

A Military Second Opinion Mental Health Clinic

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Abstract

Background: The 2009 Dunt Review of Mental Health in the Australian Defence Force (ADF) led to the establishment of the ADF Centre for Mental Health in Sydney. One of the programs developed at the Centre was a mental health Second Opinion Clinic. The aim of the Second Opinion Clinic is to provide specialist assessment and management recommendations for patients with complex and treatment-resistant mental disorders.

Purpose: This paper describes the practices of the Second Opinion Clinic, the clinical outcomes and satisfaction as reported by patients and referrers, based on the first 58 patients seen at the clinic.

Method: Clinic databases of patient demographics, diagnoses, and patient and referrer satisfaction surveys were reviewed.

Results: Among the findings, it was found that the diagnosis was revised in half the patients seen, with resultant implications for treatment and management within the ADF. The clinic's practises and clinical outcomes were well regarded by both patients and referrers.

Conclusion: This paper contributes to the small body of literature reporting on mental health tertiary referral or second opinion clinics.

Keywords: second opinion clinic, tertiary referral clinic, military

Introduction

In 2009, the Dunt Review of Mental Health services in the Australian Defence Force¹ made a number of recommendations regarding the provision of mental health services in the ADF which were adopted by the Australian Government. One of these recommendations was to establish an ADF Centre of Mental Health in Sydney, with the aim of providing expert clinical advice, assessment and treatment services for complex mental health cases across the ADF. One of the services subsequently established at the ADF Centre for Mental Health was a Second Opinion Clinic. The Second Opinion Clinic aims to assist ADF medical officers (i.e. general practitioners) and mental health personnel in the management of serving permanent members of the Army, Navy and Air Force with chronic, difficult, complex or treatment-resistant mental disorders who are already under the care of a consultant psychiatrist. In line with the aims of the ADF Centre for Mental Health to be a national asset, a tele-mental health capability was also established in the centre to provide nation-wide access in a cost effective manner.²

Background to the Second Opinion Clinic

In developing the clinic, a literature review investigated suitable existing service models of tertiary referral or psychiatric opinion clinics. However, few descriptions

of such clinics were located and no descriptions of a military-specific tertiary referral psychiatric service were found. The ADF Centre for Mental Health adopted Nirodi et al's³ definition of a second opinion as a 'referral request for an expert clinical consultation when the patient is already under the care of a consultant psychiatrist.' While not a tertiary referral service, the model of the GP Psych Opinion Clinic at the Royal Brisbane and Women's Hospital, of offering appointments quickly, assessing patients and providing management advice without engaging in ongoing treatment, was considered suitable as the basis for the Second Opinion Clinic.⁴

Description of the Second Opinion Clinic

The Second Opinion Clinic is a tertiary-referral service that provides one-off mental health assessments of ADF personnel who must already be under the care of medical officers and a consultant psychiatrist. Referral must be by medical officers; although it can be sometimes initiated by psychologists involved in the care of individual members. The Clinic does not provide an initial specialist assessment service and does not take on on-going management of patients. Second Opinion Clinic assessments are conducted jointly by a psychiatrist and a psychologist.

Second Opinion Clinic Practice

Upon referral, all patients are forwarded an information sheet on the Clinic and one on telepsychiatry when applicable. Waiting times for appointments are usually about two to three weeks. The assessors aim to take a systematic and analytic diagnostic approach⁵ that consists of: an extensive review of each member's medical record, psychology and personal files; a detailed clinical interview usually taking about two hours (conducted either face-to-face or via tele-psychiatry); collateral history where available; and diagnostic tests where indicated (such as using the Clinician Administered PTSD Scale when assessing Post Traumatic Stress Disorder, PTSD). Members are encouraged to bring their partner or a family member, and they are requested (but not obliged) to permit collateral history from family, friends or work supervisors.

Verbal feedback is given to the member at the conclusion of the assessment whenever possible and all patients are asked to complete a satisfaction survey to assess their experience of the clinic at the end of their appointments. A detailed report is provided to the referring medical officer within a week. While tailored to the needs of the referrer, a report typically includes a clinician-derived psychiatric diagnosis (using the Diagnostic and Statistical Manual of Mental Disorders,⁶), a formulation and a management plan that contains sequential treatment recommendations plus advice on fitness for duties, location of posting and, if necessary, suitability for retention in the ADF. All specific questions requested are addressed. Following the provision of the written report, the referrer is asked to complete an in-house

satisfaction survey of their satisfaction with the process and outcome of clinic.

