



DIRECTOR–GENERAL DEFENCE HEALTH SERVICE

HEALTH DIRECTIVE NO 260

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AN INTRODUCTION TO THE MANAGEMENT OF MENTAL HEALTH PROBLEMS IN THE AUSTRALIAN DEFENCE FORCE

References:

- A. *Australian Defence Force Mental Health Strategy Report*
- B. *Diagnostic and Statistical Manual of the American Psychiatric Association*, Volume IV, text revision (DSM–IV–TR:APA, 2000)
- C. *National Mental Health Strategy 2000*
- D. *Australian Defence Force Health Status Report 2000*
- E. Defence Instruction (General) (DI(G)) PERS 16–1—*Health care of Australian Defence Force personnel*
- F. Health Directive (HD) 236—*Medical Employment Classification Procedures*

INTRODUCTION

1. Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to both adapt to change and cope with adversity. The *Australian Defence Force Mental Health Strategy Report* (reference A) identified mental health as a key component in the overall health of the ADF and, therefore, an important factor in determining Australian Defence Force (ADF) capability. An ADF member may be completely healthy in a physical capacity, but if not mentally fit, the member's ability to perform military duties, particularly on deployment, may be partially or totally impaired.

2. Reference A further recognised that the ADF may experience a decrease in its personnel capability, and therefore, operational capability through the impact of:

- a. the inherent stressors of military service,
- b. normal life cycle issues, and/or
- c. genetic predispositions.

Essentially, the effects of such stressors may cause or exacerbate a diagnosable mental disorder, or other subclinical mental health problem.

3. Often, a definitive mental health intervention is initiated only when the individual presents for management of an acute problem, or when administrative processes suggest a possible underlying mental health concern. However, mental health concerns are not limited to the diagnosis of psychiatric problems. Mental health concerns also include conditions such as anxiety, stress reactions, reactive transient depressive episodes or other mental health problems that may, in turn, arise out of:

- a. operational service (war, warlike, peacekeeping or peacemaking);
- b. service within the National Support Area (eg occupational stressors, training incidents, etc);
- c. family problems (eg relationships, children, etc);
- d. life cycle problems (eg bereavement);
- e. personal variables (eg personality problems); or
- f. general medical or health issues.

4. Health providers should also understand that symptoms might be present in a person without being clinically significant. Such symptoms may be subclinical and only marginally impact an individual's personal or working life. In fact, the degree to which problems or symptoms pervade a person's life is a major determining factor of clinical significance. Mental health problems may not, therefore, necessarily require specific psychiatric intervention but can, instead, be dealt with by a range of mental health providers. Depending on the severity of the individual's condition, treatment modalities may include, but not be restricted to, the following:

- a. in-patient care;
- b. psychiatric intervention, either inpatient or outpatient;
- c. counselling;
- d. psychopharmacological treatment;
- e. family therapy; and
- f. outpatient group programs, including anger management groups.

5. The treatment and management of mental health problems in the ADF has traditionally been the domain of several key organisations, including the:

- a. Defence Health Service Branch (DHSB);
- b. Defence Force Psychology Organisation;
- c. Single Service psychology agencies;
- d. Defence Community Organisation (DCO); and
- e. Defence Chaplaincy.

6. Historically, coordination between these agencies has not been ideal. Noting this, reference A subsequently recognised that the creation of a cohesive and holistic ADF Mental Health Service (MHS) would assist in providing improved outcomes for ADF personnel who present with mental health problems. In view of this, DHSB has developed appropriate guidelines to address the identified deficiencies.

AIM

7. The aim of this HD is to provide guidance to health professionals for the clinical and administrative management of ADF members presenting with a mental health problem.

SCOPE

8. This Directive's aim will be addressed by discussing the following elements of patient management:

- a. **Clinical management.** The evaluation and treatment of clinical and subclinical mental health problems in a military setting is addressed in [paragraphs 21. to 27.](#) The evaluation and treatment of specific mental disorders that are of particular concern within the ADF population is contained in the remainder of the 260 series of HDs, with each addressing a particular disorder.
- b. **Administrative management.** Administrative management may include assignment of an appropriate Medical Employment Classification (MEC) to a member with relevant employment and deployability restrictions being noted. The process is introduced in this HD, but each disorder is addressed separately in ensuing health directives.
- c. **Personnel management.** The issue of liaison with Commanding Officers (CO), who will frequently be required to take some form of responsibility for the immediate and ongoing management of a member with a mental health problem or disorder, is discussed in [paragraphs 30. to 32.](#)

