Welcome to tonight's webinar. It will start at 7:15 pm AEDT.

Join a local Veteran-focused Mental Health Professionals' Network:

Networks are currently located in the following areas:

- Brisbane
- Perth
- Newcastle
- Liverpool (NSW)
- Gippsland
- Townsville
- Canberra
- Melbourne
- Adelaide

To join or find out more, click on the **supporting resources tab** (bottom right of your screen) and view the 'Join a network' document.

Mental Health and the Military Experience

WEBINAR SERIES

mhpn
Mental Health Professionals' Network

Australian Government
Department of Veterans' Affairs

Mental Health and the Military Experience

Suicide Prevention and Safety Planning for the Veteran Community

mhpn
Mental Health Professionals' Network

Australian Government
Department of Veterans' Affairs

Tonight's panel

Prof. Barbara Stanley
Professor of Medical Psychology

Dr Jenny Firman
Chief Health Officer and GP

A/Prof Glenn Melvin
Clinical Psychologist
(Facilitator)

This webinar series

This is the fourteenth of fifteen webinars in the Mental Health and the Military Experience series. It has been made possible through funding provided by the Department of Veterans' Affairs.

Learn more about the Department of Veterans' Affairs by visiting: www.dva.gov.au

You may have noticed the webinar room looks a little different: we've had an upgrade.

To access platform's functionality and the webinar's resources, hover over the colorful icons to the top right of your screen:

- open the chat box
- access resources including ground rules, panel biographies, PowerPoint slide show and supporting resources
- open the feedback survey

Learning Outcomes

After participating in this activity attendees will:

- have increased knowledge of current U.S and Australian research and how it informs suicide prevention initiatives
- be better able to recognise and respond to risk indicators, warning signs and protective factors for suicide in the veteran community
- have increased understanding of how safety planning can be used to support veterans who are at risk of suicide, have experienced suicide ideation and/or attempted suicide
- have access to and know how to use some of the tools and resources that are available to assist with safety planning in the veteran community

How to use the chat box

The purpose of this webinar is to give health professionals the skills they need to help people more effectively in future. Personal stories of illness are very important; MHPN often includes the lived experience voice on our panels.

The chat box however is not a forum for personal stories: it is designed to complement the panel discussion by allowing professionals to share resources, and their experiences of practice.

If content in tonight's webinar causes distress, please seek care by phoning Beyond Blue 1300 22 4636 or contacting your GP or local mental health service.

Veterans, Mental Health, Suicide Prevalence and Prevention

National suicide monitoring of serving and ex-serving Australian Defence Force personnel

- Between 2001–2016 there were 373 suicides in serving, reserve & ex-serving ADF personnel with 1 day of service since 2001.
- Of these, 198 (53%) occurred in ex-serving personnel.
- The age-adjusted rate of suicide over the period 2002 to 2016 was 51% lower for current serving men, 47% lower for men in the reserves, and 18% higher for ex-serving men.
- In 2014–2016, ex-serving men aged under 30 had a suicide rate 2.2 times that of Australian men the same age.

Dr Jenny Firman

Vulnerable veterans

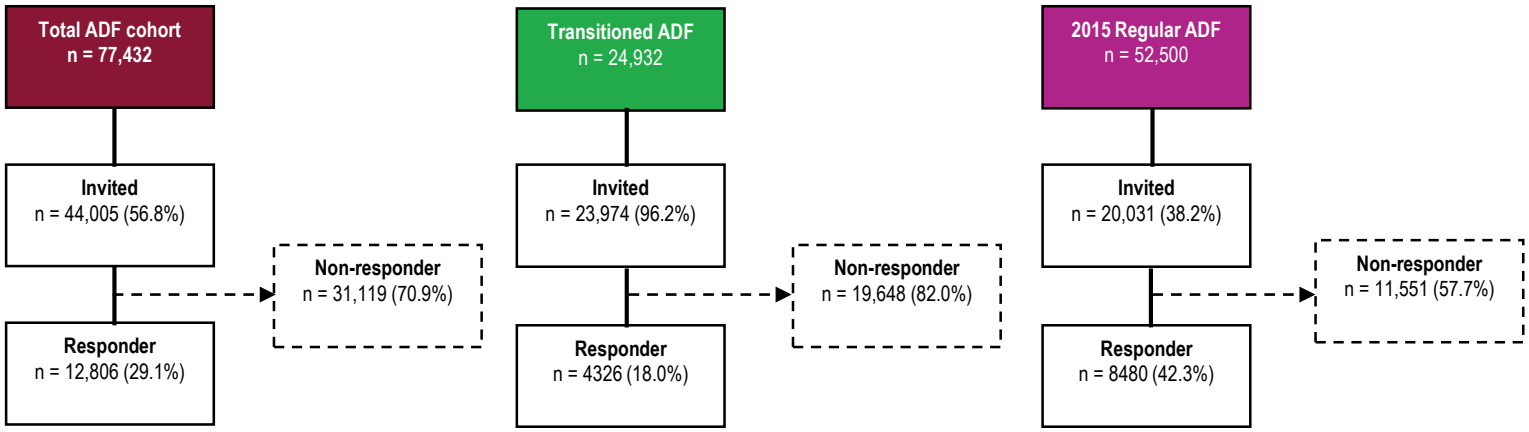
The AIHW report indicated that ex-serving men are at greater risk of suicide, compared to their peers, if they share one or more of the following service-related characteristics:

