***A World Where LivingWorks* – Podcast**
Episode 2: "Protecting Our Protectors" TRANSCRIPTS

Intro: Welcome to A World Where LivingWorks, stories of science and survival bringing together our heads and our hearts to build a suicide-safer world, talking openly about suicide is so important but we also recognise that listening to this series may bring up some tough emotions, if so please talk to a trusted family member, friend, or local support service about how you are feeling.

Visit livingworks.net and click on "FIND SAFETY" for international crisis services we are there to help you.

This podcast is brought to you by LivingWorks, a network of local suicide first aid trainers in your community and communities around the world. Visit livingworks.net to find out how you can play your part in suicide prevention.

Kim Borrowdale: You're listening to A World Where LivingWorks and I'm your host Kim Borrowdale.

First of all I'd like to acknowledge the traditional owners of the land wherever you are listening today and I would also like to acknowledge everyone out there who has been impacted by suicide, the pain it brings to our lives, and the desire to make positive change for all of us to live well.

So today's episode is all about living well in the Defence and Military communities and asking that all important question, when it comes to suicide how are we protecting the lives of those who protect ours.

So I'll be talking today to Sergeant First Class Chris Allen, Suicide Prevention Program Manager for South Carolina Army National Guard, welcome Chris.

Sgt First Class Chris Allen: Thank you for having me.
Kim Also with us today we have Dr Stephanie Hodson. Dr Hodson is the National Manager of Open Arms and has been with Open Arms since 2016. She is a Veteran herself, joining the army in 1991 and serving for 23 years.

Thanks for joining us Steph.

Dr Stephanie Hodson: Thank you, thanks for having me.

KB: So I thought what might be an interesting way to start is to tell us a bit more about you and your professional backgrounds and your organisations' focus on suicide prevention and mental wellbeing, and just the why of where you are today in your work and focus on suicide prevention. So Steph if we could start with you, tell us a bit more about yourself?

SH: Thanks for that. I've been very fortunate to be involved in suicide prevention for about 15 years, so when I actually served in the army I worked in Defence in our suicide prevention program which was all about getting people ready to be able to deploy overseas, but also be aware of how to look after their mates, how to keep their mates safe, right from the recruit training to the time they actually left the Military, and it was quite a journey just over time learning what we needed to do to in order to try and keep our service personnel safe.

Suicide in Australia is a major issue, we have nine people who die by suicide every single day and we're just a small part of that society, so for us it was all about how do we get to a point that people can safely say, 'Ya, I need help' or 'Do you need help?'.

I've been lucky enough since I left the Military to actually come into an organisation, this was founded by our Vietnam Veterans, but it is actually now for all Veterans and we look after current, ex-serving, and their families for life, so it's really nice to come from a Military background into an organisation that is dedicated in actually looking after the Military families and serving members but again for us it's about having to make sure that we don't just provide clinical services but how do we do the preventative work, how do we help people be in a place to actually look after their mates and ask the right questions.

KB: Great thank you Steph, and Chris a little bit about the National Guard and your work in the Army.

CA: Yeah so, I came in 1988 in active duty and then I converted over to the National Guard in 2006, and then in 2010 I started working with the National Guard, full-time employee, and then in 2016 I transferred over the suicide prevention office, and so since 2016 we've been building on the work that we've already done for several years with LivingWorks because when I was brought over we'd already trained over 1,500 in ASIST, and then since then our numbers have grown to over 2,000 in ASIST and then we've also added a safeTALK and we've also added suicide to Hope and also Start, so we have the full spectrum of suicide prevention services and we add to our ACE program, our Ask, Care, Escort, which is the Army suicide prevention program. So we feel that we have a very full spectrum of services to offer our service members.

We then take all that training and we expand it to our partnerships, LivingWorks obviously is one of our main partnerships, we also partner with the Veterans Administration with the Office of Suicide Prevention which falls under the Department of Mental Health in South Carolina, and the active duty component and the reserve component, and the American Foundation for Suicide Prevention. So we have a very broad spectrum that we cover, the 5 million people in South Carolina and there is about 500,000 Veterans in South Carolina, so we feel that through our training and through our partnerships is that we're casting a very large net throughout South Carolina to catch as many folks that have suicidal ideations as possible to get them then to the care that they need to help with their mental health.