DEFINITIONS

9. The following definitions are offered:
- a. **Mental Health Problem(s).** A term that refers to a range of more common mental complaints. It includes reactions to life stressors that are not necessarily diagnosable (within the normally accepted diagnostic framework), but still impact peoples' lives and functioning.
 - b. **Mental Disorders.** These are diagnosable mental health conditions that are characterised by alterations in thinking, mood, or behaviour (or some combination thereof), and are associated with distress and/or impaired functioning.
 - c. **Subclinical.** Essentially this means without clinical manifestations, and may be the early stage of an abnormality before the signs and symptoms become apparent or detectable by clinical examination. A very mild form of an abnormality can also be classified as subclinical.
 - d. **Comorbidity.** Comorbidity is the presence of coexisting or additional disorders with reference to an initial diagnosis. Comorbidity may affect the ability of affected individuals to function, and may be used as a prognostic indicator for such issues as length of inpatient care, cost factors (associated with treatment, retention or discharge), and clinical outcome.
 - e. **Mental Health Practitioner.** The terms Mental Health Practitioner or Mental Health Provider are 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.

MENTAL HEALTH MANAGEMENT

General

10. The DSM–IV–TR: APA, 2000, Volume IV, text revision (reference B) is the standard means of classifying mental disorders within the ADF. The function of DSM–IV–TR: APA, 2000 is to:
- a. provide a consistent and standardised method for classifying signs and symptoms;
 - b. facilitate communication among mental health professionals, with diagnostic terms in the manual providing a consistent and standardised means of doing so; and
 - c. act as a tool for collecting and communicating accurate public health information and statistics.

Referral sources

11. An ADF member may present to a mental health provider via, or be presented by, any of the following referral sources:
- a. self-referral, where a member may be concerned about the members own symptoms;
 - b. a Defence medical or dental centre, either as part of a regular health assessment, routine medical appointment or presentation to 'sick parade'¹;
 - c. the Royal Australian Navy Divisional System;
 - d. the military chain of command;
 - e. the 'All Hours Support Line (ASL)'; or
 - f. other professions in the Australian Defence Organisation (ADO), such as chaplains, social workers, and psychologists.

Management principles

12. The following principles are to be applied to the management of ADF members who present with potential mental health problems.

13. **All ADF members are entitled to mental health evaluation.** As outlined in [paragraph 9.](#), a member may present with a range of physical or psychological mental health symptoms from a variety of referral sources. Regardless of referral source, all members who present, or are presented, for assistance are to be assessed by an appropriately qualified mental health practitioner. The assessment process is discussed in [paragraphs 22. to 27.](#) of this HD.

14. **No ADF member should be denied access to mental health treatment.** Once a mental health problem has been identified, all serving members are entitled to mental health treatment services that are responsive, accessible, orientated to the needs of ADF personnel and integrated with general health care (reference C). No member should be denied treatment due to:

- a. the member's own fear of being pejoratively labelled, or in any way stigmatised or discriminated against;
- b. pressure from work to continue to perform at full capacity regardless of the member's mental health problem(s); or
- c. employment and deployment consequences.

To assist members who may be reluctant to either seek advice or proceed with treatment, the ADFMHS web site (see www.defence.gov.au/dpe/dhs) has been designed to demystify mental health and to encourage members to ask for assistance.

15. The establishment of the ASL may also assist in easing access to services and destigmatising and demystifying mental health support.

1 A medical officer, dental officer, nursing officer, physiotherapist or medical assistant can identify mental health symptoms that require assessment and opinion.

16. **Early intervention and appropriate management of mental health problems will provide the best health outcome for the individual, the family, coworkers and the ADF.** The level of service provided should incorporate the principles of best practice. Table 1 outlines the level of service appropriate when symptoms of a mental health problem arise in an individual member. The treatment levels of Psychological First Aid and Level One will be discussed in HD 261—*Prevention of Mental Health Problems in the Australian Defence Force* (to be issued). The remainder of this HD will concentrate on Levels Two, Three and Four.

