Psychological trauma and the ADF

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TO THE EDITOR: Milton's article on psychological trauma[1] raises a number of concerns. The article does nothing to explain the high rate of suicides and diseases among the returned troops. Since the Vietnam Welcome Home March (3 October 1987), I have been living with post-traumatic stress. I have seen enough damaged soldiers to know that there is a problem. I commanded a platoon in Vietnam; at least 15 members are now on total and permanent impairment pensions, one is known to have suicided, six are missing, whereabouts unknown, and three others should have a total and permanent impairment pension.

The article was brought to my attention by a former Regimental Medical Officer (RMO) who served in Vietnam. This RMO claims that many people are being damaged because of the current treatments for post-traumatic stress disorder (PTSD). He said that the article was excellent because it was published in *ADF Health* and it was well researched, logical and backed by an impressive bibliography. Yet, David Bell (cited as a personal communication), Yolande Lucire (cited in reference 10 of Milton's article) and Milton commonly cross-reference each others' work. Only one other reference involves Australian research.

Milton asserts that a US study found no benefit for patients who had been treated for PTSD. He then makes the illogical suggestion that they may not have been ill. It is possible that the treatment did not work, but if the patients were not ill, why were they receiving treatment?

The writer shows no knowledge of the Australian veterans' health system. For a total and permanent impairment claim to be successful, the agreement of three doctors is needed. Normally, these are the soldier's general practitioner, a specialist of some description, and at least one doctor from the Department of Veterans' Affairs (DVA). For every defrauding soldier, at least three doctors must have been persuaded the person was ill. So if the veterans' community has a problem, there is, on the face of it, a much bigger problem in the medical profession.

Every Australian veteran claiming a benefit is first screened to see if he actually served, and his record of service and medical documents are obtained. These medical documents play a part in the following discussions with DVA. If a claimant does not have any medical records, he is asked to explain why.

Once the former serviceman's military identity has been established, he must submit a statement of claim. This submission is checked by an organisation called Writeway Research (Tuross Heads, NSW), which is staffed by former military people. All claims are reviewed using a database of all Australian contacts and patrol reports. Once this organisation identifies the soldier and the unit and forms an opinion of the validity of the claim, it then checks with other service personnel who were present at the time of the incident. I have been contacted a number of times by Writeway, and have given an opinion as to the circumstances outlined so that events can be confirmed. On one occasion, I questioned the claimant's sequence of events. I find it hard to believe that the United States does not have a system that follows similar protocols to check claims for pensions.

Further, false war veterans in Australia are outed by the Australian and New Zealand Military Impostors website (http://www.anzmi.net).

Just because there may be a fraud or two, there seems to be a need to smear the whole diagnosis. This is absurd. There are laws to deal with fraud. The solution is not to refuse treatment to everyone just because someone may gain a benefit who should not. What about those who commit suicide because they receive no help?

I agree that medication seems useless. However, there are strategies such as meditation, retreats and counselling which could be used, but the medical profession or DVA either do not consider or are loathe to use them. These strategies would reduce the cost of the current medical/pharmaceutical model, which seems to be failing the veteran badly.

Unfortunately, the views espoused in this article have been repeated in some organisations which are supposed to represent veterans. Even though the article was published as a personal view, there is a danger that people will accept it as fact.

1. Milton R. Psychological trauma and the ADF. *ADF Health* 2005; 6: 85-87. ❑

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TO THE EDITOR: Milton highlights problems in the psychological management of personnel in the aftermath of serious incidents.[1] The challenge for mental health in the Australian Defence Force is to counter these hazards.

Milton paints a picture of a somewhat disjointed and confused approach to trauma management, where seemingly "anything goes". Perhaps the unfortunate legacy of the critical incident stress management movement he described was that it was seen to "dumb down" the field of psychological trauma management, endorsing almost anyone as a trauma counsellor, rigidly focusing on only one type of intervention at the expense of others, and concentrating on counsellors' having to get involved early and do something, rather than on developing appropriate understanding of the condition and its processes.

The countermeasures to the hazards identified by Milton lie in comprehensive mental health strategies, endorsing stand-

ards of treatment based on best practice or consensus opinion, and better training and support of mental health professionals.