- aged 18–29 years
- discharged involuntarily (particularly if discharged for medical reasons)
- left the ADF with less than one year of service
- held a rank other than commissioned officer at discharge

Dr Jenny Firman

Transition and Wellbeing Research Programme

Survey response rates for the Transitioned ADF and the 2015 Regular ADF



Dr Jenny Firman

Suicidality in transitioned ADF members

Transition and Wellbeing Research Programme – Mental Health Prevalence Report, 2017

Self-reported suicidal ideation, plans and attempts in the Transitioned ADF

Suicide n (%) represent those answering yes to these items	Transitioned ADF 2015 (n = 24935)		
	Weighted n	**%**	**95% CI**
Felt life not worth Living	7208	28.9	(27.3, 30.6)
Felt so low thought about committing suicide	5294	21.2	(19.8, 22.8)
Made a suicide plan	1965	7.9	(7.0, 8.9)
Attempted Suicide	505	2.0	(1.6, 2.6)
Any suicidality*	5342	21.7	20.2, 23.3

** Calculated as yes to either felt so low thought about committing suicide, made a suicide plan, or attempted suicide*
Note: 95%CI: 95% Confidence Interval

Dr Jenny Firman

Awareness of risk factors

- **Not all individuals with evident risk factors will be suicidal;** conversely, some individuals may show no apparent or very few risk factors, and yet still may go on to suicide.
- Highlights the idiosyncratic nature of suicide risk factors and the need for evaluating an individual's suicidality.
- Risk factors are valuable, not through provision of a predictive check-list or categorical based 'risk factor' scale, but to aid in providing an estimation of a person's suicide vulnerability.

Dr Jenny Firman

Protective factors

- Significantly lower all-cause mortality in the **full-time serving and reserve ADF populations** compared with all Australian men provides evidence of a healthy soldier effect;
- Significantly lower suicide rates for men serving full time and in the reserves, compared with all Australian men (AIHW 2017b), are consistent with significantly lower mortality from all causes of death in these groups.