Method

Clinic databases of patient demographics, diagnoses, and patient and referrer satisfaction surveys were reviewed.

Results

Fifty-eight patients had been referred to and assessed at the Second Opinion Clinic as at February 2015. Of these 11 (19%) were female and 47 (81%) male – which is similar to the gender distribution in the Australian Defence Force – making this sample representative of the ADF with regard to gender. The average age was 35 years for men, and 26 years for women. Just under half (47%) were from the Army, with a similar proportion (44%) from the Navy. Only 9% were from the Air Force. About one-third (30%) were officers and more than two-thirds (70%) enlisted personnel. Just under half had deployed on active service at the time of their assessment.

Reasons for referral to the clinic included: confirmation/review of a current diagnosis; advice on medical management; assessment of fitness for retention in the ADF; advice on medical classification within the ADF; fitness for ADF deployments; and fitness for specific ADF postings. There are a greater number of reasons for referral than individual patients, due to multiple reasons for referral for some members. Figure 1 displays the distribution of reasons for referral for the 58 patients seen at the clinic at the time of writing.

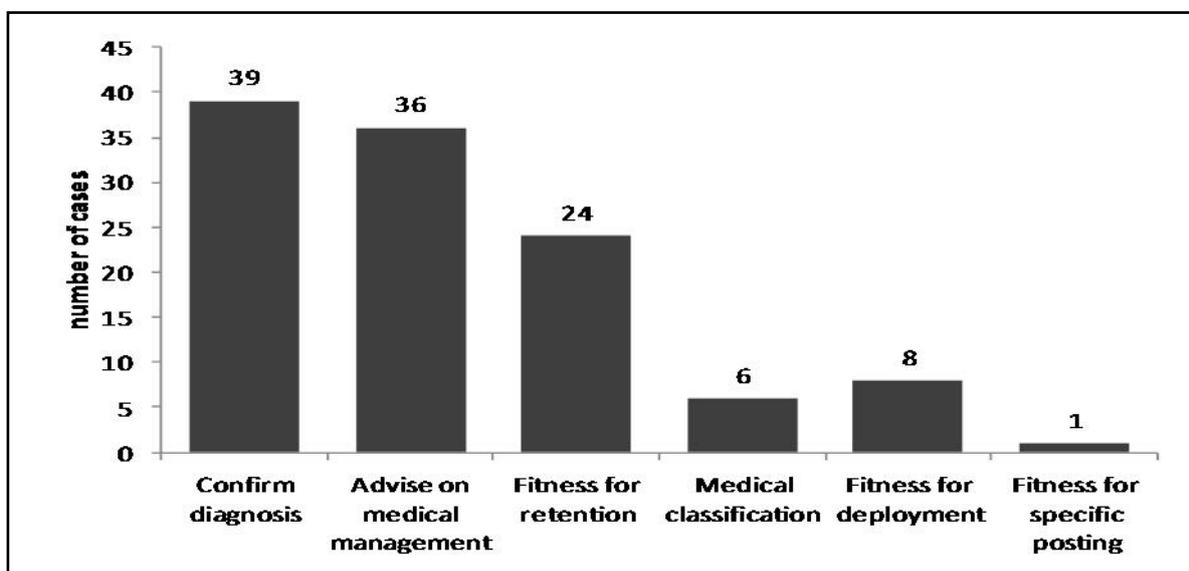


Figure 1: Reasons for referral of patients (n=58) to the ADF Second Opinion Clinic