While Milton notes that traumatologists do not agree on how to prevent and treat psychological trauma, the past few years have seen a series of expert opinions, best practice, and consensus approaches developed (such as the practice guidelines from the International Society for Traumatic Stress Studies;[2] and a consensus workshop involving the US Departments of Health and Human Services, Defense, and Veteran's Affairs, and the American Red Cross[3]). Some evidence-based treatments (both pharmacological and psychological) show promise to reduce symptoms and suffering and promote recovery. Although these guidelines and treatments may not please everyone, they come with a high level of professional endorsement — not only does this provide confidence for the practitioner, but presumably it would come from the same professionals who may later be called to challenge practices in a legal setting. This could stifle some creativity on the part of some therapists. However, given the professional uncertainty and fertility for litigation, endorsement of preferred treatments and management strategies that are consistent with professional consensus or best practice must be essential.

Overall management strategies for mental health problems and illnesses exist. The Mental Health Strategy of the Australian Government Department of Health and Aged Care provides generic levels of intervention in mental health management.[4,5] This framework outlines prevention strategies, early intervention strategies, treatment strategies and continuing care strategies — each with specific goals, and each with high applicability and adaptability to the management of psychological trauma in the ADF. The continuation of care from one level to another would not see "failed therapy" until all levels of intervention have been exhausted. Further, the promotion of a clearly stated and comprehensive strategy would broaden awareness of all levels of trauma management to those who work in the field.

Clinical training, accreditation, and monitoring of service should be priorities for ADF health services. To provide the appropriate level of clinical input, I recommend that a clinical reference panel (including senior clinicians, academics and service provision administrators) for ADF trauma-related mental health oversee and endorse the management strategy, standards of clinical care, training, and provide clinical guidance and consultation when needed.

I believe that resource limitations and professional uncertainty in traumatology have allowed the hazards described by Milton to develop. An approach involving comprehensive management strategies, endorsement of standards of care, training of personnel, and clinical guidance should reduce risks of the legal and professional challenges described by Milton, and more importantly, benefit our ADF personnel, who deserve the best care possible.

1. Milton R. Psychological trauma and the ADF. *ADF Health* 2005; 6: 85-87.
2. Foa EB, Keane TM, Friedman MJ, editors. Effective treatments for PTSD. Practice guidelines from the International Society for Traumatic Stress Studies. New York: Guilford Press, 2000.
3. National Institute of Mental Health. Mental health and mass violence: evidence-based early psychological intervention for victims/survivors of mass violence. A workshop to reach consensus on best practices. Washington, DC: US Government Printing Office, 2002. Available at: http://www.nimh.nih.gov/publicat/massviolence.pdf (accessed Mar 2006).
4. Promotion, prevention and early intervention for mental health: a monograph. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000.
5. National Mental Health Plan 2003–2008. Canberra: Australian Government, 2003. ❑

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IN REPLY: I am sorry my article offended Morris; that was not my intention. In preparing it, I was troubled by the way fraudulent claims, including many I have directly encountered in Supreme Court actions, cheapen the regard the public has for those genuinely afflicted by war service. I was also concerned about extravagant claims regarding treatment, for effective care of veterans needs to be of proven benefit to the individual, not for academic advancement or to establish treatment empires. Morris refers to procedures for assessing claimants using experienced military officers and mentions a website targeting military impostors. I agree these positive developments fill a need.

Rayner provides thoughtful comment about how psychological trauma can best be managed in Australian Defence Force members. If treatment is under-resourced, as Rayner says, compensation seems over-resourced. Since publication of my article, I have received letters describing how easy it is for service members to claim compensation for traumatic stress. Unfortunately, any treatment method, however well planned and agreed upon, is handicapped when substantial rewards are easily accessible in regard to the condition being treated and motivation for recovery is reduced.

Although it might be politically expedient to focus resources more on compensation than on treatment, such an approach does not favour successful therapy and returning members to duty. If service members are to be effectively treated for trauma, the ADF might need to make some difficult decisions about access to compensation. Such decisions would not require a committee; but if a committee is appointed, as suggested by Rayner, its members should be disinterested parties in regard to trauma, compensation and litigation. ❑