Dr Jenny Firman

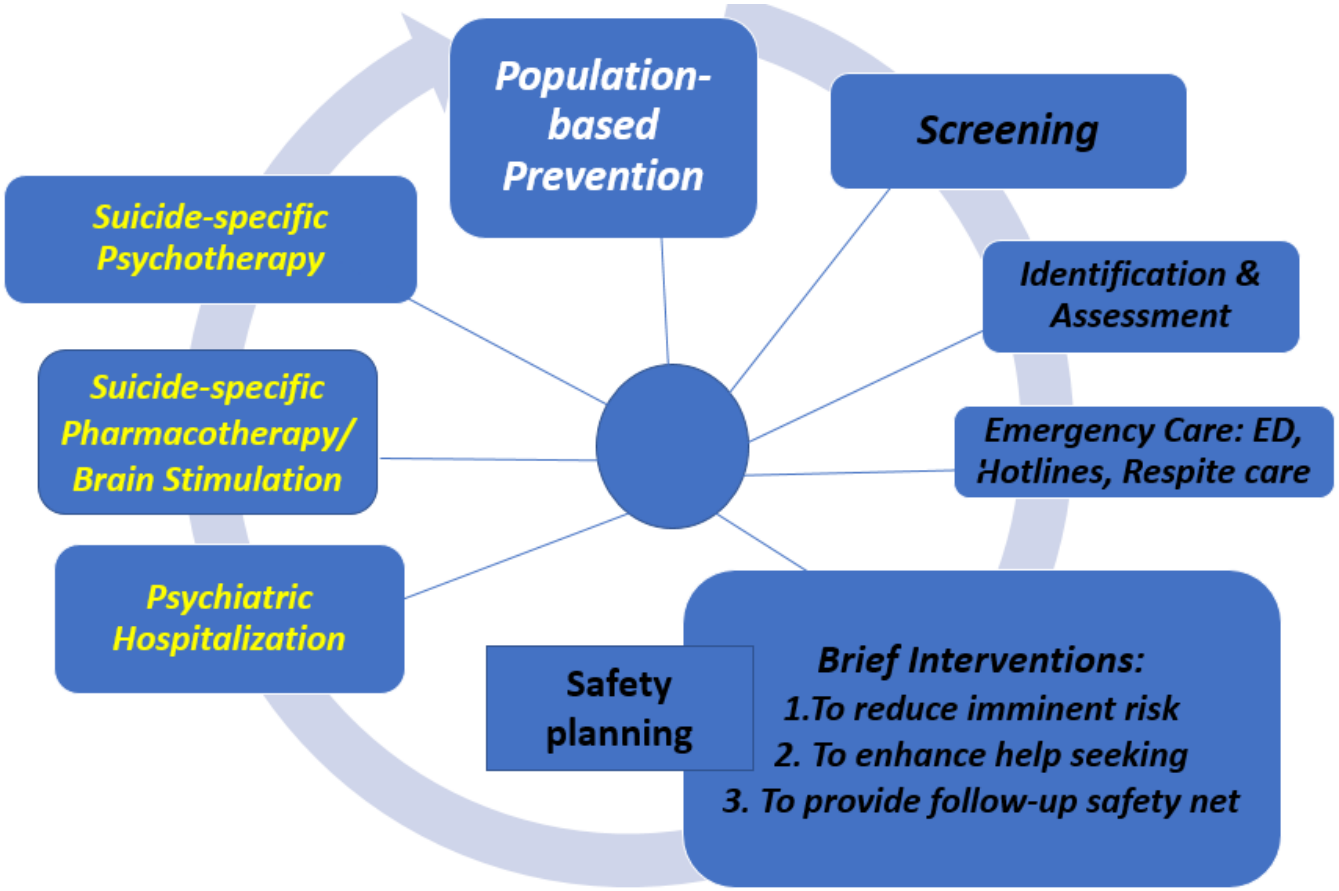
Protective factors

- Research on protective factors in the field of suicide prevention is still in its infancy and has largely been based on the literature around protective factors in mental health in general. Includes:

- Spiritual or religious faith including religion and moral objections to suicide
- Cultural identity, norms and values of country of origin
- Problem solving and coping
- Self-esteem, self-efficacy and perceived competence
- Responsibility to family (children, spouse/partner)
- Good physical health (especially in old age)
- Being married (for men)
- Fear of stigma and social disapproval
- Compliancy with treatment, and help seeking behaviour
- Restricted access to lethal means of suicide
- Hopefulness and plans for the future
- Fear of suicide death

Dr Jenny Firman

Suicide Prevention Components

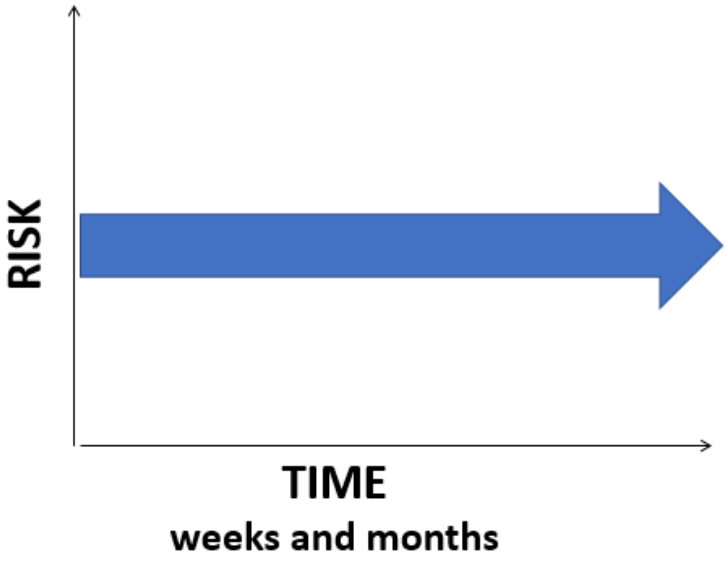


Prof. Barbara Stanley

Elevated, More *Chronic* Suicide Risk

e.g. Depression, SUD, Hopelessness, Persistent Stressors.

