Submission to the Senate Select Committee on Mental Health

Sons and Daughters of Vietnam Veterans in Australia

Introduction

From 1962 until 1975, some 50,000 Australians served in Vietnam. The mental and physical health problems faced by many of those veterans are well known.

From 1950 until the present, those Vietnam Veterans had some 90,000 sons and daughters. The mental and physical health problems faced by those sons and daughters have only recently been identified and responded to.

Sons and daughters of Vietnam Veterans are three times more likely than other members of our age cohort to commit suicide. We are more likely to die in accidental deaths. We are more likely to experience depression. We are more likely to abuse alcohol or other drugs. Simply being a son or daughter appears to be enough to result in elevated risk of mental illness.

However, many sons and daughters have also developed remarkable personal resilience to the challenges in our lives. The purpose of this submission is to draw the Committee's attention to sons and daughters as a distinct mental health community, and to explain some ways in which Australia's mental health system can help us.

Emergence of sons and daughters as a group at risk

In the late 1990s, the Australian Institute of Health and Welfare (AIHW), on behalf of the Department of Veterans Affairs, conducted the "Morbidity of Vietnam Veterans" study, which aimed to establish a complete picture of the health of Vietnam Veterans and their families. The first volume of the report, which looked at male veterans, was released in April 1998. Its mental health findings included findings that:

- 30 percent of Veterans reported experiencing panic attacks
- 31 percent of Veterans reported suffering post traumatic stress disorder (PTSD)
- 41 percent of Veterans reported anxiety disorders; and
- 45 percent of Veterans reported depression.

Volume 1 of the morbidity study also discovered profoundly alarming statistics regarding the sons and daughters of Vietnam Veterans. As part of the survey of veterans, researchers asked about the causes of death for sons and daughters who had died prior to the survey. They reported their findings, along with the expected ranges based on ABS data. The numbers are so tragic that they need not be further introduced:

Manner of death	Reported number	Expected number	Expected range	Reported, % of expected
Illness	893	805	749-861	110.93
Suicide	247	75	58-92	329.33
Accident/other	887	365	328 - 402	243.01

To place these figures in context, senators should realise that there is an inevitable overlap between suicide and accidental death, because where the suicide method chosen is, for instance, a deliberate single vehicle collision, it may be impossible to distinguish from an accidental death. In addition, a person with a suicidal ideation may be more likely to engage in risky behaviours which may lead to accidental death.

These statistics are heartbreaking. It is even more heartbreaking to realise that it is likely that many more attempts at suicide were made, but not recorded as they were not completed (and thank goodness).

A validation study was conducted in 1999. This study confirmed the results in the initial morbidity study. Further research was conducted by the AIHW on suicide among sons and daughters, resulting in the release of *Supplementary Report No. 1: Suicide in Vietnam Veterans' Children*, released in July 2000. This report is at Attachment A.

This study examined 111 confirmed case of suicide among sons and daughters, and looked more closely at aspects of those suicides including the age of the son or daughter at death, their birth cohort, and their manner of suicide.

It found that the elevated rate of suicide was consistent across more a decade from 1988 through 1997. The best full year was 1989, where the suicides among sons and daughters was merely double the expected rate. In 1993, the worst full year, suicide among sons and daughters was nearly 6 times the expected rate.

Characteristics of sons and daughters

Sons and daughters of Vietnam Veterans are an elusive group to describe other than simply as sons and daughters. Some were born as long ago as the 1940s. Others are very young. More may yet be born. In the main, however, sons and daughters were born between 1960 and 1985, making them currently 20 to 45 years of age.

Beyond this, all is guesswork. Sons and daughters are difficult to identify for a number of reasons. In many cases, sons and daughters have little to do with their parent or veteran parent and so can be difficult to identify. For many of us, "son or daughter of a Vietnam Veteran" has never been a meaningful label. Certainly not something we might associate with depression or other mental illness we may be suffering.

We are left, therefore, with evidence of a large population of Australians who are substantially at risk of mental illness or suicide, but who have no idea that this is so. They are likely to have no idea that mental health services are available to them through the Vietnam Veterans' Counselling Service. In some cases they may not even be aware that they are the son or daughter of a Vietnam Veteran.