You, know we roughly have about 800 folks that die from suicide each year in South Carolina, of those about 150 of those are Veterans and so it significantly impacts what is happening in South Carolina so, we're doing with the hope that we can affect change in South Carolina and also nationwide, I mean nationwide we have 45,000 that die by suicide each year and of that 7,000 are Veterans, so the Veteran population is at much greater risk from dying by suicide than the average person and so we are really trying to reach that audience, and it's difficult right, because Veterans don't really for the most part want to be bothered for the most part, they keep to themselves and so that puts them at a risk, you know a higher risk you know being loners and we're trying to reach that population, so it's difficult sometimes but that's why I'm doing the work that we're doing to get the word out as much as possible.

KB: Absolutely.

CA: That's why I'm doing it, in a nutshell.

KB: Great thanks Chris.

And what about, you talked a little bit there about the sort of risk factors of Veterans in terms of isolation for example, with both active personnel and Veterans, what are some of the environmental and occupational sort of risk factors that impact on people working in the Military or who have previously worked in the Military and Defence? What sort of things do we need to understand about people working in these roles and coming out of these positions?

CA: Typically what I'll do when we provide training is, especially with ASIST, that's the one we do most often, I usually lead into that with going back to whenever they first came in the Military, and even to go back before that, so in the school system when a child is sick in the school system, we send them to the school nurse, they're evaluated and they're treated and maybe even sent back to the classroom or sent home, so we can condition our children to seek care.

When we go in the Military we're again indoctrinated, in all branches, not just - I'm in the Army now - but just all branches, similar indoctrination, we are brought into the system, we are in a training environment and we're told, OK, over here is sick call where you can go and get treated, at the same time we tell them if they miss too many training hours we're going to send you home, so that's basic training, that's when they first come into the Military and then they come out of basic training and every time they go into a training environment or they go into a mission environment, they are told the same thing, here is the care but if you miss too much of the mission or you miss too much of the training then we have to either recycle you into training or take you off the mission.

We're as children we're indoctrinated to go seek care, in the Military where actually they don't say it right, they don't say we don't want you to get care, but in your indoctrination when you come into the Military that's what really we're telling you, there is care but we don't want you to get care. So that leads in to now, we have a high rate of suicide and now we're trying to reach active duty and Veterans to say we want you to get care, even though we've indoctrinated you into not wanting to get care, now we want you to get care.

KB: And that would be hard to turn around the kind of subtle training.

CA: Right, you're talking about 10, 20, 30 years of indoctrination that we're trying to combat against, so the biggest risk factor is the indoctrination that we do, whether it's subconscious or consciously to our servers as far as help-seeking behaviour, right, so it's the behaviour that we've indoctrinated into them, on top of that the high rate of deployments that we've had over the last 10, 15 years, throughout the world right, Australia, America, the UK, throughout the world we've asked a lot of our service members, they've sacrificed not only their lives but their families, the relationships, right, and suicide is a relationship issue, so when you predispose somebody to an environment that breaks down the relationship at home and then you send them home from the many different deployments that we've had around the world to a broken relationship and now you're, in essence breaking another relationship because they have this relationship with their unit they built through the deployment, you send them home to a broken relationship, you're breaking the unit relationship, you're really putting them at greater danger of having thoughts of suicide.

So, it's not a secret, in a year after the deployment, that is the most dangerous part of a service member's life as far as suicide is concerned, and then the first three years after they leave the

Military for good, for retirement is a very dangerous part, so it's really all about relationships, you know, you're building relationships in the Military and then you either break them when you come back from deployment and then your long term relationships, your spouses, your boyfriends/girlfriends, your children, parents even those relationships are put under a strain during the cycle of deployments that we've had over the years.

You know, so here you are indoctrinating them to not seek care and you're breaking up all their protective factors which is creating a risk factor, then you put them into an environment that does not know, a civilian environment, that they do not know how to relate to a Veteran, that kind of puts the relationship between the Veteran and the civilian at a strained relationship, so they don't want to reach out to a civilian doctor for help because they don't understand, they really don't want to talk to even a Veteran Administration provider because maybe they don't understand, we could go on and on, so another risk factor that we deal with on a regular basis is, the risky behaviour, so whether it is alcohol or drugs or just the lifestyle in general, not a healthy lifestyle where they might not be technically homeless but they are constantly on the move, moving from house to house or apartment to apartment or from one friend's couch to another friend's couch, so this constant movement does not lend itself to having a sense of security and stabilisation with a Veteran community.