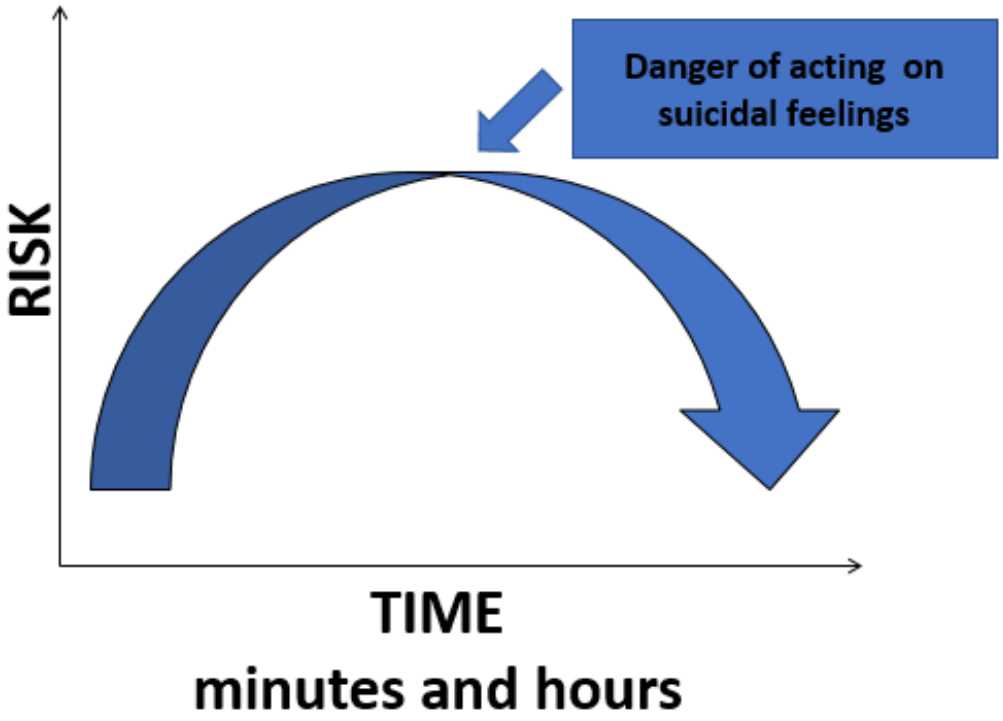
Treatment: disorder-specific and suicide-specific psychotherapy, medication



Prof. Barbara Stanley

Acute Suicide Risk Fluctuates Over Time

Treatments: brief crisis interventions, fast-acting medications, emergency care



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Targets of Suicide Prevention Interventions

--Acute risk interventions +

--Chronic (longer term) risk interventions +

--Build emotional reserve and resilience

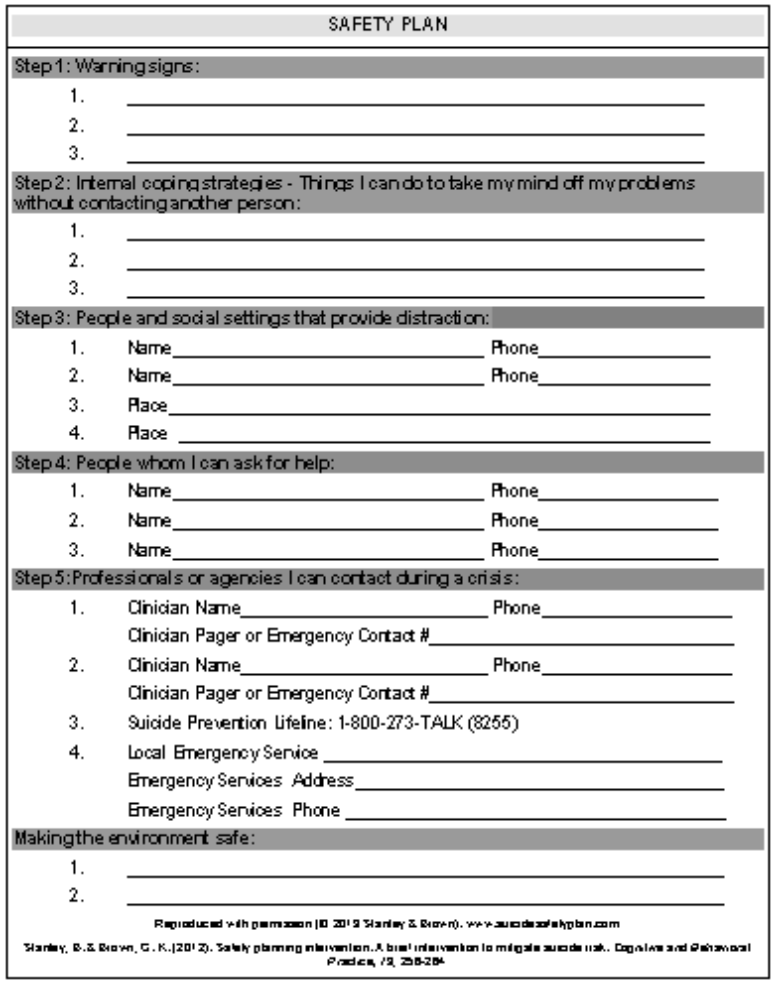
Prof. Barbara Stanley

Plane Safety Measures

Prof. Barbara Stanley

Safety Planning Intervention 'SPI' (Stanley & Brown, 2008)

