Defence Safety Authority

Focused Review of Suicides among Armed Forces Personnel

August 2018

Defence Safety Authority

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DEFENCE SAFETY AUTHORITY FOCUSED REVIEW OF SUICIDES AMONG ARMED FORCES PERSONNEL – FINAL REPORT

EXECUTIVE SUMMARY

1. The UK regular Armed Forces (AF) have experienced declining suicide rates since the 1990s. Despite this downward trend in suicide rates, Defence is not complacent and recognises that the death by suicide has a devastating effect on families, friends and workplaces, as well as an economic and capability cost. Suicide is potentially preventable and deserves a similar level of Defence resources to that applied to preventing death from accidents. Therefore, the Director General (DG) of the Defence Safety Authority (DSA) recommended a focused review of suicides in Service Personnel (SP) to identify additional measures for preventing suicide. This proposal was supported by the Chief of Defence People (CDP) and the Surgeon General (SG), and endorsed by the Vice Chief of the Defence Staff (VCDS).

2. This report is based on evidence drawn from a review of Defence publications, an examination of published statistics relating to suicide, a systematic review of the academic literature, interviews with 53 key stakeholders across Defence, a national and international benchmarking exercise and an original academic study of self-harm in the UK AF.

3. The review recognised the considerable amount of work already undertaken by Defence, in order to improve the mental health of SP and to prevent suicide. Defence already has comprehensive policies and procedures that cover promotion of mental wellbeing, and the prevention, detection and treatment of mental ill-health. Notable recent achievements include provision of additional funding for Departments of Community Mental Health (DCMH), introduction of a unified patient care pathway for mental health, the establishment of a dedicated 24-hour crisis helpline, and partnering with the Samaritans to provide resources for those contemplating self-harm. These activities are underpinned by a comprehensive mental health and wellbeing strategy.

4. Benchmarking of suicide prevention policies suggests that UK Defence policies are comparable, and in some areas superior, to national and international provision. Furthermore, although the comparative data have substantial limitations, UK military suicide rates appear to be lower than that of most other AF, and the UK Police Service. Nonetheless, every suicide is a tragedy that could be prevented, and this report makes 22 recommendations to try to further reduce suicide rates within the UK AF. The three key recommendations are: **establishment of a Suicide Prevention Working Group (SPWG), confirmation of the TORs and membership of the SPWG, and development of a Defence Suicide Prevention Plan**.

5. The review noted that both the Army and RAF policies and procedures had been recently updated. RN policies could benefit from a similar approach in order to clarify the strategic assignment of suicide prevention tasks. Furthermore, while there are areas of good practice within the single Services, reports and identified lessons are inadequately shared across Defence, and there is no unified formal process to confirm implementation of lessons. This report makes recommendations to address these concerns, and proposes that lessons identified in a 2016 summary of suicide investigations should be reviewed and prioritised for implementation. It is suggested that Defence Primary Healthcare should publish guidance on best practice for internal case note reviews, psychological autopsies and the external investigation of suicides. As welfare and medical services tend to be 'stove piped', it is recommended that welfare services are embedded within DCMHs. The full list of recommendations is at Annex P.

INTRODUCTION

1. Annual reports published by the Office for National Statistics (ONS) show that there has been a consistent downward trend in suicide rates in the United Kingdom since 1982 with the most significant decrease in the rate of suicide occurring from 2015 to 2016; this is the largest decrease for some two decades. There were 5965 suicides registered in the UK in 2016. Around three-quarters of all UK suicides occur in males; this proportion has been constant since the 1990s. Rates of suicide across UK countries vary. The English, Welsh and Northern Irish suicide rates fell between 2015 and 2016, with a small rise observed in Scotland.[1]

2. Figures published by the Ministry of Defence show that there were four confirmed suicides in the UK AF in 2017 with a further 12 awaiting coroner verdicts.[2] For the 20-year period 1998-2017, 309 suicides and open verdicts occurred among UK regular AF personnel; 292 among males and 17 among females. Consistent with trends in the general population, the UK regular AF have experienced declining male suicide rates since the 1990s. The suicide rate among males aged 16-59 years in the UK general population was 18 per 100,000 compared to a UK AF rate of 8 per 100,000 in 2017.[3]

3. Despite the downward trend in suicide rates, Defence is not complacent and recognises that the death of someone by suicide has a devastating effect on families, friends and workplaces, as well as an economic and capability cost.[4] Defence has its own Mental Health & Wellbeing Strategy.[5] This is based upon a Promote, Prevent, Detect and Treat approach. In addition, the Royal Navy, Army and Royal Air Force have service-specific policies, procedures and guidance on mental health that reflect their respective operating environments. Nonetheless, suicide is now one of the commonest causes of death in Service Personnel (SP) after accidents and cancer.[6]

4. The Director General of the Defence Safety Authority, while recognising the significant previous work in preventing suicide, has suggested that the rate of suicide in SP should be even lower, given the age profile of SP,[7] the absence of usual risk factors for suicide such as unemployment, and the relative absence of a past history of significant mental ill health, the so-called 'healthy worker effect'.[8] Suicide is potentially preventable and deserves the application of a similar level of Defence resources that is applied to preventing death from accidents. Therefore, DG DSA recommended a focused review of suicides in SP to identify additional measures for preventing suicide, through an examination of Service Inquiries, Learning Accounts and the application of best practice. This proposal was supported by the Chief of Defence People (CDP) and the Surgeon General (SG).