Department of Veterans Affairs programs

The Department of Veterans Affairs responded to the figures outlined above by developing a "sons and daughters" program which had the following strategies:

- to develop an understanding of the key issues and risk factors for the mental health of sons and daughters;
- to provide appropriate intervention for "at risk" sons and daughters within the VVCS and within other relevant agencies;
- to provide mental health promotion programs for the sons and daughters and parents; and
- to pilot innovative strategies to address the identified mental health issues. Risk factors and general well being issues for sons and daughters.

At a practical level, the sons and daughters program has resulted in:

- efforts by the Vietnam Veterans' Counselling Service to inform other health professionals, and particularly primary care providers, about the added mental health risks associated with sons and daughters;
- extension of the counselling services of the Vietnam Veterans' Counselling Service to sons and daughter aged 36 years or less, for issues relating to their veteran parent's war service;

- initial consultation and assessment for sons and daughters regardless of the nature of their issue (for appropriate referral to more specialised agencies if the issue does not relate to the veteran parent's war service);

- development of a range of group programs and "psycho-educational" programs to assist sons and daughters to develop skills of resilience;

- the publication of a book, entitled … *and the Pine Trees seemed Greener after that*, which contains written and visual pieces by sons and daughter, reflecting their lives and experiences, and which also contains written pieces by mental health experts in areas such as depression, relationships, parenting, drug and alcohol abuse, and resilience. We have provided, with this submission, a copy of this publication for each Senator on the committee. The book is available free of charge to veterans, partners, and sons and daughters.

Impressionistic evidence, and a more detailed study evaluation study undertaken in July 2003, suggest that these programs have been effective in contributing to the mental health outcomes for the sons and daughter who are aware of the program. Because sons and daughters are, as noted above, a disparate group, the reach of these programs has been somewhat less than might be hoped for – approximately 8,000 of the 90,000 sons and daughters have had some contact with the DVA or the VVCS.

The submitters' authority

Because sons and daughters are not a coherent group, and because "son or daughter of a Vietnam Veteran" is not, in most cases, an important self-identifier for sons and daughters, there is no single "peak body" to speak on our behalf. Some groups and networks have begun forming around Australia, but compared to advocacy groups which exist in other areas of mental health, the sons and daughters groups are in their infancy.

Consequently, while the authors of this submission presume to speak on behalf of sons and daughters of Vietnam Veterans, our right to do so must be subject to challenge. Having said this, we are among the more active sons and daughters.

Dr. Anthony Marinac was on the editorial panel for … *and the Pine Trees seemed Greener after that* and co-wrote the depression article for that publication. He has been appointed by the Minister for Veterans Affairs to participate as a representative of sons and daughters in a consultative forum for a feasibility study currently underway into the health of sons and daughters. His father served in 2 Squadron RAAF in Vietnam.

Ms Anne Matheson is a psychologist and social worker, and is an active participant in the Sons and Daughters Victorian Network. She has conducted research, volunteer work, and professional work within veteran communities. Anne is also a representative of sons and daughters in the consultative forum mentioned above. In addition, she is on the Scientific Advisory Panel for the same project. Her father served in the 8th Battalion, Royal Australian Regiment, in Vietnam.

Responses to terms of reference

(b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care.

Prevention

It is clear that some sons and daughters have poor mental health, and poor skills of resilience. While there is no conclusive study, it seems almost certain that some element of this poor mental health arises from the mental health and parenting skills of the Veteran parent. Indeed, it almost offends common sense to avoid this conclusion. For most sons and daughters, it is now too late to prevent the experiences of these formative years from having an impact. However, a lesson may be learned from the sons and daughters of Vietnam Veterans.

The lesson, simply, is that whenever Australia chooses to send men and women into armed conflict, they expose those men and women to traumatic experiences. For some, perhaps many, of those personnel, this exposure to trauma will result in mental illness, or leave them vulnerable to later mental illness. In turn, this may result in their children growing up in family circumstances not dissimilar to those which faced many sons and daughters of Vietnam Veterans – with the potential for similar consequences.