Level	What	When	Who
Psychological First Aid ^(a)	Indicated prevention and early intervention	immediate	ALL ADF personnel
Level One	Case identification and first aid	hours	Chaplains Social Workers DCO Military Support Officers Psychological Examiners EEO Contact Officer Medical Assistants Nursing Officers Medical Officers Dental Officers Psychologists Junior Commanders Others
Level Two	Early treatment	days	Medical Officers Psychologists Social Workers Psychiatric Nurse Chaplains
Level Three	Standard treatment	months	Psychologist with appropriate clinical training and experience. Medical Officer with appropriate clinical training and experience. Psychiatric Nurse with appropriate clinical training and experience. Social Worker with appropriate clinical training and experience. Psychiatrist with appropriate military experience.
Level 4	Expert advice and supervision	ongoing	Panel of Senior Specialists with relevant professional and military experience.

Notes

- (a) This involves better education of existing ADF members with stress management, suicide prevention and alcohol awareness. In addition, education at a number of training levels is to be introduced so that ADF personnel will be exposed to ongoing training throughout the life of their ADF career.

Table 1: Mental Health Treatment Levels for ADF personnel

17. **An individual military member cannot be treated or supported independently from their social and personal circumstances.** Military life creates unique pressures that affect the individual and family. Therefore, it is essential that families be considered as part of the mental health management of the member. This can be achieved by families having access to:

- a. DCO,
- b. chaplains, and
- c. any other individual or group provider who has the potential to be of benefit to the family.

18. **A holistic approach to treatment should be facilitated through the professional network embodied in ADF multi-disciplinary Regional Mental Health Teams.** An initiative of the ADFMHS has been the establishment of a multidisciplinary collaboration between the ADO, individual members and all levels of mental health service provision. ADF Regional Mental Health Teams (RMHT) have subsequently been established in each ADF area. These teams:

- a. facilitate access to the most appropriate services for ADF personnel;
- b. are cost-effective and avoid duplication of services;
- c. promote mental wellbeing;
- d. facilitate early identification and intervention;
- e. are governed by common doctrine;
- f. have centralised support and direction;
- g. provide a peer review capability; and
- h. conform to privacy and confidentiality requirements.

19. The composition, roles and tasks of RMHT are the subject of a draft DI(G) *Australian Defence Force Regional Mental Health Teams*. RMHT are to collaborate with Directorate of Mental Health (DMH) to ensure that policy and best practice guidelines are being applied in each area.

20. **Treatment should be based on both best practice and evidence-based clinical practice.** Evidence-based practice is an approach to health care wherein health professionals use the best evidence possible; that is, the most appropriate information available, in order to make clinical decisions for individual patients. This approach values, enhances and then builds upon clinical expertise, and also enhances a provider's knowledge of illness mechanisms and pathophysiology. It involves complex and conscientious decision making based not only on the available evidence but also on patient characteristics, situation and preferences. Finally, such treatment recognises that health care needs to be individualised, fluid, and involves uncertainties and probabilities.

21. **Whenever possible, evaluation and treatment at or near the member's unit is the preferred first line of management.** Whether the situation is a crisis or a clinical/subclinical presentation, the initial contact person must respond swiftly and sympathetically. By remaining close to known health practitioners and personal support systems, the member may feel safer and be more likely to accept help. However, it is also important to recognise that, in some cases, immediate referral to a specialist area or person away from the member's normal geographical location may be required, eg hospital (civilian or Service), Alcohol Rehabilitation and Education Program, psychiatrist or clinical psychologist. If this is the case, the member should be reassured that both personal safety and mental wellbeing are of the utmost importance and remain a primary health priority. At this stage, it is also essential that family support mechanisms be put into place to assist the member and family to adjust to, and cope with, the member's absence and treatment plan.

22. **In areas of deployment, at sea or remote localities, unless psychological assets are deployed, the principles of 'Psychological First Aid' as outlined in HD 261 (to be issued) will need to be applied.** Thereafter, when the member can be repatriated, appropriate mental health management will be conducted in a facility most suited to the member's requirements eg own medical unit, external facility or organisation.

CLINICAL MANAGEMENT

23. **Preliminary assessment and evaluation.** In order to identify those members who require further mental health evaluation and some form of treatment, the following personnel should be trained to administer and evaluate a preliminary screening mental health questionnaire (the Mental Health Screen) during a structured interview setting:

- a. mental health practitioners,
- b. senior medical assistants, and
- c. psychological examiners.