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[1] Statistical bulletin: Suicides in the UK: 2016 registrations. Registered deaths in the UK from suicide analysed by sex, age, area of usual residence. ONS, 2017. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registrations.

[2] Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017 published 27 Mar 18. https://www.gov.uk/government/collections/uk-armed-forces-suicide-and-open-verdict-deaths-index.

[3] Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017 published 27 Mar 18. https://www.gov.uk/government/collections/uk-armed-forces-suicide-and-open-verdict-deaths-index.

[4] The most recent analysis estimates that each suicide costs the economy in England around £1.67 million. Source Preventing Suicide in England: Third Progress Report of the Cross-Government Outcomes Strategy to Save Lives published January 2017.

[5] The Defence People Mental Health and Wellbeing Strategy 2017-2022. https://www.gov.uk/government/publications/defence-people-mental-health-and-wellbeing-strategy.

[6] Deaths in the UK Regular Armed Forces: Annual Summary and Trends over Time 1 January 2008 to 31 December 2017 published 27 Mar 18. https://www.gov.uk/government/statistics/uk-armed-forces-deaths-in-service-2017

[7] The average age of the general population is 40, with suicide being commonest in the 45-59. In comparison, the two largest age groups in the Armed Forces are 20-24 (19%) and 25-29 (24%).

[8] https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html.

METHOD

5. VCDS directed that the review should include a national and international benchmarking exercise. The TORs for the suicide review were endorsed by VCDS on 21 Feb 18. The agreed TORs are at Annex A. DG DSA, CDP and the SG agreed to provide manpower for the review. The suicide review team commenced work on 28 Mar 18 under the lead of Lt Col [redacted] from the Academic Department of Military Mental Health (ADMMH), Kings College London; CDP was represented by Wg Cdr [redacted], and the DSA by WO2 [redacted] REME. The team used a variety of approaches to try to identify additional measures to prevent suicide in SP.

6. The suicide review team analysis and report is based on evidence drawn from the following sources:

a. A review of Defence and single Service publications relating to suicide prevention policies, procedures and guidance.

b. An examination of published statistics relating to suicide in the United Kingdom AF and AF from other nations.

c. A systematic review of international academic literature relating to military suicide published between 2010 and 2018.

d. Interviews with 53 key stakeholders and subject matter experts, responsible for setting strategies, delivering healthcare and welfare, and undertaking suicide investigations. The full list of interviewees is at Annex B.

e. A national and international benchmarking exercise.

f. An original academic study of self-harm in the UK AF.

7. The review team was set nine objectives. Each of these objectives was considered in detail with specific methodology, key findings and recommendations as set out below. Supporting documentation, including reviews, precis of long documents and critical analyses, are detailed in the Annexes to this report.

RESULTS

OBJECTIVE 1: Determine the governance of suicide prevention across Defence by investigating the ownership of policies, resources and risks.

8. **Defence Policy**. Defence does not currently have a specific suicide prevention strategy or plan. However, the current Defence People Mental Health and Wellbeing Strategy five-year plan aims to reduce suicide risk by optimising mental health.[9] The strategy is owned, but not funded, by CDP. While it does not specifically address suicide prevention, the strategy adopts a multi-disciplinary "through-life approach" to mental health and wellbeing, using a structured approach of promotion, prevention, detection and treatment. Promotion and prevention policy is owned by CDP while detection and treatment are shared between CDP and SG. The strategy seeks to provide SP with the means to manage their own mental health and wellbeing, and to support the psychological wellbeing of their colleagues. If mental health difficulties persist

[9] The Defence People Mental Health and Wellbeing Strategy 2017-2022.

despite informal support, SP are encouraged to seek help from a variety of welfare, medical and specialist mental health support sources. The strategy is aligned with the NHS delivery plan and the government's focus on mental health.[10]

9. **Single Service Policies**. The single Services have developed their own specific policies for stress management and resilience-building, along with procedures for managing vulnerable individuals who are thought to be at risk of suicide and/or self-harm. These policies reflect the organisation and operating environment of each Service, and cover individual vulnerability management using clear written guidance. The intention of the policies is to reduce or manage risk at a local unit level. This is a collaborative process that includes multi-disciplinary agencies, the Chain of Command, welfare and healthcare personnel.

10. **Risk and Resources**. Single Services claim full command of their personnel and, therefore, own the suicide risk. In all the reviewed publications, risk ownership is assumed to be at single Service level although the risk owner is not clearly articulated. Interviews with Army and RAF staff officers indicate that the assignment of suicide prevention tasks is clear, in particular, relating to the management of suicide-vulnerable SP at unit level. The RN has several departments within Naval Personnel Strategy that deal with welfare, health, wellbeing, resilience, and casualty reporting. However, there is less coherence in the RN strategic approach compared to the other two Services. At unit level, for all three Services, tasks are shared between the clinical, welfare and safety personnel, with well-established networks providing clear direction in the welfare, medical and safety areas. Local risk and resource management is currently owned by the Chain of Command (CoC) via the unit health or welfare committee, care forum or equivalent. Of note, the unit commander does not, however, own all resources, as some are not integral to the unit and are sometimes shared, for instance in the case of medical and welfare assets. The ownership of both risk and resources in the Joint area proceeds under the assumption of full single Service command. However, local delivery is delegated to the CoC.