The only way to prevent this, short of avoiding conflicts, is to ensure that when service personnel leave an area of conflict, *and for years thereafter*, the government must pay close and constant attention to their state of mental health. By preventing or minimising mental illness among veterans of Rwanda, Somalia, East Timor, Bougainville, the Solomon Islands, Afghanistan and Iraq, government may also prevent consequent mental illness among their sons and daughters.

Early intervention

The DVA's group programs in areas such as parenting, relationships and lifestyle skills, are all important ways to provide early intervention, supporting sons and daughters before acute problems develop. However, these programs only reach a relatively small number of sons and daughters. Many sons and daughters – and perhaps those most at risk – have no idea that these services are available to them.

The best forms of early intervention for sons and daughters are likely to come about as a result of primary carers realising that a son or daughter in the early stages of, say, a depressive episode, is at additional risk of that episode becoming acute and possibly leading to self-harm or suicide. However, in order to do this, primary carers (and in particular general practitioners) must realise that sons and daughters of Vietnam Veterans are at risk; and, further, they must realise that it is legitimate, and in the case of patients born between 1960 and 1985 important, to inquire as to whether they have

a parent who served in Vietnam. The presence in the family of a veteran parent must become an important part of the medical history for that patient.

Through sons and daughters program, the Vietnam Veterans Counselling Service has distributed information kits to other health carers, including GPs. These may be of some assistance. However, GPs are constantly bombarded with all sorts of information. To the best of our knowledge, there has been no follow-up testing to establish whether these kits were able to cut through the "static" of information supplied to GPs; neither has there been testing to establish whether GPs or other primary carers now routinely seek to establish whether or not the risk factor "son or daughter of a Vietnam Veteran" is present in patients who present with mental or psychological illness.

In many cases, we suspect that early intervention from sons and daughters will come about as a result of our mothers. Partners of Veterans group have been becoming more active in recent years, and many partners have been learning for the first time about the additional risks faced by sons and daughters. Armed with this knowledge, it is often the partners who prompt the son or daughter to seek counselling or care.

Crisis care

Like all others who find themselves on the point of suicide, sons and daughters who are in need of immediate crisis care should call 000. Anyone, any time, who confronts the possibility of suicide must realise their life is in danger and dial 000.

In addition, sons and daughters are entitled to call the Veterans Line on 1800 011 046. The name "Veterans Line" may well be an impediment to some sons and daughters using this service, which is a pity as the counsellors associated with this service are most likely to recognise the particular needs of sons and daughters.

Finally, like all others, sons and daughters may seek help through other crisis care agencies such as Lifeline. The VVCS has taken steps to advise other crisis care agencies of the situation of sons and daughters of Vietnam Veterans, and we understand that some agencies have included this question on their triage or initial assessment forms. We submit that this should be universal.

(d) the appropriate role of the private and non-government sectors.

Sons and daughters who receive counselling through the VVCS are often treated by counsellors who provide their services on a contractual basis, rather than being directly employed by the VVCS. This is particularly the case in rural and regional areas. In most cases, this is not problematic – it is unreasonable to expect the VVCS to maintain a stock of in-house counsellors right across Australia.

However, the use of contract counsellors does pose a challenge which the VVCS must manage. Contract counsellors may not have any particular knowledge about, or interest in, either Veterans or sons and daughters. The VVCS has recently begun

paying much more attention to "skilling up" contract counsellors who seek contract work through the VVCS.

This situation is unlikely to be unique to sons and daughters. Any central agency who seeks to use contract counsellors must not assume that those counsellors come equipped with the specialised skills needed to deal with that client group. The use of contracts counsellors cannot mean less need to invest in the skills and knowledge of the counselling staff.

(f) the special needs of groups such as children, adolescents, the aged, indigenous Australians, the socially and geographically isolated, and of people with complex and co-morbid conditions and drug and alcohol dependence.

This is perhaps the most important term of reference for sons and daughters. It is vital that this committee recognises sons and daughters of Vietnam Veterans as a distinct group with distinct needs, just in the same way that adolescents, the aged, indigenous Australians and rural and regional Australians are recognised as distinct groups with distinct needs.