- Clinical intervention that results in a prioritized written list of warning signs, coping strategies and resources to use during a suicidal crisis
- Creates a tool for participants to use in distress: step-wise increase in level of intervention
  - Starts "within self" and builds to seeking help from external resources such as emergency services
- Plan is step-wise but individual can advance in steps without "completing" previous steps
- SPI can be done in one brief session and altered over time
- Safety Planning process is brief - about 45 minutes



SAFETY PLAN

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

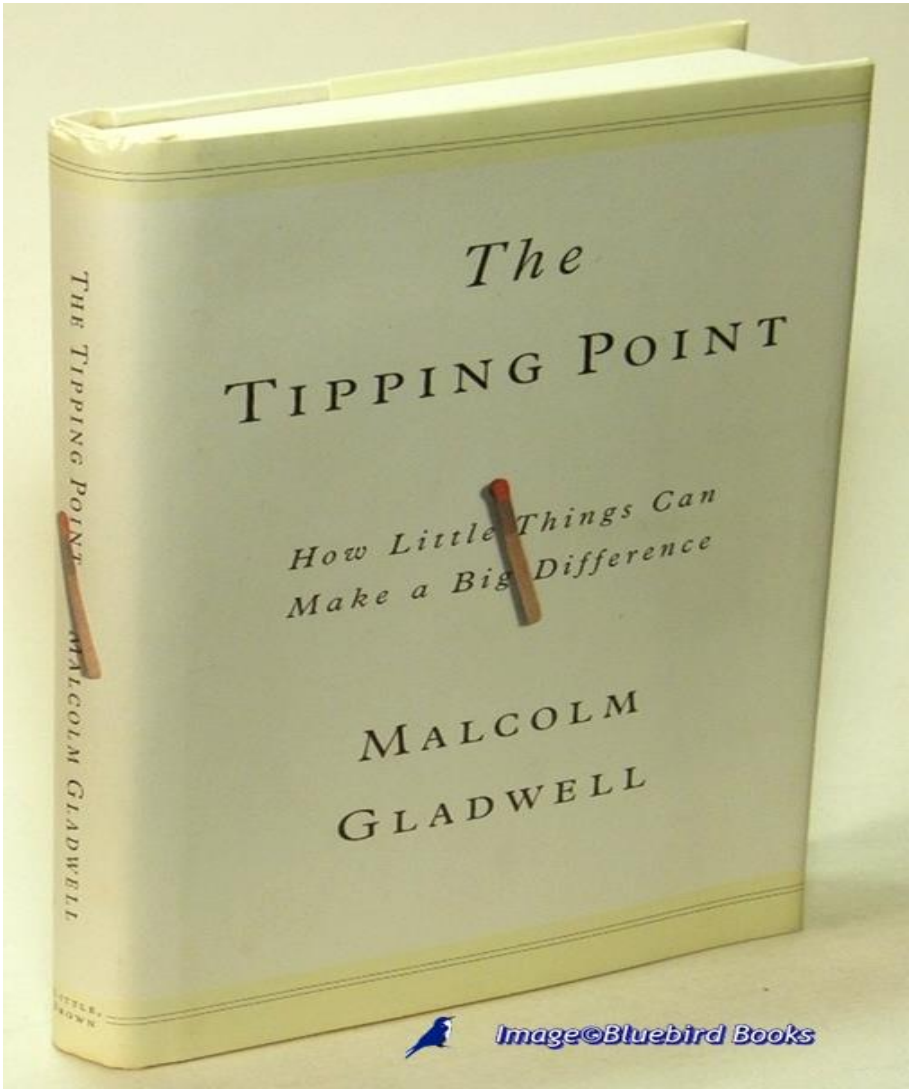
1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service _____
   Emergency Services Address_____
   Emergency Services Phone _____

Making the environment safe:

1. _____
2. _____

Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19, 256-264.

Stanley & Brown (2017)



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Evidence-Based Risk Reduction Strategies

- Brief **problem solving and coping skills** (including **distraction**)
- Enhancing **social support**
- Identifying emergency **contacts**
- **Motivational enhancement** for further treatment
- **Means counselling** / Means Safety
- Reasons for living (optional)

Prof. Barbara Stanley

Quality Components of Safety Planning: Safety Planning is a clinical intervention, *not a form*

- Treat the suicidal individual as a **partner**
- Psychoeducation is key:
  - Explain how suicidal crises come and go
  - Describe the suicide risk curve
  - Explain how the safety plan helps to prevent acting on suicidal feelings
  - Explain when the safety plan should be used
  - Explain how using the strategies enhances self-efficacy and a sense of self control
  - Don't make assumptions; ask questions
- Obtain the suicidal crisis narrative to understand warning signs