11. Annual suicide monitoring is undertaken by the Army and RAF. The Army has reinvigorated a Mental Health Working Group which examines Army rates and suicide prevention measures while the RAF undertake post-incident reporting that explores all aspects of suicide-related cases. The RN monitors events, but has not instigated formal procedures. When personnel with suspected mental health disorder are referred for medical assessment, responsibility for clinical care policies and procedures is owned by SG. Additional funding of £28M has been provided by Defence for military mental healthcare services over the next 10 years.

12. **Governance and Assurance**. Given that suicide now ranks among the most common causes of death in SP, it is important to dedicate specific resources to suicide prevention. Suicide statistics and prevention policies are discussed as agenda items within the bi-annual Mental Health Steering Group (MHSG). However, despite direction from the Defence People Mental Health and Wellbeing plan, the Suicide Prevention Working Group (SPWG) has not yet met. The MHSG currently monitors Key Performance Indicators relating to a range of mental health and wellbeing support activities, but there is no clear assurance process to confirm that suicide prevention recommendations and policies are being implemented. Furthermore, there is a lack of evidence of effectiveness of suicide prevention measures. The SPWG could be given responsibility for implementing the recommendations laid out in this report and other investigations. This Working Group (WG) should be attended by suitably empowered representatives from across Defence in order to drive the implementation of measures to prevent suicide and to share best practice.

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[10] https://www.england.nhs.uk/2017/03/next-steps-on-the-five-year-forward-view/.

Recommendation 1: Reinvigorate the Suicide Prevention Working Group to drive the implementation of suicide prevention measures and to share best practice across Defence.

Recommendation 2: Confirm the TORs and membership of the Suicide Prevention Working Group.

Recommendation 3: Review the Royal Navy policy document RN BRd 3(1) and clarify strategic ownership of safety, healthcare, welfare policies, practices and reporting.

OBJECTIVE 2: Determine the extent to which published statistics accurately compare the level of suicide in Service Personnel (SP)with those in the general and other populations.

13. Historical studies examining UK military suicide have been published.[11,12] The main contemporary source of information relating to serving personnel is the annual report provided by Defence Statistics (DS).[13,14] The annual Statistical Notice provides summary information on suicides and open verdict deaths among serving UK regular AF during the 20-year period 1998-2017. The Notice includes both coroner-confirmed suicides and open verdict deaths, in line with the definition used by the Office for National Statistics (ONS). DS carries out an annual audit of MoD data and makes comparisons with the UK general population using population level suicide data held by the ONS. Although DS are a finite resource, when capacity allows, ad-hoc reports, using data related to suicide in specific sub-groups and self-harm, are also produced.

14. The methodology used to compare populations in the latest annual DS report is widely used in civilian research, is considered an accurate method for comparing age groups in two distinct populations, and provides some context when interpreting UK military suicide rates. There are some limitations to the approach, given that there are substantial differences in the characteristics of the civilian and military populations. Potential confounders such as employment status, the healthy worker effect and military selection influences are described in the latest DS notice. Inability to control for such factors affects the validity of military versus civilian comparisons, but this is unavoidable given the form of the currently available data. Comparing military with other occupational groups is not possible at present given the characteristics of the civilian population dataset. The current approach to suicide monitoring and analysis has been in place for some time. Therefore, it is timely to review the data being collected by DS to assess whether any additional questions can be addressed. The full review of the current approach to suicide data analysis is at Annex C.

15. DS have recently developed and introduced a new methodology for monitoring suicides in military personnel, which aims to identify meaningful rate changes in 'real time'. The analysis has been applied retrospectively to military data collected over the last 10 years. This approach also needs to be reviewed.

16. To date, no international military suicide rate comparisons have been completed. However, in collaboration with epidemiologists in the US and Canada, DS is developing novel methodology to compare, at an international level, suicide rates across these three militaries

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[11] https://www.gov.uk/government/statistics/causes-of-deaths-that-occurred-among-the-uk-veterans-of-the-199091-gulf-conflict.
[12] https://www.gov.uk/government/collections/causes-of-deaths-among-the-uk-armed-forces-veterans-of-the-1982-falklands-campaign.
[13] Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017 dated 27 Mar 2018.
[14] https://www.gov.uk/government/statistics/uk-armed-forces-suicide-and-open-verdict-deaths-2017 (Select 'Excel data').

using a World Health Organisation (WHO) defined population as a comparator. Data from other nations were considered but excluded, as the information relating to suicide deaths was either unavailable, or the numbers too small to allow for meaningful analyses. The work is not yet finalised but will be published as part of the TTCP-21[15] work stream. Preliminary findings suggest that the rate of suicide in the UK military is lower than both the Canadian and the US military.

