Stress and mental health support to Australian Defence Health Service personnel on deployment

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TO THE EDITOR: Major Haas's recent article[1] deserves a considered reply. Major Haas appears rather disappointed in the results of his survey. The fact that ADF healthcare professionals declined to use any counselling services (and expressed little intention of doing so in future deployments) should be cause for celebration, not despondency or a call for further research. It is encouraging that healthcare professionals can deal with perceived stress in a manner that does not necessarily include intervention from the so-called "experts". Resilience is something that should be actively encouraged within the ADF — the "experts" are there to be used, but should not be automatically seen as a first port of call.

As healthcare professionals, we should be in a position to initiate individualised care, and call in the specialists only when initial efforts have either failed or the scenario is beyond the clinical scope of that particular healthcare professional. "Stress" should be treated in a similar fashion; the practice of instant teleportation of mental health "experts" to a trauma scene to weave their shamanic hex over victims, is, thankfully, being terminated. Why is it assumed that the mere presence of mental health practitioners will have a beneficial effect? Cantor and Baume showed that a major increase in psychiatrists and psychotherapists to an under resourced region in the USA was associated with no change in the suicide rates.[2] My own research project indicated that ADF members' preferred choice of help (when it came to selecting a source of help for depression) was "friends" and "family".[3] A healthy cynicism obviously prevails in the ADF. This was recently exemplified on board *HMAS Kanimbla*, when only 10% of the mid-term psychology questionnaires were returned to the embarked psychologist.

Major Haas rightly claims that it cannot be determined why healthcare professionals delay seeking mental health services. Perhaps one could postulate that the delays are due to an appreciation that mental health services are of more value for psychosis and other acute illnesses, rather than the normal vagaries of life that most can deal with by talking to friends and families. Any further research in this area should raise that specific question — the answers would be enlightening. One fears that the respondents would be deemed to be either in "denial" or "oppositionally defiant", and that "treatment/counselling" would be necessary until the correct responses were finally elicited.

Despite their sceptical philosophy, 70% of participants in Major Haas's survey felt that counselling services should be deployed. The same respondents would probably say "yes" to a deployed dietitian, aromatherapist or podiatrist. The more hands on deck the merrier. What use and value they would actually be is questionable.

Why is there a need for commanders to encourage soldiers to use available mental health services? Obviously, if there is a problem, then these facilities can be accessed (just like physiotherapists or optometrists). To actively encourage such attendance, irrespective of any perceived problem, reeks of paternalism and the re-emergence of the "nanny-state". Cynics might suggest that the statistical data gleaned from such active encouragement may be used to reiterate the fallacious claim that, as the mental health services have been so well attended, they *must* be relevant. Let's encourage resilience, not reliance.

Major Haas mentions the possibility of increased financial costs associated with delays in attending mental health services. This is an excellent point, as early intervention in a disease process often leads to better health outcomes. This is assuming that there is some evidence of a disease process already being present (eg, early episodic psychosis, glycosuria). There are not usually secondary financial gains to be made from, for example, schizophrenia or diabetes. Post-traumatic stress disorder offers a very lucrative package, and increased financial costs (to the taxpayer) associated with attendance at mental health services have skyrocketed. What would happen if the pot of gold at the end of the post-traumatic stress disorder rainbow was suddenly removed? Does anybody truly believe that the number of people attending mental health services with symptoms of post-traumatic stress disorder would remain constant if the secondary (financial) gains were severely restricted? It is appreciated that this very concept might be enough to induce flashbacks, anxiety, nightmares and increased arousal in certain self-serving corners. Naturally, we should be proactive when dealing with mental health issues — but let's divert those huge cash payouts towards something useful (such as increasing mental health literacy levels).

Finally, regarding the Holy Grail of "evidence-based research/practice": while our practice needs a grounding in evidence and research, let's not put all our eggs in one basket. Are we to focus exclusively on the "evidence", with no room for perception, interpretation, independent lateral thinking, or intuition? We may as well become pharmacists. Telling a hypomanic patient that her serum lithium levels are a little low is obviously based on the evidence from the pathology lab. Getting her to take medication is not something that is "evidence based". Are we now expected to tell patients that it is pointless for them to pray just because recent research indicated that prayer had no significant effect on medical outcomes?[4] A visit to any courthouse will show five mental health "experts" arguing with five other "experts" over the mental state of a defendant. This interpretation depends not so much on the evidence, but on how that evidence is construed in the mind of the expert. Multiple variables are apparent; culture, training, worldviews, personal habits, priorities and life experiences. The "evidence" is in there somewhere. Evidence suggests that Joan of Arc was psychotic, and suffered from auditory and visual hallucinations; the Catholic Church takes a different view. How many healthcare professionals abuse alcohol, smoke, don't

exercise enough and eat too much fat — despite the wealth of evidence suggesting that it is not particularly healthy to do so? If they won't accept the "evidence" how can they expect the patients to? In the Nanny State, they mask their pomposity with authoritativeness.

Conflict of Interest Statement: I declare no potential conflicts of interest.

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Being a good neighbour

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TO THE EDITOR: Much has been made of a perceived change in the foreign policy of the Australian government with its commitment of Australian Defence Force personnel to a policing support role in our neighbour states, such as the Solomon Islands. Papua New Guinea has already voiced its support for such an effort, and Australia is to be commended for wanting to help.

At the recent Military Medicine Conference in Sydney in 2002, I presented a paper on the use of ADF Reserve personnel with the catchy title of "Goodwill hunting". I suggested that the ADF could put together teams of medical specialists in various disciplines and could deploy such teams on a short-term basis to provide a much-needed resource to our neighbours.

Such medical deployments by ADF personnel demonstrate our goodwill towards our neighbours and can do much to engender goodwill in return.

The argument is often made that there is no support facility after these experts leave. The answer, in part, is for deployed personnel to provide an educative service to local doctors, perhaps supported by ongoing training within Australia for doctors from our region.

I feel confident that there are sufficient like-minded colleagues who would be prepared to contribute their time and expertise to such an effort. We have a wonderful opportunity for Australia to show a commitment to the improved health of neighbouring peoples — and what better way to do so than in the proud uniform of the ADF.

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