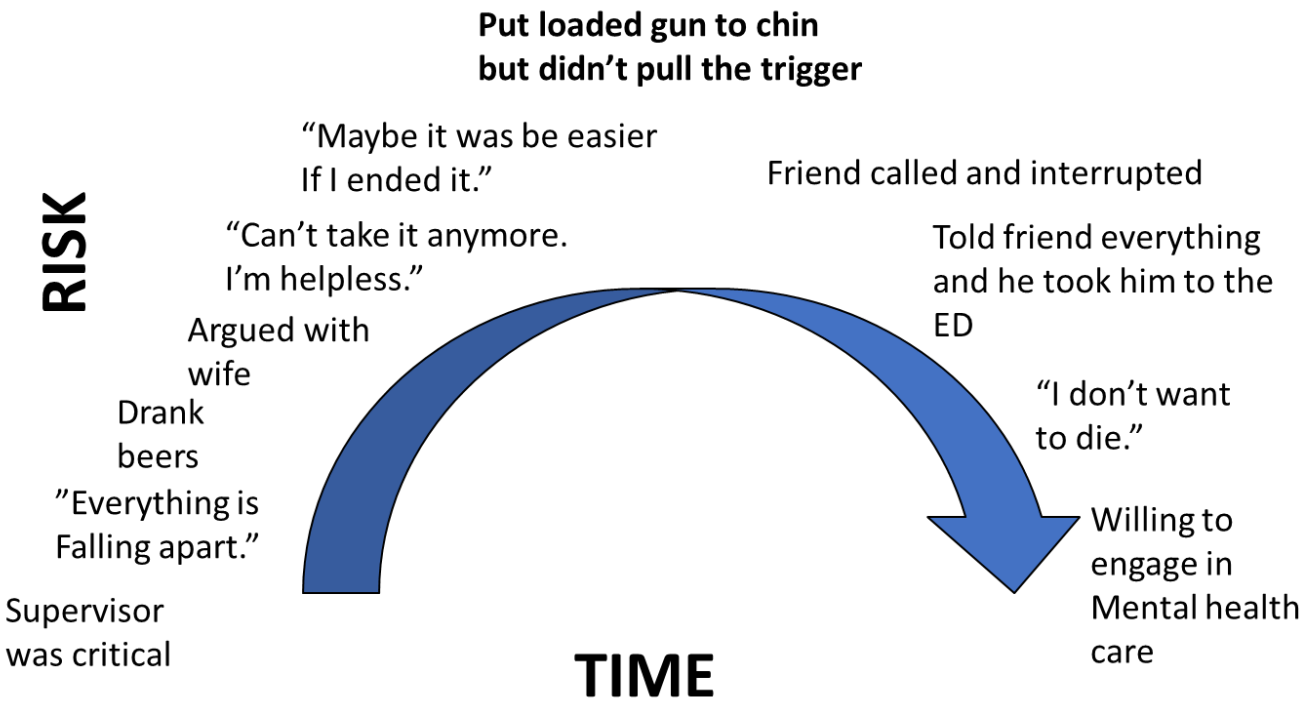
Prof. Barbara Stanley

Suicide Crisis Narrative

- Identify the suicidal crisis/suicide attempt
- Do not ask WHY the event occurred
- Choose a starting point for the narrative
- Identify the links in the chain
- Stance of a reporter; ask for the events, thoughts, feelings and behaviors without making causal connections
- Maintain a validating stance and attend to affect throughout the process

Prof. Barbara Stanley

Suicide Risk Curve Example



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Overview of SPI Steps

1. Recognizing **warning signs**
2. Employing **internal coping strategies** (without contacting another person)
3. **Socializing** with others as a way of **distraction**
4. Contacting family members or friends for **support** to help resolve crisis
5. Contacting mental health **professionals** and agencies
6. Enhancing **means safety** / reducing potential for use of lethal means
7. Identifying **reasons for living** (optional)

Prof. Barbara Stanley

SAFETY PLAN

Step 1: Warning signs:

1. When I get really depressed
2. Thinking "I have nothing to live for"
3. Sleeping more during the day

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. Look at pictures of my son
2. Watch a game on TV- baseball or football
3. Lift weights at the gym

Step 3: People and social settings that provide distraction:

9. Name Anthony (brother) Phone 543-555-2145
10. Name Sarah (friend) Phone 456-555-1182
11. Place Go to the park around the corner from my house
12. Place Go to the movie theater

Step 4: People whom I can ask for help:

7. Name Aunt Barbara Phone 112-555-8678
8. Name Uncle Tim Phone 332-555-7689
9. Name Sarah (friend) Phone 456-555-1182

Step 5: Professionals or agencies I can contact during a crisis:

9. Clinician Name Dr. Spencer (psychiatrist) Phone 556-555-3214
   Clinician Pager or Emergency Contact # 556-555-4386
10. Clinician Name Dr. Adams (primary care) Phone 556-555-2187
    Clinician Pager or Emergency Contact # 556-555-2198
11. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
12. Local Emergency Service Hospital Emergency Department
    Emergency Services Address 18 Green Road
    Emergency Services Phone Dial 9-1-1

Making the environment safe:

1. Will avoid driving when feeling suicidal
2. Will ask Uncle Tim to hold on to the key for my gun lock

Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*, 256-264

Prof. Barbara Stanley

Suicide Prevention Resources

Research

JAMA Psychiatry | Original Investigation

Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department

Barbara Stanley, PhD; Gregory K. Brown, PhD; Lisa A. Brenner, PhD; Hanga C. Galfalvy, PhD; Glenn W. Currier, MD; Kerry L. Knox, PhD; Sadia R. Chaudhury, PhD; Ashley L. Bush, MMA; Kelly L. Green, PhD

IMPORTANCE Suicidal behavior is a major public health problem in the United States. The suicide rate has steadily increased over the past 2 decades; middle-aged men and military veterans are at particularly high risk. There is a dearth of empirically supported brief intervention strategies to address this problem in health care settings generally and particularly in emergency departments (EDs), where many suicidal patients present for care.

OBJECTIVE To determine whether the Safety Planning Intervention (SPI), administered in EDs with follow-up contact for suicidal patients, was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge, an established high-risk period.

Author Audio Interview

Prof. Barbara Stanley

Safety Planning Intervention: Veterans' Administration (VA) Study

- Safety Plans administered in the ED to patients who were experiencing a suicidal crisis but did not require hospitalization (moderate risk)
- Structured follow up phone calls to assess risk and review and revise the safety
- Enrollment: N=1,640, Mean age = 48 (SD=14), 88% men

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018).

Prof. Barbara Stanley

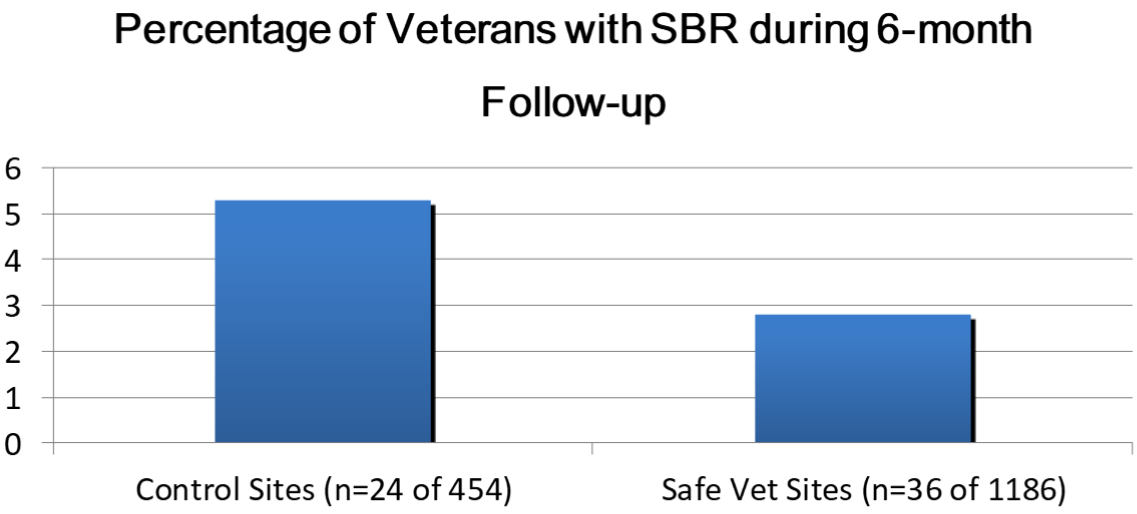
Services Provided: SPI+

- Number who received Safety Plan Intervention:
  - SAFE VET Sites: 1,178 (99.3%)
  - Control Sites: 106 (23%)
- Follow-up Weekly Calls Until Engaged in Services
  - Veterans Who Completed at least 1 Call: 1,063 (89.6%)
  - Mean Number of Completed Calls: 3.7 (SD=3.3, Range: 0-26)
  - Mean Number of Attempted Calls but could not contact: 3.4 (SD=3.4, Range: 1-23)
  - Mean Number of Days Between First and Last Completed Call: 43.5 (SD=40, Range: 0-307)

Prof. Barbara Stanley

Does SPI+ help to decrease suicidal behavior?