17. The Chair of the relevant NATO Research and Technology Group (RTG) was asked by the review team to confirm whether additional comparative military suicide data were available. Most NATO partners are currently unable to provide data in a form that would enable meaningful comparison. To provide further context, the suicide review team carried out a search of peer-reviewed literature to establish whether usable data had been published in peer-reviewed academic journals. Some historical studies reporting military suicide rates, using the same metric as the UK, were available and additional non-peer reviewed reports containing relevant suicide outcome information were made available by NATO partners. Given that the UK Police Service is a hierarchical organisation with traumatic exposure inherent to some areas of work, the suicide figures for this organisation were also considered. Published male suicide rates are 8 per 100 000 in UK regular AF[16], 22 per 100 000 in the US active component[17] and 24 per 100 000 in the Canadian regular forces.[18] A full comparison of military suicide rates is at Annex D. Although not directly comparable to these military rates, there were 23 male and female police suicides in England and Wales in 2016, giving an approximate suicide rate of 18 per 100 000.[19]

18. The suicide review team concludes that, although the available comparative data have substantial limitations and should be considered as providing only limited context, UK military suicide rates appear to be lower than most other published military and civilian groups including the UK Police Service.

Recommendation 4: Defence to continue to monitor suicide rates in Service Personnel and to publish an annual statistical note on suicide that highlights the limitations of the current methodology.

Recommendation 5: Confirm the value of the new suicide rate monitoring methodology at 12 months' post introduction.

Recommendation 6: The Suicide Prevention Working Group to explore the collection of alternative or additional statistics by Defence Statistics in order to identify additional measures for preventing suicide in Service Personnel.

OBJECTIVE 3: Determine organisational progress on the implementation of recommendations from past Service Inquiries, Learning Accounts and the recommendations made by Defence Statistics in 2016.

19. DS summarised the lessons learned from UK military Service Inquiries (SI) and Learning Accounts (LA) following suicide and open verdict deaths and consolidated the resulting

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[15] The Technical Cooperation Program – a NATO working group

[16] Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017 published 27 Mar 18. https://www.gov.uk/government/collections/uk-armed-forces-suicide-and-open-verdict-deaths-index.

[17] Department of Defense Suicide Event Report 2015. http://www.dspo.mil/Portals/113/Documents/CY%202015%20DoDSER%20Annual%20Report.pdf?ver=2017-06-23-151226-953

[18] 2017 Report on Suicide Mortality in the Canadian Armed Forces (1995 to 2016). Surgeon General Health Research Program SGR-2017-002 October 2017.

[19] Office for National Statistics, Number of Police Officers that died by Suicide in England and Wales, 2015-16

recommendations. Lessons learned from 18 post-suicide inquiries were synthesised into seven common themes organised in three domains; People, Surgeon General and single Service (some with wider application across the three Services). Re-analysis of data by the review team suggested that a crucial step had been omitted from the process of generating recommendations, namely, subjecting the emergent themes to final critical review before recommending actions. The recommendations detailed in the report appear not to have been considered by the MHSG since 2016. Previously, LA/SI derived recommendations were considered regularly by the steering group and progress toward implementation was monitored against an action matrix. The review team could find no evidence that the recommendations contained in the Loose Minute had been systematically implemented across Defence. A summary of the SI/LA data and the suicide review team critical analyses are shown in Annex E.

Recommendation 7: Suicide Prevention Working Group to review the lessons identified from previous investigations into military suicides for implementation across Defence.

Recommendation 8: Mental Health Steering Group to review the 2016 DS Loose Minute and prioritise recommendations for implementation across Defence.

OBJECTIVE 4: Assess the recommendations in recent national publications to identify additional measures to prevent suicide.

20. On direction from VCDS, this objective was expanded to encompass a benchmarking exercise where UK AF suicide prevention policies and procedures were compared with policies in AF from other nations and with UK Emergency Services' suicide prevention activities. Five sources of information were used in the benchmarking exercise:

a. NATO Suicide Prevention Guidelines.[20]

b. Canadian AF (CF) Suicide Prevention Strategy.[21]

c. Preventing Suicide in England – the National Strategy: Third Annual Report.[22]

d. Preventing Suicide in Scotland.[23]

e. Suicide and self-harm prevention in the UK Police, Ambulance and Fire and Rescue Services.[24]

21. Where guidance and policy was relevant to UK Defence, the suicide review team found that the UK AF approach is compliant with strategies a. to d. listed above and, of note, had a more extensive and coherent approach to suicide prevention than the UK Emergency Services. Given that the various strategies were found to be complex and lengthy, the key points and, where appropriate, best practices have been summarised and are detailed at Annexes F to J. A particular strength of the Defence approach to suicide vulnerability risk management is the requirement to convene a management committee and produce a written care action plan for all

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[20] North Atlantic Treaty Organization, Science and Technology Organization, Research Task Group 218 (2016). *Military Suicide Prevention: Report Prepared for NATO Leadership* (STO-TR-HFM-218). Geneva: STO/NATO. https://www.sto.nato.int/publications/STO%20Technical%20Reports/STO-TR-HFM-218/$$TR-HFM-218-ALL.pdf

[21] http://www.forces.gc.ca/en/about-reports-pubs-health-suicide-prevention/expert-panel-prevention-strategies.page

[22] https://www.gov.uk/government/publications/suicide-prevention-third-annual-report

[23] http://www.gov.scot/Topics/Health/Services/Mental-Health/Suicide-Self-Harm.