The particular needs which we have are:

- Concerted activity to learn how many sons and daughters of Vietnam Veterans there are, who they are, and where they are;

- Provision of advice to sons and daughters that they face additional mental health risks as a result of their parents' service;

- Awareness among all crisis care providers that, particularly for a suicidal client, it is important to learn whether their mental health history includes parenting by a Vietnam Veteran; and

- Government commitment to ongoing funding and support for counselling for sons and daughters.

- In addition, we need to know we will be the last generation to face this. We need to know that the Defence Force is paying more attention to psychological care for troops returning from battle, both immediately after service and for some years thereafter.

(g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness

(h) the role of primary health care in promotion, prevention, early detection and chronic care management

These are perplexing questions. On the one hand it would be simple to argue that primary health carers play a vital role in all of these things. And so they do. However the complexity of primary health care increases by the day. Many areas of Australia

face a shortage of GPs and other health care professionals, placing further pressure on those who *do* practice. There is, simply put, a limit to what we can plausibly expect from primary health carers.

What might we, as sons and daughters, plausibly expect from primary health carers? We argue that for patients born between 1960 and 1985, it should be routine for doctors, when first seeing this patient and learning about their history, to learn whether they have a veteran parent. The mere presence of this line on the patient's history card makes it more likely that, if they do face an episode of mental illness, the doctor will make the connection between the patient's condition, and the services available to support them.

(i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated

According to the VVCS, sons and daughters come into contact with the service for "episodes of care". That is, they encounter a particular crisis or difficulty, undergo sufficient counselling to get them through, then move out of contact with the VVCS until the next time they have a particular need for care. This mode of contact has both advantages and disadvantages.

An advantage is that the risk of iatrogenesis is lower. Sons and daughters do not appear to be inclined to become dependant on counselling services on a regular, long term basis. They want to get in, get well, and get out.

A disadvantage, of course, is that by engaging with services episodically, sons and daughters may deal with an immediate crisis without laying the groundwork for longer term mental health.

(l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers

The issue of stigma as it relates to sons and daughters is very interesting. Sons and daughters themselves face no particular stigma from society in general. However for Vietnam Veterans the story is different. The stereotype of the "crazy Viet Vet" is still current for many people, and is still regularly fed into Australian culture from Hollywood. Despite the recent reconciliation between Australian society generally and Vietnam Veterans, it remains the case that for many years – and for most of our childhoods - our fathers were social pariahs. They were always proud to be Vietnam Veterans, and we were mostly proud of them, but society endorsed neither their pride nor ours.

Consequently, for many sons and daughters it was easier and safer to either ignore the fact that their parent was a veteran, to pretend they were not a veteran, or to join with the rest of society in holding them in contempt. If being a son or daughter meant, in the eyes of society at large, being the son or daughter of "one of those crazy blokes

who fought in that unjust war" then it is little wonder that many sons and daughters do not readily self-identify as such. The consequence, as noted above, is the frustrating situation where we know there are 90,000 of us out there, we know there are 90,000 at risk, but we can only find one in ten of them.

(n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated

As noted above, knowledge regarding the mental health challenges faced by sons and daughters of Vietnam Veterans came about virtually by accident. The focus of the morbidity study was clearly in Vietnam Veterans. It would have been entirely justifiable for the research team to erase the question about the manner of death for sons and daughters, in favour of another question about the Veteran themselves. ?Had that happened, there would be no sons and daughters program, and even the minimal awareness which currently exists within the sons and daughters community would be lacking.

It is, of course, in the nature of research that sometimes these happy accidents occur. And the potential for new research is limitless, while the money available to support that research is not.

Overall, the Department of Veterans Affairs must be commended for the efforts it has made to find out more about the mental health challenges facing sons and daughters. We did not lobby for any of this. We are not – or, at least, were not – a key client group for the DVA or the VVCS. These agencies simply saw the tragic suicide figures which emerged from the morbidity study and realised something had to be done.

As relative newcomers to the mental health "community" in Australia, however, we were surprised at how disparate the different arms of the profession are. Having conducted its initial focus groups with sons and daughters, the VVCS had to invest significant time and money into disseminating knowledge about the risk factors for sons and daughters into the wider mental health community. We were surprised that few pathways appeared to exist for this to happen.

