Submission No 3

Inquiry into the Care of ADF Personnel Wounded and Injured on Operations

Name: Dr Andrew Khoo
Consultant Psychiatrist
Director of Group Therapy Day Programs
Toowong Private Hospital

Organisation: Private Capacity

Submission to the Defence Sub-Committee and the Joint Standing Committee on Foreign Affairs, Defence and Trade.

PO Box 6021

Parliament House

Canberra ACT 2600

Dr Andrew Khoo MBBS FRANZCP

Consultant Psychiatrist

Director of Group Therapy Day Programs

Toowong Private Hospital

PO Box 822

Toowong QLD 4066

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Mr Jerome Brown

Secretary

Joint Standing Committee on Foreign Affairs, Defence and Trade

PO Box 6021

Canberra ACT 2600

Dear Mr Brown,

re **INQUIRY INTO THE CARE OF ADF PERSONNEL WOUNDED AND INJURED ON OPERATIONS**

Thank-you for the opportunity to provide a submission to the Committee on this critical issue for distressed ADF Personnel, the Australian Government and health providers throughout Australia.

My name is Dr Andrew Khoo. I attained my fellowship from the Royal Australian and New Zealand College of Psychiatrists in 2002, receiving a College medal for my final year dissertation on Post Traumatic Stress Disorder. As well as being a private psychiatrist in Brisbane, I have worked in the Group Therapy Day Programs at the Toowong Private Hospital (TPH) for the last 11 years and have held the position as Director of this unit since 2004. Toowong Private Hospital is recognized as Queensland's leading private mental health care facility and is seen as a specialist centre in veterans mental health.

The TPH Group Therapy Day Programs area has run outpatient CBT based group therapy programs for currently serving ADF personnel and ex serving members with Post-traumatic Stress Disorder (PTSD) and Alcohol & Drug (A&D) for the last 12 years. Our programs are accredited by the Australian Centre for Post-traumatic Mental Health (ACPMH). To this point we have helped 1000 military/ex-military personnel and we have published, or are in the process of publishing, several academic papers in peer reviewed psychiatric journals.

This document will address the terms of reference as outlined in your letter. My comments or suggestions are based on my experience working with mentally unwell veterans and on evidence from the international peer reviewed literature (which I will attempt to reference throughout). Obviously I will restrict my input to psychiatric conditions, and most particularly depressive disorders, anxiety disorders and PTSD, and alcohol and drug use disorders.

Discussion of Terms of Reference

The 2010 Australian Mental Health Prevalence and Well Being Study carried out on serving ADF personnel found that over a 12 month period, 20% of the ADF population suffered from some from of mental health disorder. Whilst this is a similar rate to the general community, we are talking about a younger, more motivated, male dominated and physically more robust cohort. When the same cohort were asked if they had ever experienced an affective, anxiety or alcohol use disorder, this number increased to over 50%. If we combine these findings with US figures which show rates of 25-30% of returned soldiers exhibiting significant psychological symptoms ie a diagnosable mood, anxiety or substance use disorder, it would be a reasonable assumption to make that overseas deployment and exposure to trauma increases the incidence of psychological distress and disorder.

(a) treatment of wounded and injured ADF personnel while in operational areas;

Terms like PTS (post trauma syndrome) or COSR (Combat Operational Stress Reaction) attempt to capture any psychological distress following operational trauma. There is a bank of psychiatric literature dating back to the early 1900's which argues for on site crisis intervention (2). One of the oldest and best recognized of these approaches comes from Kardiner and Spiegel and is known as the PIE model (3). PIE stands for;

Proximity – treat casualties close to the front or in the operational area

Immediacy – treat without delay

Expectancy – with the expectation of a return to the front after rest/replenishment

The US military has extended this model and incorporated the use of BICEPS;

Brevity – Interventions are 1-3 days

Immediacy – treat without delay

Contact – Chain of command and unit remains in touch with soldier

Expectancy – with the expectation of a return to the front after rest/replenishment

Proximity – treat casualties close to the front or in the operational area

Simplicity – Brief, straight forward therapeutic methods used.