[24] Senior and well-informed emergency service representatives provided written material to the review team and participated in telephone conferences.

personnel thought to be at risk.[25,26] This is less formalised in the RN than the other two Services.[27] Although recommended in some of the strategy documents, routine general screening for mental health symptoms and risk factors for suicide is not recommended, as there is good evidence that screening in non-clinical settings is ineffective in UK military personnel.[28,29]

22. UK national guidance recommends expanding any suicide prevention strategy to explicitly include self-harm. Single Service guidance for self-harm management is currently available. However, the provision of self-help materials is less well developed and could be considered by the SPWG, in collaboration with the Samaritans; this group is currently generating a military pamphlet 'How to approach people in distress/mental health pocket guide' and a webchat service for SP to contact the Samaritans digitally. Defence does not have representation within the National Suicide Prevention Alliance (NSPA), despite this being specifically recommended in the National Suicide strategy for England as best practice.

23. The suicide review team concludes that the current Defence approach to suicide prevention for SP is at least as good as that detailed in national and international strategy documents. Two possible areas for further development were identified.

Recommendation 9: Mental Health Steering Group to review currently available self-help resources for deliberate self-harm and oversee the development of a resource package for Defence.

Recommendation 10: Mental Health Steering Group to consider the benefits of joining the National Suicide Prevention Alliance.

OBJECTIVE 5: Determine the utility of creating a Defence Suicide Prevention Plan.

24. Most of those interviewed by the review team recognised that factors contributing to suicide are complex and not easily addressed with simple measures. The Defence People Mental Health and Wellbeing Strategy recommends using comprehensive Promote, Prevent, Detect and Treat interventions to promote good military mental health and wellbeing which may, in time, help to prevent suicide. Promote, Prevent and Detect are largely carried out in the non-clinical setting, using training, education, welfare support and health promotion approaches. Escalation to clinical assessment and healthcare is required when mental health disorder symptoms are suspected or established.

25. An important step in preventing suicide is limiting access to lethal means. DS lists the two main suicide methods used by SP as hanging/strangulation/suffocation (50% of all cases) or firearms and explosives (17%). Where possible and practical, steps have been taken to offset such risk and the control of access to military weapons for vulnerable individuals is detailed in current policy.[30] Given that all reasonable steps are already being taken to limit access to lethal means within military establishments, no new additional prevention measures were identified by

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[25] Army General Administrative Instruction (AGAI) Volume 3, Chapter 110 which contains suicide vulnerability risk management guidance.
[26] Annex E to AP9012 Chapter 6.
[27] BRd 3(1) 24-1 June 2016 Version 7 Chapter 24 Appendix 3 To Annex 24D.
[28] Rona, R.J., Hooper, R., Jones, M., Hull, L., Browne, T., Horn, O., Murphy, D., Hotopf, M. and Wessely, S., 2006. Mental health screening in armed forces before the Iraq war and prevention of subsequent psychological morbidity: follow-up study. BMJ, 333(7576), p.991.
[29] Rona, R.J., Burdett, H., Khondoker, M., Chesnokov, M., Green, K., Pernet, D., Jones, N., Greenberg, N., Wessely, S. and Fear, N.T., 2017. Post-deployment screening for mental disorders and tailored advice about help-seeking in the UK military: a cluster randomised controlled trial. The Lancet, 389(10077), pp.1410-1423.
[30] Pulhheems Administrative Pamphlet 10 (PAP10).

the suicide review team. It is not possible to control the actions of SP and reduce access to the means for suicide when at home or in non-military settings.

26. Another key method of preventing suicide involves reducing risk factors. The Defence policies provide detailed guidance about recognising suicide risk[31], introducing mitigation approaches and ways of providing personnel support, and are continually updated. The Army OP SMART Mxt project, currently in development, involves specific work strands on suicide and self-harm; the Army suicide prevention strategy has recently been updated to include new education and training programmes and guidance for providing psychological support post-suicide. In 2018, the RAF revised and updated policy document AP 9012 Chapter 6 which provides guidance and direction on suicide and self-harm. All the single Services deliver comprehensive mental health awareness and education programmes during phase 1 training. The three Services have also provided guidance to the Samaritans who are developing an assistance and prevention programme for the military community with £3.5M of London Interbank Offered Rate (LIBOR) funding. In addition, Combat Stress provides 24-hour access to a helpline for those in distress or crisis. Other initiatives include the mental health network and mental health events such as 'Thriving at work' hosted by the Permanent Secretary and Chief of Defence People.[32]

27. The UK National Strategy for suicide prevention recommends that every local area in the UK has an annually updated, multi-agency suicide prevention plan, with agreed priorities and actions.[33] Defence has a clear Mental Health & Wellbeing Strategy but does not have a discrete, unified, suicide prevention plan. Among the various interviewees who provided material for the suicide review, opinion varied about the requirement for a new plan. However, there was enthusiasm for consolidating current policies, procedures and guidance into one concise document to act as a reference point. JSP 661 is currently in development and will help to consolidate many relevant policies.