Some organisations and networks do exist. Auseinet, the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (www.auseinet.com) is one good example. These do some fantastic work. However this could be built upon.

We submit that the Government should, in conjunction with mental health professionals, fund a "clearing house" of mental health information and research in Australia. This should be oriented at researchers and practitioners rather than at mental health consumers. Researchers should be able to register their current research projects and browse for others doing similar work. It should be possible to publish and circulate findings, work in progress, or even just good ideas. Where an organisation (such as, in our case, the VVCS) has information which could be useful

to others right across the profession, this should be disseminated. The effect of such a clearing house would be to make *current research work harder*.

(p) the potential for new modes of delivery of mental health care, including e-technology

In many cases this has gone well beyond mere potential. Many mental health providers and organisations already have an online presence, and for many younger people the internet is likely to be their first port of call for information and guidance. If the Committee wishes to learn about websites which are already delivering advice and encouragement online, it may wish to consider some of the following sites, which sons an daughters have found helpful:

Beyond Blue - www.beyondblue.org.au

Beyond Blue has a focus on depression, but has some wonderful areas such as "BlueVoices" where experiences of depression are shared. Importantly, the "Immediate assistance" link is easy to find and may put people in crisis directly in touch with support.

YBBlue – www.ybblue.com.au

YBBlue is a section of the Beyond Blue website with a specific focus for young adults in the 17 – 25 age bracket. From the Committee's perspective the interest factor may be that Beyond Blue has taken these steps to deliver mental health advice in different internet "packaging" for different client groups.

HeadRoom – www.headroom.net.au

HeadRoom has a focus on adolescents and teens, so may be a little "young" for sons and daughters but it is an excellent example of how the web can be used to engage younger people.

Department of Health and Ageing, Mental Health Branch – www.mentalhealth.gov.au

For a contrast, look at the Department's page. We realise that the current government is uncomfortable with corporate-style logos and approaches to presentation, but in reality this graphics-light, text-heavy list of links is quite uninviting compared to the websites indicated above. It is difficult to find information. It's just not set up to help.

We would invite Senators to log onto this website and see how long it takes you to find a useful, practical answer to the question "I am feeling depressed and suicidal. Who can I talk to, and who will help?"

On Beyond Blue, one click. Hit the "immediate assistance" button and you're there. On YBBlue, one click. Look for the bright red and yellow exclamation mark saying "Need help now?" and you're there. On HeadRoom, no clicks. It's (unfortunately) in the fine print at the bottom of the page, but the resources are there. Otherwise, pick your age group and click "services" for a more comprehensive list (so, 2 clicks).

On the Mental Health Council of Australia's website, one click. Click the "Help & Information" link and you're there. On the Lifeline website, 13 11 14 is the first thing you see. On Mensline Australia, 1300 78 99 78 is the first thing you see.

On the Department's website, start with "contact us". It's just a switch number. So try scrolling down to resources. Nope, nothing there. Mental Health Publications? Nope. National Suicide Prevention Strategy? Nope. A link called "Mental health Branch Links" leads to links to media organisations! Another one, also called "Mental Health Branch Links" gets us to a number of the websites mentioned above. From here we can click beyond blue and get some help. The government website was no help at all.

The point here is twofold: first, to deliver useful information to young people online it must be presented attractively and in an engaging way. Second, the crisis care resources need to be absolutely "in your face" the moment a person logs on. It should be easy to locate information. For consumers, a page like the Department's page is, regrettably, pointless.

Summary and Recommendations

As a consequence of this submission, we have four recommendations to make to the Committee.

1. We recommend that the Committee, in its report, recognise that sons and daughters of Vietnam Veterans are a mental health community with its own distinct characteristics and risk factors.

2. We recommend that the government continue its commitment to supporting sons and daughters of Vietnam Veterans and to arresting the tragic suicide rate among us. We are grateful for the work undertaken so far.

3. We recommend that the government establish and fund a mental health "clearing house" which proactively seeks to make links between different areas of the mental health community in order that research, insights and practices can be disseminated as widely as possible.

4. We recommend that the government review its web publication strategy, and that the Department of Health and ageing be given permission to make its mental health site look as little like a government website as possible.