So if I had three risk factors, you know it would be the predisposition to not seek care, the relationship, and the instability of a Veteran's life as a whole, they are probably the three biggest things that put Veterans at risk.

KB: Thank you, Chris that makes sense, especially thinking about how in terms of help seeking, how someone can understand that experience that you've both worked through and people coming home and then trying to reach that understanding with other people.

Steph, what are your thoughts on the main risk factors and help seeking behaviours when it comes to Defence and Military?

SH: Look, I completely agree with Chris in sense that's coming up, the big three about very much also the Australian experience. I think the difference for Australia is that we are a much smaller Military and therefore, I was telling Kim earlier, you could put the Australian Military into the Pentagon. But being small allows you to be more connected and a little more agile and what we actually find with our suicide rate in Australia, is when you are serving your risk of suicide is significantly lower than the general community but when you leave, it doubles.

So, we've been looking at what are the factors about when you're serving that are protective that you lose when you transition and it goes exactly to what Chris was saying, the fact that while you're serving, you're in a big team environment. What we do know about Australians, interestingly they will seek help, so for about a decade now, even more, 15 years we've been doing these yearly suicide prevention training every year, so people know where to get help and they know that help is there and ASIST and safeTALK has been a huge part of that training.

What one of the barriers to seeking care though, is the belief that I can do it myself, the belief that I should be able to do it myself which goes exactly to what Chris was saying about induction training, the fact that you are trained to cope in really difficult and extreme environments and then all of a sudden you find that you're in a situation where you're feeling that you're not coping, so one of the hardest things in your own head is, I should be able to cope with this and I should ask for help.

Now when people are in the Military they actually live really closely together, they are very connected, if somebody doesn't turn up to work, people notice, if someone's having a bad day, people notice. Our trouble is when people transition out of the military or they come back from a deployment and have a long period of leave, what we do find is they are no longer as connected, so when they are not having a good day, their mate's not there to actually say, 'Hey how are you going?' So we find the major risk factor is that loss of sense of team as people transition out, or if they go from full-time service into reserve service.

The other one is loss of meaning, one of the best things you could do is serve your country, one of the best things you could do is, when someone asks you, what do you do for a living, you know, I serve in the Defence Forces, and people are interested in you and then all of a sudden you leave and your sense of self, your sense of meaning, finding the right job afterwards that gives you that sense of meaning, is really tough and I think for the first couple of years, even for myself when I left, it will take you two years to adjust, I said no way you know, and two years later I was having coffee with the same people and saying, oh my goodness it was so hard, the first couple of years, readjusting to not being able to go back on base, not having the same sense of team, not having the same sense of purpose, as much as I have purpose, it's not the same as when you were serving, so loss of team, loss of meaning, and then the impact on family, the impact on family is absolutely huge. You've been away for long periods of time and all of a sudden, you're back full-time in the family, it's not always going to be the honeymoon you think it's going to be and that puts lots of pressure on people. For me, the loss of meaning, the loss of team, and the family.

Having said that, they are all things we can intervene on, they are all things we can actually work on and being aware of how to ask your mate are they doing OK, being aware of staying connected and being very aware when somebody's family is in crisis, they're really at risk, is all things, through things like ASIST and suicide prevention training, we can actually get confident to actually ask those questions to people.

KB: That's great, I love what you're saying about the strengths that you have when you're serving, thinking about the strengths like the teamwork and the adaptability and being agile, excellent coping skills and particularly dealing with really, really tough situations, what about the things that people see when you're on duty and when you're out on tours and how are people doing in terms of processing that information and is it almost like you're walking in two worlds there between your Military life and your home life?

SH: I actually think Chris will probably be able to add to this as well, but definitely I think it's one of the hardest things, is that we send service personnel to do those tough jobs for us, but when you come back you don't have a frame of reference always to talk about it, so you go back to your small country town and you're trying to talk about your experiences and they can't even conceptualise what you've seen.