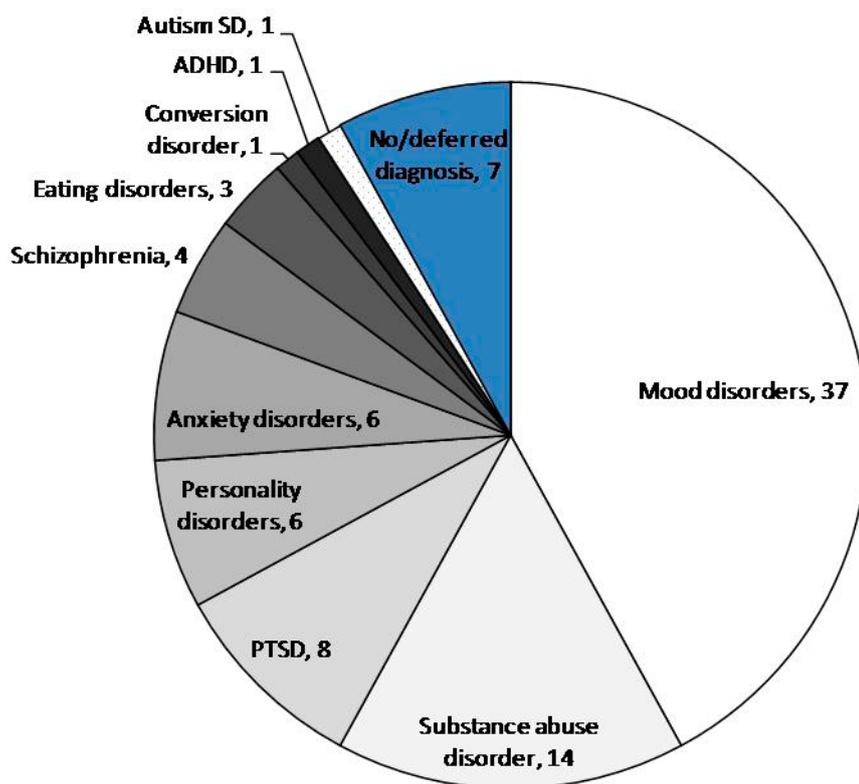


Figure 2: Diagnoses made by the ADF Second Opinion Clinic (n=88)

A wide range of mental health diagnoses were made for the first 58 patients seen at the Second Opinion Clinic; including no mental disorder. There are a greater number of diagnoses than the number of patients seen, as twenty-two patients (38%) were diagnosed with more than one disorder, with Alcohol Abuse the most common co-morbid problem (20%, n=12). Figure 2 displays the range and proportion of the major diagnostic clusters made in the clinic among the first 58 patients seen. The total number of diagnoses exceeds the number of patients due to some patients receiving more than one diagnosis.

Second Opinion Clinic Diagnosis versus referrer diagnosis

Assessment at the clinic led to a revision of the original diagnosis in about half of the patients seen. Examples of changes in diagnosis included: a previous diagnosis of Major Depressive Disorder (MDD) changed to Bipolar II Disorder; a single episode of MDD changed to Recurrent MDD; Bipolar Disorder changed to Borderline Personality Disorder; and Bipolar Disorder changed to no mental disorder. While on the surface the original and revised diagnoses sound similar, there can potentially be significant variations in the treatment and management of patients with the revised diagnoses

(including their suitability for retention in the service, medical employment classification, fitness for deployment and suitability for specific postings).

Consumer evaluation of the Second Opinion Clinic experience

Two types of consumer evaluations were utilised – those of patients and those of referring medical officers. Satisfaction with the clinic experienced by patients was measured using a 12-item Defence Health Service Outpatient Satisfaction Survey commonly used in ADF Health Service outpatient clinics. This questionnaire uses a five-point Likert scale to rate: explanation of tests; involvement in decision-making; privacy; respect; explanation of personal information; encouragement to ask questions; access to emotional and physical support; being treated courteously if in distress; advice about maintaining health; cleanliness of the clinic; flexibility in arrangements; and reasonableness of waiting times. Evaluation of the experiences of referring medical officers was made using a satisfaction survey developed in-house, but based on the ten-question Primary Care Assessment Survey,⁷ which has been utilised in similar circumstances. This questionnaire uses a five-point Likert scale to rate: information and promotion of the clinic; ease of contact; waiting