28. Given that suicide is now one of the commonest causes of death in SP after accidents and cancer, the suicide review team concludes, on balance, that there is merit in producing a stand-alone suicide prevention plan for Defence.

Recommendation 11: Develop a Defence Suicide Prevention Plan in line with Government recommendations.

OBJECTIVE 6: Determine new ideas for preventing suicide, by reviewing the scientific literature and by working with Academic Department of Military Mental Health to identify the risk factors for deliberate self-harm and suicide in Service Personnel.

29. **Deliberate Self-Harm in the UK Military.** Two new academic studies were conducted. The first was a study of self-harm. Lifetime Deliberate Self-Harm (DSH) and suicide attempts (SA) are both significant predictors of subsequent death by suicide. Both factors were estimated using data derived from three phases of a large UK military cohort study[34] and an additional, linked telephone interview study. In the cohort study, the rate of lifetime DSH

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[31] A history of previous suicide attempts; mental health referral / diagnosis, serious medical problem; relationship problems; significant loss (death of someone close; loneliness and isolation; current / pending disciplinary / legal action including investigations in relation to sexual offences; alcohol and substance misuse; spouse / children of a suicide victim; sexual orientation and gender identity.

[32] http://defenceintranet.diif.r.mil.uk/News/BySubject/PeopleinDefence/Pages/Thrivingatwork.aspx.

[33] https://www.gov.uk/government/publications/suicide-prevention-third-annual-report page 7, para 4.

[34] The cohort study is a large, representative sample of the UK Armed Forces who provided health, wellbeing and lifestyle information as part of an ongoing programme of research. Research findings derived from the cohort can be used to reliably estimate outcomes in the whole UK Armed Forces.

remained relatively constant across the first two measurement points.[35] However, in 2014-16 the rate rose to 4% and 7% among serving personnel and veterans respectively. The rate among telephone interview study participants was much higher.[36] Both DSH and SA were related to a range of factors associated with the following: poor mental health, inadequate social support, stigmatising beliefs about mental illness, negative attitudes to mental illness, suicidal thoughts and formal medical help-seeking. Commissioned officers and members of the RAF were significantly less likely to report lifetime suicide attempts, while women were significantly more likely to report lifetime DSH. Alcohol misuse had no significant association with either SA or DSH.

30. We, therefore, conclude that there are several modifiable factors associated with DSH and SA, and that Defence is appropriately focused on improving mental health support, reducing stigma and improving access to social support networks. This study and its findings are described in full in Annex K.

31. **Literature Review of International Military Suicide.** The second academic component was a systematic review of the international military suicide research literature published between 2010 and 2018. The systematic review contained 169 peer-reviewed academic studies that met a pre-determined quality threshold. Most of the academic papers identified in the literature search originated in the United States. However, many factors were applicable to suicide prevention in the UK military. The available evidence suggests that predicting the risk of suicide is a complex task and, given the random nature and low incidence of military suicide, attempts to draw clear conclusions and make firm practice recommendations are often misleading. Key learning points arising from the literature review are described in Annex L and could be used by the SPWG to develop policy and guidelines. ADMMH has the capacity to expand this literature review, with frequent updates, to assist Defence in formulating suicide prevention policies.

32. Although numerous risk factors for suicide were identified in the literature review, mental ill health represents a key risk factor in death by suicide. The promotion of mental fitness is likely to be an important preventative strategy. Timely and easy access to high quality mental healthcare is arguably the most important consideration in any suicide prevention strategy.

33. Defence Primary Healthcare (DPHC) have identified gaps in clinical mental healthcare provision, and variation in the quality of mental health services. In order to improve care, mental healthcare service delivery has been reconfigured; primary care is undergoing an optimisation process and a unified patient care pathway for mental health has been introduced. This pathway is summarised in Annex M. These changes in care provision may help to close potential gaps in healthcare provision. During the suicide review process, weaknesses in current mental healthcare provision and under manning were highlighted. The capability and capacity of military primary care physicians to deliver step one psychological interventions (as recommended in the unified care pathway SOP) was questioned by interviewees, particularly in the context of locum staff employment. In addition, concern was raised about the ability of junior nurses to conduct robust risk assessments, and about the capacity of consultant psychiatrists to provide comprehensive supervision to junior staff carrying out this activity. The suicide review team concludes that the effectiveness of the unified care pathway should be reviewed.

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[35] The rate was 2% among serving personnel and 4% in ex-service veterans in 2004-06 and 2% and 5% respectively in 2009-10.
[36] In the telephone interview study, the rate was 17% among serving personnel and 19% among ex-serving veterans.

Recommendation 12: Academic Department of Military Mental Health (ADMMH) to expand the current military suicide literature review to include civilian studies and increase reporting frequency to biannually.