So your sense of isolation, we know that it's not lacking a network around you that puts you at risk, it's feeling connected to that network, so when you leave the Military, when you're in the Military you've got other people with frame of reference, you can talk to about your experiences and they get what you've been through, all of a sudden you're living in a world where people can't actually understand that frame of reference and some of the things you've seen they might think that they can understand but in fact you end up feeling very isolated and disconnected from your community because what you've seen is not something that someone in a small country town in Australia would have seen and that's a good thing, it's a really good thing that we live in countries where it is surprising and it's challenging for us to go overseas and see this

tough stuff, but it does actually put these people slightly to one side, and it's why our Veteran community actually needs additional support out and for us to have services.

It's why I'm really proud to be part of an organisation like Veterans and Family Counselling Open Arms because of the fact that our Vietnam Veterans really struggled, 10 years later they fought for a service where they could get, and Chris mentioned this, Military Aware Counselling, they insisted that it be slightly away from our Veterans Affairs so we're connected but separate to the Veterans Affairs Department, but the biggest thing about our service is we have a whole heap of ADF (Australian Defence Force) lived experience, so Veteran peer workers are right through our organisation and in fact it's our peer workers who do a lot of our suicide prevention training, people who can actually talk the talk, Veterans helping Veterans, and in Australia we're really lucky, the Vietnam Veterans fought for this, 30 years on we still have a service that's free and it's for the Veteran and the family because in fact the biggest reason we see people in the service, the reason they come through the door is family issues and relationship issues, just like Chris said. You then use that to build the trust for someone to talk about their trauma history or the other events that happened during their service.

KB: That makes absolute sense that people that have been there would be able to then give peer support, I know Chris you're a trainer as well, it would have made the world of difference to have a room of current or ex-service people seeing someone who they can relate to, their colleague, their peer, someone else who wears that uniform with pride, rather than, you know, I could go and do the same training if I'm trained to give that training, but to be able to stand with your peers, you must get such a good reception to the fact that you're actually helping them with those skills that they need that you've been in the same place and are from the same place.

CA: Right, right, right, right.

KB: And so talk to me about your specific programs, so the work that you do for LivingWorks Chris, you told us a bit earlier about the volume of people that you've trained but is that also available to families and communities of service people and Veterans?

CA: Absolutely, so when we offer our training we do not turn anyone away, anybody can come into our classes, in fact we actually find that we have better classes as integrated that they are, we've had on a regular basis, we'll have, whenever we're teaching and we're participating, so in the class you may have you know, enlisted, officers, you'll have physicians, you'll have teachers, you'll have mums, dads, children, when I say children - young 20s, you know, late teens - so you'll have a broad spectrum in the class so when you break out into the workgroups, small groups, it really opened everyone's eyes, opens the service members' eyes, it's opens the family members' eyes, of course we try to as much as possible split the families into different groups as much as possible but I haven't had a class yet that – let me back up - sometimes our classes, they are voluntold to go the classes, in the Military you know, we need to have our class filled up and they'll send folks to the class, you have people that are voluntold, I've never had a class that even with folks that don't really want to be there in the beginning, they don't leave the second day being, having their eyes opened, and being much more aware of the issue, in fact a lot of times they will say, I did not realise so many other people were struggling also, and so at the end of the second day, it lends itself to, even though they didn't want to be there, now they see the importance of having the training and now they are actually more likely to go get help, even though we are training them to be care givers, we're also helping them take care of themselves which is an important part obviously of the training, the self-care and so yeah, having that broad spectrum of having the civilian community and having our community partners, our trainers are shared, you may have a Military trainer or a civilian trainer, a trainer

from the VA, a trainer from a peer support group and then obviously the attendees are broad spectrum so that I feel is putting the energy in our program.

When I first started, because we didn't have these partnerships, or we actually, we didn't use them to the best of you know, more efficient capability, we would fight to try and get eight people in a class you know eight to 12 people in a class, but now because we have these community partnerships, each class is over flowing where they're feeding into the next class, so we always have 30 people in the class and that just lends itself to a better learning environment and also a better teaching environment for the instructors, so you know it's just taken a life of its own, now we have people wanting to come into the class instead of us begging people to come to the class to be trained.

KB: I love that, you've gone from voluntold to a waiting list.

CA: Absolutely, absolutely.

KB: It is really good to that you have a mix of those roles because it must be a nice side benefit as you say, you are actually teaching people to be the help giver, but also they learn a bit more about self-care, but also by having the different experiences in the room it can also build that community and family understanding, so a really, really powerful side benefit of the training.