The content of the Mental Health Screen, along with instructions for its administration and interpretation is found in HD 262—*Administration of the Mental Health Screen* (to be issued). Mental Health Screen results may indicate that a patient needs to move along to the next step in the assessment process; that is, referral to a suitably trained mental health practitioner for further evaluation, assessment and/or treatment.

24. Even at the earliest stages of assessment and evaluation, if a mental health problem can be identified, be it clinical or subclinical, the member should be reassured that mental health problems are:

- a. common, thereby reducing any concerns about stigmatisation;
- b. generally responsive to effective treatment;
- c. addressed in a step-wise manner using best practice methods; and
- d. treated in a confidential setting.

Often these facts are enough for a member to both accept ownership of their symptoms and embark on formal mental health treatment. This reassurance is particularly powerful when delivered by personnel who are already known to the patient, eg a trusted medical officer, nursing officer or chaplain.

25. **Advanced assessment, evaluation and treatment.** As indicated above, when the Mental Health Screen indicates that further assessment or treatment is warranted, the patient is to be referred to a suitably trained mental health practitioner. At the conclusion of this more advanced assessment, the practitioner should be able to offer an appropriate treatment plan, or may decide that referral for more specialised assessment and opinion or treatment is necessary (for example, for neuropsychological assessment and rehabilitation recommendations). At this stage, additional consultation, advice and treatment may also be sought from, or provided by, any of the following:

- a. liaison with a member's work supervisor and/or CO;
- b. the Military Compensation and Rehabilitation Service (MCRS);
- c. Transition Management Services;
- d. the Department of Veterans' Affairs (DVA);
- e. the Vietnam Veterans' Counselling Service; and
- f. any other service provider whose expertise has been demonstrated to be effective and efficient.

26. Any treatment offered to a patient should be planned on an individual basis, but may include:

- a. counselling (individual and family);
- b. behaviour therapy;
- c. cognitive behaviour therapy;
- d. psychotherapy;
- e. pharmacotherapy;

- f. inpatient programs;
- g. outpatient programs; and
- h. support groups.

27. The procedures outlined in paragraphs 23. to 26. should apply regardless of whether the member is presenting for the first time with a mental health problem or with a recurrence of a pre-existing problem.

28. **Medications.** The prescribing of, and maintenance of prescription documentation for, any psychotropic medication is to be in accordance with extant health policy. Specific medications will be the subject of health directives related to each specific disorder. Procedures for the issue of emergency prescriptions are also to be in accordance with extant health policy.

29. **Reserve members.** Reserve member entitlements for assessment and treatment of mental health conditions related to their military service are articulated in DI(G) PERS 16–1.

30. **Specialist employments.** Where necessary, the following categories of specialist employment will be dealt with separately in each HD:

- a. aircrew,
- b. divers,
- c. submariners,
- d. air traffic controllers,
- e. ground defence, and
- f. special forces.

ADMINISTRATIVE MANAGEMENT

31. **General.** The member's Medical Officer should not only be the primary caregiver but should also manage any medical administrative matters that arise. Essentially, this will mean that the Medical Officer takes on a case manager function, with input provided from other relevant mental health care practitioners. Liaison with the Senior Medical Officer may also be required for general advice, in complicated cases, or when a second opinion is required.

32. **MEC and deployability.** When a member presents with a mental health problem, the Medical Officer should, in consultation with other mental health practitioners involved in the case, make an assessment as to the member's current deployability, prognosis and consequent appropriate MEC. General guidelines as to appropriate MEC are provided in the specific HD for each disorder. However, attention is drawn to extant policy, HD 236—*Medical Employment Classification Procedures* for general guidance regarding assignment of a MEC to an ADF member.

PERSONNEL MANAGEMENT

33. Mental health is a command responsibility, and mental health intervention in the military environment aims to contribute to the operational effectiveness of personnel. Commanders are not expected to treat a member in any health professional capacity, however, 'treatment of the situation' is essential. Essentially, this means that commanders need to be cognisant of any special workplace considerations that may apply to their member, and the expected duration of those changes/considerations. For example, commanders will need to understand what work restrictions may be placed on the member. Mental health providers should, similarly, have a full understanding of the member's workplace, how that workplace can help or hinder treatment, and also how any employment restrictions can impact the workplace and therefore the member.