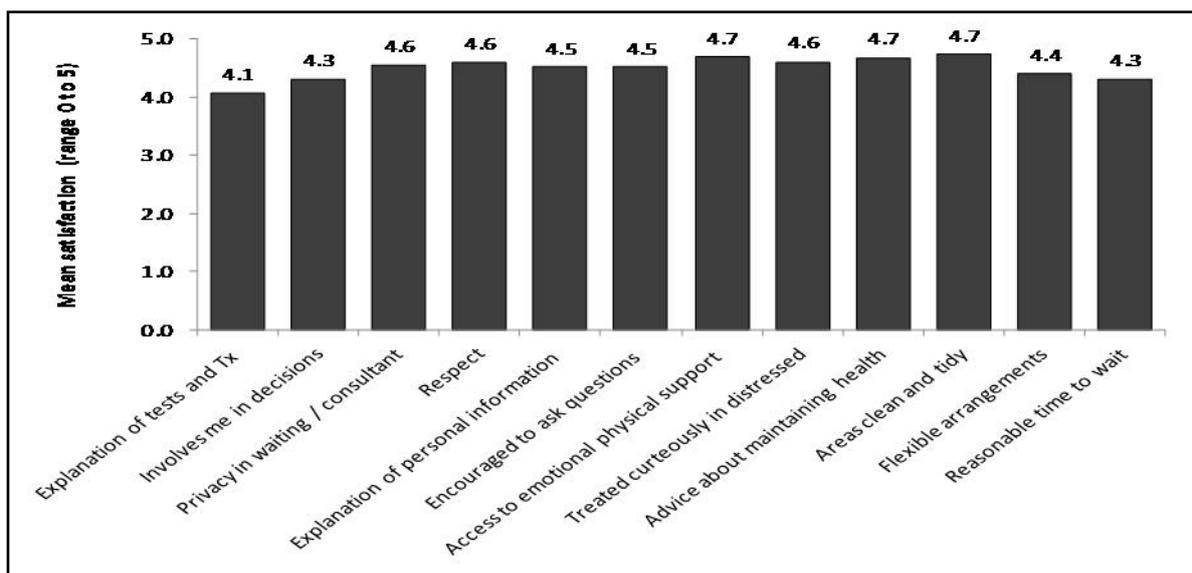


Figure 3: Patient evaluation of the ADF Second Opinion Clinic (n=38)

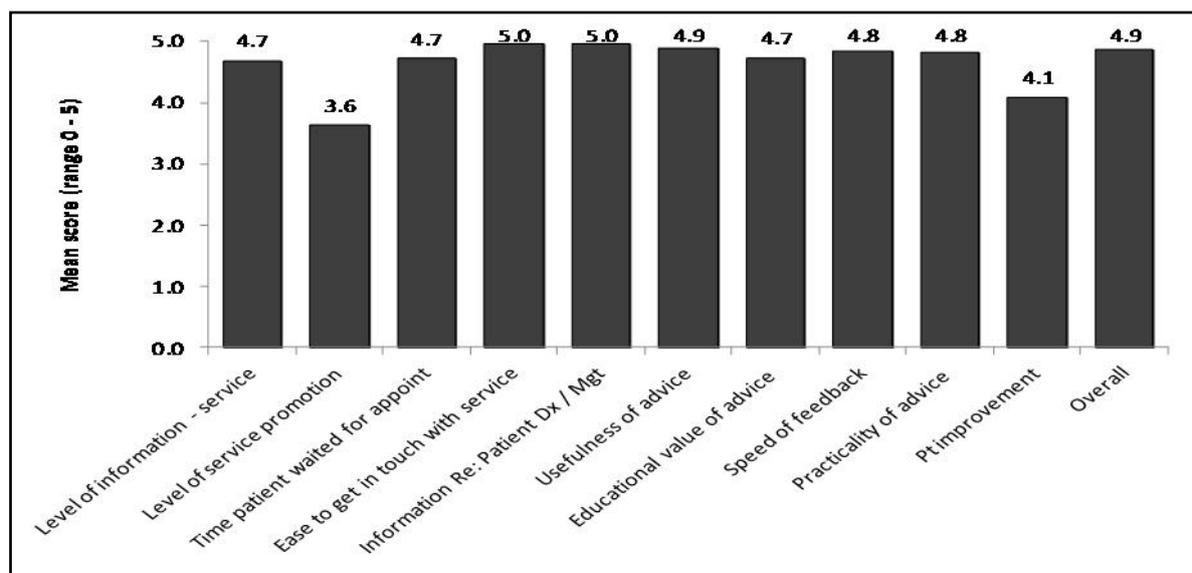


Figure 4: Referrer satisfaction with ADF Second Opinion Clinic (n=44)

time to be seen; clinical information about patients; usefulness of advice provided; educational value to the referrer; timing of reports; practicality of advice; patient improvement; and overall satisfaction with the clinic.

The average scores for the consumer satisfaction of patients are presented in Figure 3. Approximately two-thirds of patients (n=38) responded to the survey. On each of the twelve domains assessed, possible scores range from zero to five. For patients of the Second Opinion Clinic who responded to the questionnaires, the average ratings ranged from 4.0 to 4.7. The highest average rating was for access to emotional physical support, advice about maintaining health and areas clean and tidy, while

the lowest average rating was for explanation of tests and treatment.

Almost three-quarters (n=44) of referring medical officers returned a satisfaction survey, with the average results of these questionnaires presented in Figure 4. Similarly to the patient survey, the possible range of scores was zero to five. The average rating by referrers across the eleven domains assessed, ranged from 3.6 to 5.0, with the highest average rating for ease to get in touch with the service and information about patient diagnosis and management and the lowest average rating for level of service promotion. There was a notable omission in most referrer responses to an item rating patient improvement – so this item was not included.