Recommendation 13: Review the unified care pathway for mental health in 12 months' time to ensure that it is being delivered and that it is effective.

OBJECTIVE 7: Assess the root cause analysis and case reviews of probable suicides on the Automated Serious Event Recording (ASER) system from 2012 to date in order to identify any new lessons.

34. An overview and discussion of the strengths and weakness of the Automated Significant Event Reporting (ASER) system is provided at Annex N. The system is primarily a patient safety reporting tool with reports initiated by healthcare personnel in DPHC. Probable suicide cases are abstracted from the steady flow of ASER reports that come through the system. They are treated as Sentinel Events[37] and subjected to a three-step investigation and learning process, which ultimately produces recommendations and good practice guidance for clinicians. Although written guidance for the investigative process, including psychological autopsy, is provided, it is not standardised and can lead to variations in the quality of reports on the ASER system. SO1 Mental Health, DPHC, is currently drafting a guidance note to provide clear direction to investigating clinicians.[38]

35. In order to maximise the opportunity for learning, it would be helpful to consolidate the outputs from all investigations and learning processes. Feedback from interviewees suggests that the Defence Lessons Identified Management System (DLIMS) and ASER do not interact with each other. Interoperability across both systems would help to bridge the gap between the medical domain and management activity, which would help to ensure that information gained and lessons identified are comprehensively understood and implemented. Furthermore, while there are areas of good practice within the single Services, there is limited sharing of reports and recommendations across Defence, along with a lack of a unified formal process to confirm that recommendations have been implemented. Overall, the impact of implementing recommendations on suicide and self-harm prevention is largely unknown.

Recommendation 14: Defence Primary Healthcare to publish guidance on best practice for Department of Community Mental Health internal case note reports, psychological autopsies and the external investigation of suicides.

Recommendation 15: Internal reviews, psychological autopsies and external reviews to be collated by the Defence Medical Services Regulator on at least an annual basis.

Recommendation 16: Suicide Prevention Working Group to review collated reports, Service Inquiries recommendations and Learning Accounts in order to identify new measures to prevent suicide of Service Personnel.

Recommendation 17: Defence Medical Services Regulator to audit the implementation of recommendations to prevent suicide in Service Personnel.

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[37] Suicide is characterised as a Sentinel Event. A Sentinel Event is defined as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.

[38] Department of Community Mental Health (DCMH) management following the death of a patient – DRAFT guidance note – currently in development.

OBJECTIVE 8: Investigate how the communication of 'at risk' Service Personnel could be improved between the Defence Medical Services, National Health Service, Welfare Services and the Chain of Command (CoC).

36. The requirement to communicate risk at unit level is clearly articulated in single Service publications. However, interviewees suggested that there is tension between clinical services, welfare services and the CoC, particularly regarding the depth of detail that can be communicated in unit committee fora and when interacting with the CoC. Information sharing appears to be of greatest concern to medical personnel and may represent a communication shortcoming, particularly when the medical representative is a civilian locum practitioner who has limited awareness of Defence policy. Concerns appear predominantly to relate to medical confidentiality and the potential to stigmatise individuals with a mental health 'label'. The Army has produced comprehensive guidelines relating to medical confidentiality which should help to remove any doubts about disclosure.[39] This could be used across Defence.

37. The single Services have robust welfare support procedures in place where all casework interventions are coordinated using electronic systems. Army Welfare Services and Royal Navy Welfare utilise the Joint Army Navy Information System (JANIS) casework management system, while RAF welfare workers use SSAFA's Care Director system. The latter is currently being enhanced to enable the secure transfer of referral information between professionals. Specific codes of confidentiality and information-sharing protocols are adhered to across the Services. Welfare professionals encourage potentially at-risk personnel to seek professional support and can act as advocates. However, they are authorised to breach confidentiality when SPs are deemed to be at significant risk to themselves or others.[40] RAF PS&SWS managers reported that their staff have well developed relationships with key station personnel and overall feel that communication is good.[41] Nonetheless, welfare and medical services tend to be 'stove piped', which reduces opportunities for clear, frank and potentially life-saving exchanges of information.

38. Although there are procedures in place to inform military medical services when an SP presents with self-harm to the NHS, interviewees were concerned that this procedure is not robust. It is wholly reliant on SP disclosing their military status in the Emergency Department, the receiving ED doctor being aware of the formal communication procedure and the availability of facsimile apparatus, the current default confidential communication method. The system breaks down completely when SP choose to access private healthcare providers. There is a real risk that self-harm out of hours may not be identified and followed up on. The suicide review team were unable to identify a method of closing this gap using current medical information systems.

Recommendation 18: Consider Army guide to medical confidentiality for adoption across Defence.

Recommendation 19: Defence Health and Wellbeing Board to consider embedding welfare support in DCMHs.

OBJECTIVE 9: Analyse how probable suicides are investigated by Defence and the Defence Medical Services Regulator in order to identify best practice and a standardised approach to future investigations.

