Information for ADF Mental Health Providers

Identification and treatment of mental health issues amongst ADF members is a key priority area for Defence. Unique occupational risks, coupled with a duty of care to all Eligible Personnel (EPs) necessitates specific requirements around risk assessment, disclosure and management. Communication between external and on-base mental health care providers is integral to ensuring coordinated care.

Mental Health management team

Mental Health Professionals (MHPs) employed within Defence health facilities include psychologists, mental health nurses, mental health social workers and Defence medical officers. Responsibilities of an on-base MHP include:

- Conducting intake assessments, mental health reviews and risk assessments
- Providing clinical monitoring for members referred to external providers
- Reviewing patient progress
- Liaising with all stakeholders (including external providers) as part of a multi-disciplinary team
- Ensuring ADF members at risk of suicide, self-harm or harm to others receive appropriate assessment and support as soon as practicable
- Coordinating treatment planning and management.

Although the clinical lead for mental health is the on-base Medical Officer (MO), they may nominate a MHP as the primary point-of-contact for external providers.

Assessment of risk

While Defence MOs and MHPs are responsible for assessing a member's risk of suicide, self-harm and/or harm to others and implementing risk management strategies and protocols, external providers are expected to monitor risk during off-base treatment and conduct risk assessments within their clinical guidelines.

The following four categories are used by Defence to specify risk:

- **High risk**
  Defence EPs assessed as being at high risk usually possess multiple, severe or complex risk factors. These may include significant mental health history, strong ideation with motivation to engage in risk behaviour, evidence of planning and preparation, poor behavioural control and coping mechanisms, significant stressors and potential substance use problems. Protective factors are limited and verification of collateral information is difficult. Defence EPs assessed as being at high risk are likely to be managed as inpatients at a civilian public or private health facility.

- **Medium risk**
  Defence EPs at medium risk will typically have a number of mild severity risk factors or a smaller number of risk factors of greater severity. These may include a few episodes of previous relevant behaviour, moderate ideation with vague planning and limited preparation, ambivalence towards engaging in risk behaviour, some stressors present with limitations on usual coping mechanisms and minor substance use concerns. Protective factors would typically be evident but diminished in number or power and collateral information is only partly verifiable. Defence EPs assessed as being at medium risk may be managed as inpatients or outpatients (as clinically indicated).

- **Low risk**
  Defence EPs at low risk will typically have a few mild risk factors present. These may include limited history of previous risk behaviour, infrequent ideation with no motivation or planning to engage in risk behaviour, limited presence of stressors with effective coping and no substance use concerns. Some protective factors are evident and collateral information is largely verifiable. Defence EPs assessed as being at low risk are likely to be managed as outpatients and will be regularly reviewed by on-base MO/MHPs.

- **No foreseeable risk**
  Defence EPs are assessed as having no foreseeable risk if there is no evidence of any current risk to the individual or others. No evidence of ideation, motivation or planning of suicide, self-harm or harm to others is present.

Please note
Where a clinician has low assessment confidence or determines high changeability in the EPs condition—yet all other risk factors indicate low or no foreseeable risk—they should manage the EP as being at medium risk and notify the MO or MHP accordingly using clinical correspondence.

Similarly, if you identify an EP at risk of harm to themself or others (which has not been previously noted) or there is an elevation in the level of identified risk – you must notify the Defence MO or MHP as soon as possible (preferably by phone, then follow-up in writing).

Clinical reporting and communication

Communication between external health providers and Defence MOs/MHPs is essential for coordinated care and support of the welfare process. Medical Specialists (psychiatrists) are required to submit a clinical report via iRBS after each consult, and Allied Health (psychologists) after the initial, every series of six and final consults. If a treatment plan is

warranted for your proposed care, this should be included in your initial Clinical Report – with progress against the plan advised in subsequent Clinical Reports. Communication with the MO/MHP also needs to occur at the time of a significant clinical event (such as increase of risk to self/others or repeated non-attendance).

A mental health case review is conducted by the MHP after every sixth psychology session (when the report is provided). It is also conducted if a report identifies new or significant change to a clinical status or treatment plan, new complexity is identified or there is medium to high risk.

Within the Defence working environment there are specific organisational and occupational restrictions or requirements associated with certain conditions or medications to ensure the safety of the EP and others. Liaising with the Defence MO/MHP will help you understand these and facilitate rehabilitation, including return to work or occupational transition.