A US military paper reports that COSR's can account for up to 50% of the battlefield casualties experienced on operation and that the correct use of there procedures can return 95% of affected individuals to duty (4). Although founded on sound theoretical

underpinnings, the effectiveness of these models has never been proven and there is controversy surrounding utilization of any form of mandatory intervention ie debriefing or critical incident stress debriefing (CISD) in that they have not been shown to prevent (and may even increase) subsequent PTSD.

Contemporary academic opinion currently would favour the use of Psychological First Aid (PFA) rather than debriefing (5,6) and, with respect to the military, particularly aspects of psychoeducation, information on the various symptoms to monitor for and basic coping strategies, and appropriate avenues of referral both within the ADF and externally. The Royal Marines have been employing Trauma Risk Management (TRiM) since the early 2000's. TRiM is defined as a proactive, post traumatic peer group delivered management strategy that aims to keep employees functioning, provides education and support, and identifies those requiring specialist support (7). Military non-medical personnel are trained as TRiM practitioners and embedded within all units. This model has good anecdotal evidence and some preliminary scientific support. It is now also employed in the Royal Navy, the British Army and the RAF (8).

I would advocate for an extension of the ADF's "Keep Your Mates Safe" initiative where junior NCO's are trained to identify predictors of suicide in their men. I feel this model could be broadened to include indicators of psychological distress, non suicidal depression and PTSD.

(b) repatriation arrangements for wounded and injured personnel from operational areas to Australia;

I am unaware of current ADF protocols for repatriation of psychologically unwell personnel. It would however make sense that an attempt be made to manage individuals with COSR's on site initially. An individual should be repatriated if there is a clear DSM IV TR psychiatric diagnosis (to allow early specialist intervention) or if their COSR does not respond to onsite management.

(c) care of wounded and injured personnel on return to Australia, including ongoing health, welfare and rehabilitation support arrangements;

<u>Health & Rehabilitation</u>

Firstly, contemporary expert opinion would argue that all returning troops be provided with a PFA session – including psychoeducation on human responses to trauma, basic signs & symptoms to look for, support services, non-judgemental management and access to specialist treatment.

From 10 years experience treating current and ex-serving personnel, I am convinced that an ongoing, predominantly internal (ie on base ADF management) approach to treatment will remain a significant barrier to early identification of psychiatric illness. It is a recognized

phenomenon (and a recurring theme from my therapeutic contact) that there is a healthy stigma around mental illness in the male dominated military culture. Further there is a pervasive suspicion that military health personnel are not bound by the same confidentiality constraints as their civilian counterparts. Given a relative lack of civilian qualifications, many servicemen/women (with mortgages and young families) fear the impact that disclosing psychological injury will have on their ongoing employability, deployability and promotional opportunities.

The ADF's recent initiative of giving their employees a mandatory 2 year period of treatment/rehabilitation/vocational training (either back into ADF employment or into the civilian world) once a significant injury is identified is a great step forward.

Welfare

A transparent, simple and efficient procedure for allowing an injured ADF member to access health care and support, and if need be to smoothly transition to DVA funding, should be the goal.

(d) return to work arrangements and management for personnel who can return to ADF service;

I was very encouraged to recently hear that the ADF had reconsidered their stance on the non-operational status of all members on antidepressant medication. The majority of newer antidepressant agents are very well tolerated, widely prescribed and utilized, and allow an individual to operate at full capacity in any number of occupations. Operational status should be judged on an individual case by case basis through good channels of communication between specialist and employer (precisely as it is in the civilian situation with driving, operating heavy machinery, police officers, emergency workers, etc).

(e) management of personnel who cannot return to ADF service including:

(i) the medically unfit for further service process;

Care should be taken to involve the ADF member as much as is reasonably possible in decision making. The process of resolving the loss of one's career path is easier for an individual if they feel that it was their considered choice, or at least that their difficulties were acknowledged. The use of independent external psychiatrists/psychologists (with experience in dealing with military personnel) would reduce the perception of being deliberately moved on by the system, or of confidentiality breaches within the ADF.

It is my feeling that this collaborative process of medical discharge along with the aforementioned defined period of rehabilitation and vocational training would allay the feelings of abandonment by the services often reported in recently discharged personnel.

This perception of rejection contributes in a significant way to anger and guilt, both of which are poor prognostic factors in PTSD, anxiety disorders, mood disorders and substance use.