Discussion

Even though the UK National Institute of Clinical Excellence recommends access to Second Opinion Clinics,⁸ there is little information in the literature about the activities and outcomes⁹ of these clinics, and therefore little with which to compare the outcomes of the ADF Second Opinion Clinic. The sample of patients seen at our clinic was small and involved consecutive recruitment – and while a limitation in a study, seems consistent with the experience of other tertiary referral services.^{3,10}

Patients seen at our clinic met a number of the inclusion criteria for what are seen as complex or refractory disorder,^{10,11} including diagnostic uncertainty hampering treatment, persistently high symptom burden, significant impact on functioning, persisting pattern of incapacity despite appropriate treatment and multiple co-morbidities increasing the likelihood of chronicity.

The main reason for a Second Opinion Clinic is to review primary diagnoses. The change in diagnoses in about half the cases seen at the clinic could potentially reflect on the validity of the primary diagnoses or be compared to the distribution of mental health disorders in the ADF; but more likely reflects the difficulty or uncertainty in making diagnoses in the cluster of diagnoses referred to the clinic. In the case of the Second Opinion Clinic, the largest cluster of disorder was the depressive disorders – which was over-represented in the Second Opinion Clinic compared the distribution of mental health disorders across the ADF.¹² However, it was inferred from this finding that primary mental health service providers may have greater difficulty in definitive diagnoses of depressive disorders or that depressive disorders have greater complexity, co-morbidity or treatment complications. This in turn could lead to targeting professional development in the assessment and management of depressive disorders.

The number of diagnoses that were changed is significant because this is likely to result in significantly different clinical management and altered recommendations about fitness for duty or retention in the military. While there are relatively few reports on the outcomes of similar clinics, the finding of 50% of diagnoses being revised is relatively large.^{3,13} This could be attributed to the uniqueness of a military sample, or reflect the small sample sizes being compared.

Given that the aim of the clinic was to diagnose on a one-off basis, rather than treat patients, and that satisfaction surveys were completed immediately after assessment, it is not surprising that the patient improvement item in the referrer satisfaction survey

was often found to be not relevant to referring medical officers and so not included. It would be reasonable to expect that a one-off assessment would be unlikely to result in improvement in a patient's condition, when all patients were referred because of complexity or treatment resistance. As some patients were seen face-to-face and other seen via tele-psychiatry, it may have been interesting to compare the two modalities. However, the sample size was considered too small to make any meaningful comparisons between these two groups. Overall, referring medical officers rated most elements of the clinic more favourably than patients, but not by much – and exact comparisons are difficult to make as different questionnaires were used. In the satisfaction rating of referring medical officers, the lowest rating was for 'level of service promotion'. This indicates that the service had not been as well promoted to medical officers as they would have liked. The time frame for the first 58 patients naturally involved the early days of the clinic, including its pilot and establishment phases. It should not be expected that a new clinic is well known during its pilot and establishment phases. While it is anticipated that with time the service will become more familiar to primary medical officers across the ADF, it also indicates a need for wider promotion of the service – especially given the generally positive regard for the clinic by referring medical officers and patients.

Conclusions

The ADF Centre for Mental Health's Second Opinion Clinic is a practical example of the ADF's focus on improving mental health services for military personnel by focussing on more specialised diagnosis of mental health conditions. The importance of the clinic is not just in regard to clinical outcomes for patients, but potentially impacts on their employment and therefore, contributes to the operations of the ADF. A review of the first 58 patients seen in the clinic indicates that a change in diagnosis (and possibly in treatment, management and employment) by the second Opinion Clinic occurred in half the cases seen. This appears to be significantly more than in similar clinics. Depression was the most frequently diagnosed mental disorder in the clinic – indicating possible assessment or management difficulties more with depressive disorders than other disorders. Satisfaction surveys of patients and referrers indicated high regard for the practises and clinical outcomes of the clinic. This paper contributes to a small body of literature reporting on tertiary referral clinics, describing findings from what we believe to be the first military second opinion clinic.

Acknowledgements:

Special thanks to the following past and present staff of the Australian Defence Force Centre for Mental Health who assisted with the Second Opinion Clinic:

LTCOL Jacqueline Costello
LTCOL Alison Kaine
MAJ Glenn Payton
CAPT Kelly Tomlinson
CAPT Alison Causley
Dr David Said

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