Suicide Behavior Reports (SBR) During Follow-up



$\chi 2(1, N = 1640) = 4.72, p = .029$; OR = 0.56, 95% CI: 0.33, 0.95

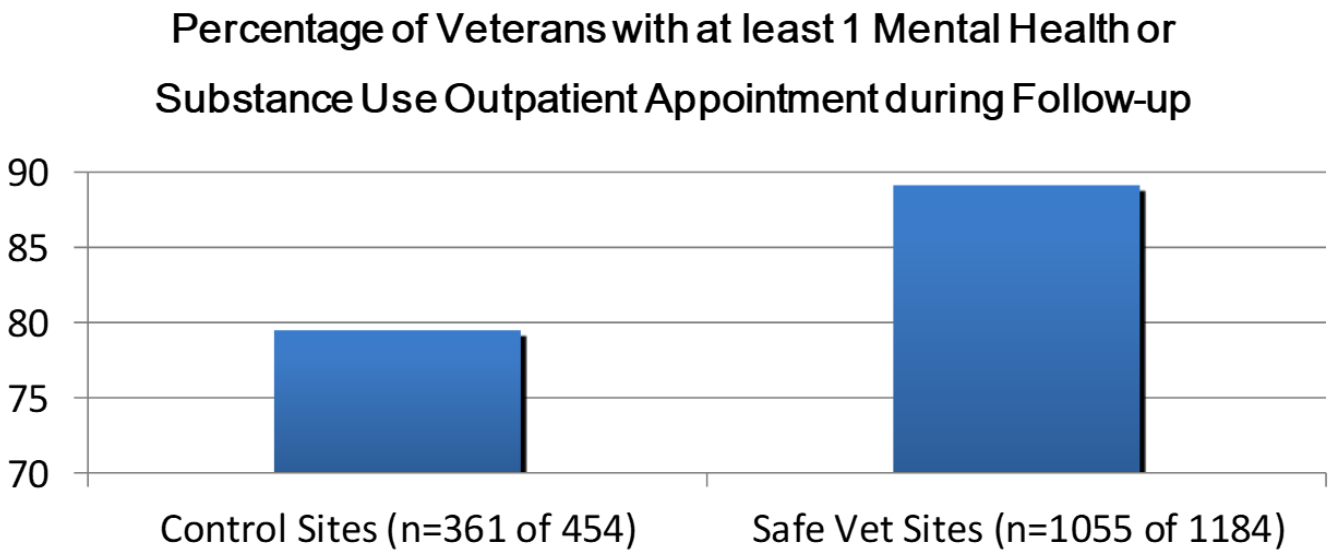
SPI+ was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behaviors over 6 months

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018). JAMA Psychiatry

Prof. Barbara Stanley

Does SPI+ help to increase outpatient treatment?

Engagement during follow-up



$\chi 2(1, N = 1638) = 25.76, p < .001$; OR = 2.12, 95% CI: 1.57, 2.82

Prof. Barbara Stanley

Access to and Uptake of Veteran Mental Health Resources and Services

What is DVA doing?

Four priority areas:

- Improving suicide prevention and mental health support;
- Improving the transition process for ADF members;
- Improving family support; and
- Transforming DVA systems, processes and organisational culture.

Dr Jenny Firman

What is DVA doing?
Services offered by Open Arms – Veterans and Family Counselling: service delivery arm of DVA

- Counselling for individuals, couples and families
- Group programs to develop skills and enhance support
- Community and Peer Advisors
- Case management for clients with more complex needs
- After-hours telephone counselling
- Mental health literacy and awareness training
- Suicide prevention training
- Information, education and self-help resources
- Referrals to other services or specialist treatment programs

Dr Jenny Firman

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Local networking

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- Adelaide

- For more information see the 'Join a network' document in the supporting resources tab (bottom right of your screen)
- Interested in leading a face-to-face network of mental health professionals with a shared interest in veterans' mental health in your local area? MHPN can support you to do so. Contact Amanda on 03 8662 6613 or email a.zivcic@mhpn.org.au.

Panel and DVA recommended resources

- For access to resources recommend by the Department of Veterans' Affairs and the panel, view the supporting resources document in the documents tab at the bottom right of the screen.

Thank you for your participation

- Please ensure you complete the feedback survey before you log out.
- Click the Feedback Survey tab at the top of the screen to open the survey.
- Attendance Certificates will be emailed within four weeks.
- You will receive an email with a link to online resources associated with this webinar in the next few weeks.

Mental Health and the Military Experience

This was the fourteenth of fifteen webinars in the **Mental Health and the Military Experience** series**,** produced by MHPN and commissioned by the Department of Veterans' Affairs (DVA).

The next webinar in the series is

Supporting the Families of Veterans: Understanding the Impact of Veterans' Mental Health on their Families, Partners and Children.

It will take place at 7.15pm (AEDT) on **Monday, 15th March 2020.**