(ii) transition from ADF managed health care and support to Department of Veterans' Affairs managed health care support;

The process of recognition by the DVA of an individuals psychiatric diagnosis/es is for many ex servicemen/women a grueling, prolonged, invalidating and dehumanizing experience. Whilst I understand that strict processes are required to efficiently and fairly investigate large numbers of claims and that the Department has a defined budget, many veterans feel that they are viewed by DVA as trying to cheat the system until proven otherwise. The majority of veterans and advocates (whom I have contact with) impression is that a steadily increasing proportion of claims seem to be proceeding to the Veterans Review Board and the Administrative Appeals Tribunal, which indicates that the DVA are looking for reasons not to provide compensation rather than ways to support their clients.

This is a difficult situation to find a suitable cost efficient solution for but the fact remains that the DVA Compensation process complicates, aggravates and perpetuates the preexisting psychological distress suffered by veterans and their families. With 69000 returned/returning ADF personnel from Timor and the Middle East, perhaps part of the answer is increasing numbers of DVA delegates/case managers, reducing their case loads, providing inservices re common veteran psychological problems, typical veteran presentations, communication styles, etc.

(iii) ongoing health care and support post transition from the ADF.

An individual who has been deemed medically unfit for further service in the ADF should leave the services with a defined short, medium and long term, multidisciplinary and evidence based medical discharge plan.

The inevitable exposure to traumatic situations during overseas deployment makes primary prevention of psychiatric conditions difficult if not impossible. Hence, the tenets of early identification and treatment are paramount. Basic psychoeducation, PFA and TRiM aim to improve identification of psychopathology and self referral. It follows then that individuals identified with PTSD, anxiety disorders, depressive disorders and substance use disorders should receive evidence based best practice management whilst in the forces and, if needs be, once they are discharged. Whilst mandatory debriefing type interventions have a conflicting evidence base, the literature is consistent with regard to the benefits of early intervention once PTSD has been identified.

With regard to PTSD, meta-analysis of experimental data and International Clinical Practice Guidelines advocate for a cognitive behavior therapy (CBT) based psychotherapeutic approach which involves trauma focused elements (5,6,9). This is seen as the primary therapeutic approach which may or may not require augmentation with pharmacotherapy.

Evidence would also promote this approach (ie CBT +/- medication) for dealing with other anxiety disorders and depressive disorders (10,11,12).

The CBT should be delivered by a trained/qualified professional and each individual should receive psychiatric review to investigate pharmacotherapeutic augmentation options. When considering management of returning troops, strong consideration should be given to group CBT, given

1. equivalent outcomes for group vs individual treatment in PTSD
2. the significant numbers of returning troops
3. the relatively low numbers of specialist veterans mental health services
4. servicemen's experience of receiving training in groups
5. servicemen's greater comfort and support around their military peers

I would suggest that the comprehensive group programs which are accredited by the Australian Centre for Post-traumatic Mental Health are most applicable.

The Veterans and Veteran's family Counselling Service (VVCS) currently funded by the DVA fills a niche in supplying qualified counselors and psychologists for individual work with veterans and their families. VVCS is often the first port of call for veterans and their families but they do not provide comprehensive group programs and are not able to appropriately address broad treatment plans given their lack of medical staff. I would suggest VVCS would function ideally within existing health structures as a service which engages and screens individuals, provides individual counseling and group psychoeducation to those who are essentially coping (or have specialist treatment options in place), and refers on those personnel with acute psychiatric symptoms for specialist assessment and treatment.

In conclusion, the authors of the US Department of Defence, Guidelines for the Treatment of PTSD feel the biggest difference we can make to treatment outcomes is to better identify individuals with disorder and maintain them in treatment. In my experience these comments would be equally applicable to a servicemen/ex-servicemen cohort if broadened to include depressive disorders, other anxiety disorders and substance misuse. Ideally treatments should be evidence based and comprehensive addressing biological, psychological and lifestyle elements. Where possible the use of multi-disciplinary input is optimal.

It is my feeling that if we are going to be comfortable as a government and a nation sending our young men and women overseas where many will become permanently injured and some will not return, then we need to make similarly "hard decisions" regarding funding the best possible care for them on their return.

Please do not hesitate to contact me should you require further information or clarification.

Sincerely

Andrew Khoo

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