CA: Yep, absolutely.

KB: Steph, what about the Open Arms experience, so tell us a bit more about the programs you've been running and types of people that would come along to that training?

SH: Very similar to what Chris said, we started probably with a much more Military focus grouping but in fact it is hard to get enough people initially to your groups, but over time we also now do community joint groups and we don't turn anyone away, so we say that anyone in the Veteran community willing to support a Veteran can come and do one of our groups with us, or can do the suicide prevention training that we offer. Mainly because in reality, the issue is when someone is in crisis there is a slight tendency for people to want to get nervous with that and when someone is in crisis they really want to get them to a doctor, but the truth of the matter is when somebody actually is going through a really tough time in their life, the healthcare system can only provide a slice of the support, it's got to be the community around them that actually helps them over the next few months and maybe sometimes years to actually deal with what they're going through.

So it's really important that we have a network people who are trained. Quite recently I was working with a group of Veterans down in South Australia and they're in a small community town and they sort of said to us, we help with the crisis support, late on a Friday afternoon and rang through to us and said, can you help with this person, so we end up on the phone supporting them because we always do, we're always supporting someone to support someone but then the following week we said right, we can run some training so that when the next crisis happens you guys are more confident and we've got now a whole heap of people that have put their hands up looking forward to doing the ASIST course because they realise that they need to have the skills to have the conversations and to have the ongoing conversations, it's not just the day that the crisis happens, it's actually being that mate for the next week, for the next month, and over the next couple of years for each other and what they were saying to me is that they just want the confidence to be able to intervene. So now we've got a group ready to go, I think in this COVID environment in particular what has been really great is we've introduced recently the

ASIST…the LivingWorks Start Program, the one-hour online, so we have a lot of people who were lined up to do a face-to-face training with us but because of community restrictions the fact that there is an online option has been really good.

So, over time we've been working on a, it's been great to have a continuum of support, you want people to be able to, if they are worried tomorrow about someone, get online and do something like Start and then once you've actually done your Start program, that can also give you the confidence to say, OK I need to take two days to go and do the ASIST and for me the strength of the programs, what we've actually found whether it was service personnel getting ready to go overseas or whether it's a Veteran in a small country town, up in the back of North Queensland, it's about having the confidence to actually say, are you thinking of suicide, are you thinking of taking your own life? Myself, as someone who has asked that question a lot in counselling, even I found on certain days it was a hard question to ask, even I found myself dancing around it and saying, ah you know are you thinking of harming yourself? But the real question is, you don't put the idea in someone's head, if they're thinking about it, if they hear the words they will then come and talk to you about it, if you actually say the question, yes they realise that it takes down the stigma and they know that there is someone there willing to listen, so I suppose for us the program has been ever expanding circle of how do we actually make sure the service personnel are actually trained and they get a lot of that in the Military, but then how do we actually make sure that the families around the service personnel actually have access and even more importantly, how do you make sure the communities can actually assist and also get access to the training and I think that the strength of the program at the moment is the fact that you can do an hour online, you can do a half day, if that's the time you've got, or when you're ready you can do the full two-day program and actually learn how to say and practice the hard questions.

KB: Thanks Steph, I think it's important to realise that, as you are saying, there are different levels of readiness and different ways of learning for people, so people might want to get started on the online course, particularly your area Chris where there is such a volume and diversity of locations and geography, perhaps people don't have their usual training grounds close to them so they could start with an online course.

What I wanted to talk about next is, just thinking about perhaps your work over the past decades, in terms of mental well-being and that human connection and getting to the place where you are today, where suicide prevention is embedded in your organisations and communities.

If you could think about one sort of moment or approach that made you most proud or that really sticks with you over the years when it comes to suicide prevention work, I know I was actually doing a bit of reading about both of you, thank you to the Internet these days, and I was really struck by something that you said Chris, when you said, it's not a career ender to get help if you hurt physically, we want you to get help, if you're hurt mentally same goes, there is no such thing as a perfect soldier out there, we all have struggles, and that really resonated with me because I think of people who are in the Defence and Military as just the toughest, the strongest, you know get through everything but just because you're technically the toughest person in the room and out there protecting us, it doesn't mean that you don't have your struggles as well and we're all human beings, uniform or not.

So I was just thinking is there something in your careers that stuck with you in terms of mental health and suicide prevention? Who would like to take that one first?