34. Commanders should feel confident in referring a member for mental health evaluation. Unlike a medical referral between health professionals, a CO is not expected to make any subjective comments on a member's mental health status. However, the CO should complete a Form PM 008—*Report on a Case Referred for a Psychiatric or Psychological Examination* and forward it to the medical officer or psychologist. It is vital that the member is aware of the reason(s) for referral, and therefore the member should be advised as to the nature of the referral, and why the referral has been made.

35. It is important to develop a solid relationship between mental health professionals, commanders and ADF members. Part of the role of the RMHT will be to liaise with command, and thus demystify the process of mental health evaluation and treatment. Command will benefit from education regarding the nature of mental health problems, and one of the functions implicit in the ADFMHS is education of command at all levels.

REHABILITATION AND SEPARATION FROM THE AUSTRALIAN DEFENCE FORCE

36. Most members will make a full recovery from their mental health problem. However, some members will not recover within the time frame dictated by extant health policy and will therefore need to be discharged from the Services. Other members may elect to take discharge regardless of their MEC.

37. Members being discharged from the military on the grounds of invalidity, for a mental health disorder, require more intensive management than those separating routinely at their own request. In fact, the military may be discharging people into civilian society who may lack the requisite abilities to function effectively within that society. Furthermore, separation following diagnosis of a chronic or intractable mental health condition often leaves the member with a number of additional problems:

- a. inability to find or maintain remunerated employment;
- b. likelihood of poor social and economic circumstances;
- c. social isolation;
- d. stigmatisation;
- e. perception of being discharged unfairly by the organisation, and the often accompanying perception of disloyalty being shown by the organisation towards the member; and
- f. impairments in areas of functioning such as:
 - (1) self-care;
 - (2) self-direction;
 - (3) interpersonal relationships;
 - (4) learning and recreation; and
 - (5) independent living.

38. These sequelae will significantly hamper the resolution or management of the primary condition unless strategies are in place to mitigate such additional problems. Strategies for such cases should aim at:

- a. focussing on improving patient capabilities, competencies, and maximising health;
- b. improving the patient's ability to adjust and adapt to their environment;
- c. improving vocational outcomes, such that the patient can enter the paid workforce and gain the positive outcomes of such involvement;
- d. actively involving the patient in their own transition management, such that the patient views him/herself as a stakeholder, not someone who is having something done to them; and
- e. ensuring that appropriate evaluation and follow-up is built into the specific strategy.

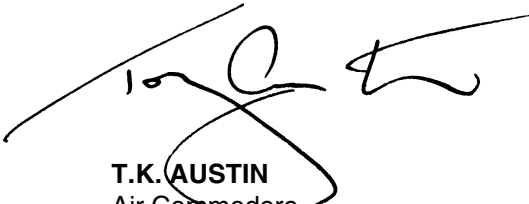
39. A number of agencies can, and do, assist in the management of a member's transition from military to civilian life. It is important for mental health care providers to have a thorough understanding of the agencies available for member assistance, and equally important that contact is initiated with those agencies prior to the member's discharge.

- a. **Transition Management Service** of the DVA assists the member's transition to civilian life whilst also ensuring that appropriate ongoing levels of care are available for the member's management.
- b. **MCRS** caseworkers can interface between the member, the military mental health provider and the MCRS contracted rehabilitation provider. This interface can enhance a smooth transition to civilian life.
- c. **DVA** will also assist the member's family, as the nature and circumstances of the underlying condition often impact the family unit.
- d. **DCO** can also be involved with providing continued support to the immediate family during the transition phases.

40. Ideally, any mental health problems that have occurred throughout a member's Service life should already have been recognised and treated so that a smooth transition to civilian life is assured. However, immediate mental health management (as outlined in this HD) must be initiated when the separation itself is a distressing event, or where separation has uncovered an underlying mental health problem. Separation should not take place until the member is stable and can be safely transferred to civilian life and civilian health care.

CONCLUSION

41. The ADF is not immune to mental health problems, with such problems having the potential to negatively impact the personnel capability of the ADF. Previously, treatment and management of mental health problems has rested with a number of disparate organisations, and the aim of the ADFMHS is therefore to integrate and streamline this process, bringing it in line with what is considered best practice. This HD provides initial guidance for a consistent and standardised approach to the clinical and medical management of mental health problems within the ADF. It also guides the further referral of members for more specialised assessment and treatment.



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