [Critical Incident Mental Health Support Phases](#)
- C. [Critical Incident Mental Health Support Call-Out Form](#)

DISTRIBUTION: DHS

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EARLIER HEALTH BULLETIN CANCELLED: Nil

LEVELS OF CRITICAL INCIDENT MENTAL HEALTH SUPPORT SERVICE PROVIDERS

1. For the purpose of this Health Bulletin the following Critical Incident Mental Health Support (CMS) levels apply:
 - a. **Level One—Mental Health Literacy.** Individual Australian Defence Force (ADF) personnel have primary responsibility for their own mental health. ADF members and their commanders will be provided with education to assist with mental health self-care and the care of others. Specialist CMS awareness training will be provided to all ranks.
 - b. **Level Two—Primary Referral or Identification.** At this level are personnel with basic CMS awareness training. This level recognises that some trained non-mental health professionals at the scene of a CI or PTE are often in the best position to:
 - (1) identify personnel experiencing mental health problems,
 - (2) advocate for such personnel,
 - (3) facilitate access to appropriate referral sources,
 - (4) provide unit liaison with CMS Teams, and
 - (5) provide appropriate basic CMS advice to both command and personnel.
 - c. This level can include Senior Medical Assistants, Psychological Examiners, Chaplains, Nurses, Military Liaison Officers, and trained CMS advisers.
 - d. **Level Three—Psycho-education and Basic Prevention.** At this level are non-mental health personnel with basic mental health management skills. In addition to the services of Level 2 providers, Level 3 providers undertake basic psycho-education, prevention, psychological first-aid, and assist higher level providers in facilitating more specialised CMS interventions (including screening of personnel). This level includes appropriately trained Senior Medical Assistants and Psychological Examiners, Chaplains, and Nursing Officers.
 - e. **Level Four—Primary Mental Health Care by generalist mental health professionals.** Level 4 providers work in CMS Teams to deliver CMS specific interventions (including psychological first aid, screening, assessment and referral as required), supervision of lower level providers and, when accredited, provide CMS training. This level health and mental health personnel with professional (tertiary) qualifications, but not necessarily with specialist skills or great experience in trauma management (ie medical practitioners, psychologists, social workers and some nursing and chaplaincy staff).
 - f. **Level Five—Secondary Mental Health Care.** This level recognises that specialist skills, training and experience may be required to effectively diagnose, treat and manage trauma responses. The aim is to prevent or minimise the possible long term debilitating effect of trauma. Within the ADF, psychiatrists, and senior psychologists, nursing officers, medical practitioners and social workers who have clinical mental health training, provide this level of service. These providers also assist and support the Level 2, 3 and 4 providers.
 - g. **Level Six—Tertiary Mental Health Care.** This level recognises the need for professionals with specialist clinical skills and qualifications to deal with more complex and severe mental health issues following trauma, and to provide clinical supervision to other service providers. Service providers at this level include mental health practitioners with the advanced qualifications, skills and experience to provide clinical supervision (ie psychiatrists and clinical psychologists).

CRITICAL INCIDENT MENTAL HEALTH SUPPORT PHASES

General

1. In general Critical Incident Mental Health Support (CMS) is designed to:
 - a. provide a high-level of flexibility to accommodate the vast array of incidents and circumstances that may occur within the Australian Defence Force (ADF), from the death of a colleague on base through to personnel exposed to a situation which presents extreme threat;
 - b. include extensive and ongoing liaison with Command;
 - c. include a process by which the provider assesses the needs, provides first line intervention, reassesses and provides further intervention when necessary, or reassesses and refers to a qualified mental health practitioner (ie when specialist treatment is needed);
 - d. include follow-up and ongoing care for individuals;
 - e. maximise existing support mechanisms;
 - f. not force individuals into unusual and potentially harmful modes of coping;
 - g. screen for protective and risk factors;
 - h. screen for chronic problems;
 - i. provide appropriate intervention for all ADF personnel, including Reservists;
 - j. allow for Australian Defence Organisation members to be involved in initial phases before referral to appropriate civilian services; and
 - k. include the coordinated support to families through the inclusion of Defence Community Organisation (DCO) and Chaplaincy.
2. CMS offers the following four phases:
 - a. Planning and Immediate Response;
 - b. Psycho-education and Screening;
 - c. First Follow-up; and
 - d. Second Follow-up.

Phase One—Planning and Immediate Response

3. The planning element of Phase One for the CMS provider includes:
 - a. liaison with command,
 - b. information gathering,
 - c. assessment of need for intervention by determining how potentially traumatising the event was, and
 - d. planning initial intervention and determining required resources.

This element is conducted as soon as possible after a call out has been received.