CA: Stephanie.

SH: There's a big question, look the one that immediately comes to mind for me is where we had a young medic who actually on operations, in fact the toughest time just to say that you have a problem is actually when you are on ops because the last thing you want to do is be sent home and you're really worried all the time that you'll let your team down.

Now she had had a series of really, really tough moments where we'd lost a few people and she put her hand up and actually asked for help, but the moment for me was - and she got the help - and she stayed in theatre a bit longer but eventually decided for her own well-being to come home, she continued in the Military and it was probably five years later, I'm sitting in a swimming pool, on a Military base and she walks up and she's been promoted and she puts in my arms a little baby and she said, you know potentially if I hadn't got that help, we wouldn't be sitting here today with this little one with me and it was like the best moment ever because she was still in the Military, she was still doing well and she had this little baby and you know she'd gone through the moment of life where it just, it just she'd lost hope and then she'd got it back and because of that she went on and so for me that was like, you know for me, it makes what you do worthwhile those sorts of moments.

KB: It really does and to see it over that long term because what you've both been saying is that it's not about a struggle or a day or things like that, it's about the support over a long period of time so it's great to hear that she felt comfortable asking for help for one and that the support was in place, and could continue serving and have a thriving family and not to say that tomorrow or in five years' time she won't have to ask for help again, but she knows that she was able to get that result from doing that, so I would hope that she would be just as comfortable asking again, if not more comfortable. Thanks Steph, and Chris, what about you?

CA: So whenever I came in, in '88, we didn't have a suicide prevention program, we didn't have a suicide prevention program manager, LivingWorks was out there but we didn't know about LivingWorks, we didn't know about ASIST, we had behavioural help, right, we had doctors but we didn't have a way to train folks, to number one, listen, because in the Military we don't do a great job of listening sometimes, we're trained to make decisions, we're trained to be fixers, right.

So, somebody back in the day would tell us, let's say that they tell us they were suicidal, to be honest with you, they wouldn't do that a lot of times back then because they were afraid of their career, but let's say in 1988 somebody came up and told me that they wanted to commit suicide because of who I am and because of how we are trained in the military, I would fix that situation, I would find them someone to go talk to probably, the on-duty psychiatrist, or I would possibly take them to the hospital and help and that's…but I wouldn't listen to them, they would tell me that they were hurting and I'd find a way to fix what's the problem.

What today I have learned through training, the best thing we can do for somebody who is hurting is to listen them, they have trusted me to say that they want to die by suicide, so the best thing to do for them is to listen to them and by listening to them I can connect with them and then after all that, then I can help them find the resource that's best for them, not everybody wants to talk to a Chaplain, not everyone wants to talk to a doctor, not everybody wants to go speak a psychiatrist or a social worker. So through the years I've seen the progression from the '80s, '90s, the 2000s, we're into 2020 of a large spectrum to look at, whenever I was trained, I was trained in 2016 to be a trainer, Gerry Dooley was our trainer and they told me that that training they were providing that day, that week, was just the beginning and that a few first

courses that we teach that actually a continuation of our training and it was probably after my third or fourth training, somebody after the class was over they went home, after they went home, they called and said that before the training they were having thoughts of suicide but then after they went through the training and they were voluntold, they needed 10 people from the unit and they were one of the 10 people that were sent to the unit, they went home after the training and instead of going through the decision to ending their life, they made the decision to go get help and they made it a point to give me a call and tell me that it worked and that going and talking with someone to help them get through that when they were thinking they didn't have any other choice to deal with what they were dealing with, that they were able to get the care that they needed and so to be honest, that person, if I had met that person 30 years earlier and I would have basically imposed my own safety plan upon them, you know, they would not have been heard and they might not have survived the thoughts of suicide.

I could do this all day long, tell you the success stories, not going to do that because we don't have that much time but that's just one example of how this training works and how far we've come, you know since the '80s when I first came in, to what we have today, we do have very robust programs worldwide right, so it's not just in one part of the world, but it's a different environment.

Jennifer Butler, Director for the Office of Suicide Prevention in the Department of Mental Health and she said it best, she said, now is the best time to have a mental health condition and when I look back at what she explained it to me, if you were struggling with thoughts suicide or any kind of behavioural health problems, today is the best day to have that because there are so many avenues to get help, that you literally cannot take a turn left or right without running into someone who is a helper, like I said there are thousands of folks training in ASIST, there is also many other suicide prevention programs out there and we support one another, it's not a competition, right, it's a very loving, open, accepting environment to be in today versus many years ago, so I think it's the best time to be alive, so.

KB: That's fantastic, thank you so much. That's all the questions I have for you, is there anything that you would like to add before we finish up today?

SH: I just want to reinforce, I think that Chris just summed that up beautifully that the bottom line is it's about listening, it's about having the confidence to actually listen, that too many times we are quickly wanted to, in the past, move somebody onto you know the medical support system, when in reality they talked to you because they want you to listen and the biggest thing we can all do is take the time to listen when somebody is asking for help, you know and that's step one and then you can start thinking about the referral pathways which are also important but listening is step one.

KB: Absolutely, I just love being able to talk to both of you about the two different jurisdictions and so many similarities in terms of your backgrounds and active service and now working with current service people and Veterans and the amount of insight in terms of the peer support that you are able to encourage for people and really building on the strengths because it is such an impressive profession to be in and such one were we have such admiration for the strength and skills and being able to apply those same strengths into your day to day life, living with your families and within communities, I think is a great aspiration to have and one that you're doing a great job, helping people to come to fruition, so thank you so much for both of you.

CA: Thank you.

SH: Thanks Kim, thanks Chris.

KB: Is there anything else you would like to add Chris?

CA: No not really, I think we did cover it, I mean if I did anything else to add it would be, when you're looking, when you're thinking about a Veteran, people have in their minds, you're not going to see the video but I'm an old man, grey hair, and I'm really kind of a picture of what they think of whenever they think of a Veteran.

However, in today's world, the reality is, today's Veteran is really the middle 20 to early 30-year-old and when you think about somebody who is, let's say 26, just for argument's sake, and they have been in the Military nine years, they could have been deployed three or four times into combat and then they are back home and they are trying to meld themselves back into a society that does not know how to absorb them and though if the listeners to this, if they have any one take away, would be, have patience with someone who they quite don't understand what makes them different or why you know, they may be hard to deal with, is to have patience with them, just to love them and to be accepting as possible because even though they look like a Veteran, a poster boy or to think about what a Veteran is, it might just be that young, that 20-something-year-old, is just struggling and won't ask for help but you may be the one person that can impact their life and so just be as open as you can with them, recognise the behavioural changes in them and let them know that you've noticed something different in them and then that will hopefully be the step that they need to actually open up and ask for help, just something to think of.

KB: That's fantastic, thanks Chris. I think we can all help to push aside the preconceived idea of what a Veteran may look like or feel like in terms of age and demographic and I think what you say in relation to just loving and understanding and you don't know what someone's feeling or thinking on the inside and the context of their life as you pass them in the street, so I think that is something we can learn about every human being and particularly Veterans.

CA: Absolutely.

KB: Thank you again for joining us today, I really appreciate talking to you, I wish we could talk for longer but I know you both have a lot to do, so I won't keep you any longer but we really appreciate you sharing your experience and appreciate the relationship with LivingWorks and the effort that you go to everyday to make more training available to the people who need it so we can support active and retired personnel.

SH: One tiny piece that goes to what Chris said about being accepting of everyone, I think that anyone who works in the area of suicide prevention also needs to realise there are times that people will die by suicide and that we need to extend that love and support to the families and those who have tried to help that person and so there are those times when despite everything we do, the person makes a choice we wish they hadn't and that in suicide prevention it's really super important, we often don't talk to the families once there has been a suicide, it's really tough on mates and what we do see is there are clusters, that one suicide can lead to more and I think the next step always is when we do lose someone that is super important that we also, everything was said about listening, everything that we've said about reaching out and connecting, happens to the family, happens to the mates, so we don't then actually see then, you know, a little cluster form.

It’s so important that in this space that we are completely accepting, you know sometimes people will make a choice we don’t want, in order to make sure that doesn’t spread, we have to be that next step of acceptance too and break down the stigmas around people where there has been a death by suicide.

KB: That’s a really good point, thank you so much Steph. That’s something I think we all need to take on board and in terms of grief and loss and those experiences, having more compassion and understanding and not shying away from it. I think both of you are doing a great job in doing that and yes, thank you, thank you for all that you’re doing.

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