- e. The immediate response element can be conducted either individually or in small informal groups and includes:
 - (1) ensuring affected members receive adequate rest;
 - (2) removing affected members from the worst of the stress (if possible);
 - (3) reassuring members and command;
 - (4) psychological first aid; and
 - (5) psychological consultancy and liaison.

Phase Two—Psycho-education and Initial Screening

- 4. Phase Two has the following three options:
 - a. **Option One.** No response required at this time. This decision is made by the CMS provider in consultation with local command, and is based on a thorough assessment of the event(s) and responses to the event(s).
 - b. **Option Two.** Psycho-education and Initial Screening. The function here is:
 - (1) provision of quality psycho-education;
 - (2) brief non-invasive screening and psychological triage;
 - (3) provision of specific psychological first aid techniques;
 - (4) referral of those individuals identified as requiring further assistance; and
 - (5) further planning.

This can be completed either on an individual basis or in a group format, dependent upon the operational requirements of the time. This option is conducted when the events were assessed as potentially traumatising.

- c. **Option Three.** This consists of psychological support and consultancy to unit activities such as memorial services, ritual ceremonies, command briefings, informal group discussions, planned support meetings for personnel and/or their families or any other group support scenario. Such interventions are voluntary and are both initiated and controlled by the unit or group themselves (with consultancy provided by CMS personnel). Their use is indicated when:
 - (1) significant loss was involved in the event,
 - (2) there is a lack of knowledge,
 - (3) there are different perceptions and rumours persisting, and
 - (4) command identifies problems with group cohesion.

Phase Three—First Follow-up

- 5. This phase is individually based and conducted approximately one week after the initial screen in Phase One. It is targeted at all personnel who completed initial screening. Its function is to:
 - a. screen for and triage acute psychological injuries (such as Acute Stress Disorder), as distinct from expected and transient distress; and
 - b. provide appropriate psychological treatments and management advice for personnel displaying acute psychological injuries.

Phase Four—Second Follow-up

6. This is completed approximately three months after the initial screen and is individually based. It is aimed at determining whether any ongoing adjustment difficulties are present. It also functions to:
- a. screen for, and triage chronic psychological injuries; and
 - b. provide appropriate psychological treatments and management advice for personnel displaying chronic psychological injuries.

Guidelines for Australian Defence Organisation Civilians, Families and the General Community

7. Guidelines for the above populations are:
- a. Within the CMS framework any individual at the scene of the event/incident is included in the initial phase of the CMS response.
 - b. Work groups may be included in the psycho-educational phases, but formal screening, and mental health care, of civilians (including Defence civilians) is not undertaken unless there is formal and approved Defence Assistance to the Civil Community tasking.
 - c. Work groups should be considered when planning rituals or memorials.
 - d. Families at all times can seek assistance from DCO or a chaplain.
 - e. Defence civilians can be encouraged to seek assistance from their local Defence Employee Assistance Program (EAP) provider, general practitioner or community mental health service.
 - f. Members of the community can seek assistance from their general practitioner and community mental health services. They may also be eligible for government-funded victim's counselling or their employer may have an EAP.

CRITICAL INCIDENT MENTAL HEALTH SUPPORT CALL-OUT FORM¹

Ship/Unit/Base:

Service:

Requesting officer:

Requesting officer contact details:

Date of contact:

Date of incident:

1. Location of the incident:

2. The Ship/Units/Base involved:

3. A brief description of the incident:

4. Did the incident involve any of the following (Yes/No)?

- a. line of duty death?
- b. non-duty death?
- c. rescue and casualty incidents involving exposure to gruesome sights, including body recovery?
- d. general accident, training accident or near miss ?
- e. natural disaster?
- f. exposure to a noxious agent?
- g. severe physical harm or injury?
- h. other (explain)?

1 To be completed by both requesting unit and Critical Incident Mental Health Support Team Leader.

5. Extent of any injuries involved:

6. Details of those involved in the incident:

7. Current location of these personnel:

8. Current status of incident:

9. When personnel will be available for CMS:

10. Whether any personnel involved are required to return to another location. If so, details of their movements are required:

11. The status of any investigation into the incident:

12. The extent of media interest in the incident:

Action Required (to be completed by CMS provider with Command input)

13. No further action at this stage (brief explanation to be provided):

14. Plan and Immediate Response conducted (date conducted and any relevant comments):

15. Psycho-education and Screening conducted (date conducted and any relevant comments):

16. Individual follow-up provided (outline arrangements with command to facilitate this):

17. Group Intervention provided (provide date and type of intervention):

18. Other (please expand):

Name and Signature of CMS provider

Distribution:

Ship/Unit/Base

DMH

RMHT

Servicing Psychology Facility