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[39] FdArmy/SpBr/G4/Med/Pol dated 10 Aug 17.
[40] Royal Navy - BR3 Art 2413 and Army - JSP 770 Art 1.1.19(a).
[41] RAF unit welfare providers and those responsible for implementing policy who provided information to the review team highlighted that communication channels were open and effective.

39. **Army.** A full description of the investigation and learning pathways adopted by the single Services are detailed in Annex O. Following receipt of a notification of completed or attempted suicide, the Army follows an investigation process that generates learning and recommendations. Although the procedure is complex, it is underpinned by detailed guidance that is clearly set out in Service publications. The Army system ensures a comprehensive investigation, review and robust learning process. Army Command Standing Order Number 1118 (ACSO 1118) provides comprehensive guidance which underpins the learning process for the Army. The review team could not find compelling evidence that the information learned from these investigations is shared with the other services through any other means, beyond the Defence Learning and Information Management System(DLIMS).

40. **Royal Navy**. The RN has clear guidance to follow when investigating a suicide or attempted suicide incident. This includes a structured reporting process, key points of contact, and how to format and write the final report. The process is very similar to that used by the Army, with adaptations that take account of the unique circumstances of the maritime environment. Although the relevant RN publications are detailed and comprehensive, they have not been updated recently.[42]

41. **Royal Air Force**. The Royal Air Force suicide prevention policy is contained in AP 9012 Chapter 6. In addition to the management of self-harm and attempted suicide, the policy details step-by-step guidance for carrying out investigations, and a structured report template with completion advice. The investigation process and report template are both similar to those adopted by the Army and RN. The RAF policy document is very clear on the processes to be followed, including timelines and ownership. Information and lessons identified from incidents are uploaded and held on both the DLIMS and Air Safety Information Management System (ASIMS).

42. **Management of Lessons Identified**. DLIMS is the single tri-Service repository for lessons identified. The system allows for external files and documents to be attached as supporting evidence. It can provide a direct link back to the Army Incident Notification Cell; this feedback loop is less clear for the other Services. The DLIMS allows a guest user to examine identified lessons using key search terms or assigned identification numbers. Some lessons are locked for sensitivity or security reasons, particularly in relation to cases of suicide. For example, 19 out of 24 suicide-related recommendations (79%) could not be accessed due to security restrictions. The DLIMS procedure is followed by all Services but, importantly, the output is not shared between Services. This represents a potential system flaw as vital information is not promulgated across the tri-Service space. As the single source of lessons identified in Defence, DLIMS should be used more extensively. Due to the sensitivity of some suicide Learning Accounts, authority for access could be granted to a tri-Service body which would ensure that the lessons identified are appropriately implemented across Defence.

Recommendation 20: Defence Learning and Information Management System to be the single repository for Lessons and Learning Accounts.

Recommendation 21: Suicide Prevention Working Group to have full access to information held on DLIMS regarding suicide.

Recommendation 22: DSA to assure that Learning Accounts and Service Inquiry recommendations are shared across Defence to ensure implementation of best practice.

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[42] RN BRD 172 last updated Sept 2012, RN BRd 3(1) last updated June 2016.

CONCLUSION

43. A focused review of suicides in SP was conducted over four months. The review team recognised the considerable amount of work already undertaken by Defence, in order to improve the mental health of SP and to prevent suicide. Defence has comprehensive policies and procedures that cover promotion of mental wellbeing, and the prevention, detection and treatment of mental ill-health. This is supported by easy access to military healthcare.

44. Notable recent achievements include the provision of additional funding for Departments of Community Mental Health, the introduction of a unified patient care pathway for mental health, the establishment of a dedicated 24-hour crisis helpline, and the partnering with the Samaritans to provide resources for those contemplating self-harm. These are underpinned by a comprehensive mental health and wellbeing strategy.

45. Benchmarking of suicide prevention policies suggests that UK Defence policies are comparable, and in some areas superior, to national and international provision. Furthermore, the suicide review team concludes that, although the comparative data have substantial limitations, UK military suicide rates appear to be lower than that of most other AF, and the UK Police Service. Nonetheless, Defence must not be complacent and this report makes 22 recommendations. The three key recommendations are: the establishment of a Suicide Prevention Working Group (SPWG), confirmation of the TORs and membership of the SPWG, and the development of a Defence Suicide Prevention Plan.

[redacted]
Lt Col
for the Suicide Review Team

[redacted]
Air Cdre
Head Defence Medical Services Regulator

ANNEXES:

A. Terms of Reference for a Focused Review of Suicides by AF Personnel.
B. List of Suicide Review Interviewees.
C. Review of the Current Approach to Suicide Data Analysis.
D. A Comparison of Military Suicide Rates.
E. Lessons Identified from Reviews of UK Military Suicides and Open Verdict Deaths.
F. Suicide and Self-Harm Prevention in UK Emergency Services.
G. NATO Suicide Prevention Strategy.
H. The Canadian AF Suicide Prevention Strategy.
I. The National Suicide Prevention Strategy for England.
J. The National Suicide Prevention Strategy for Scotland.
K. Deliberate Self-harm in the UK Military – A New Study.
L. Suicide and Self-Harm in Military Organisations - A Literature Review.
M. Unified Care Pathway for Mental Health Standard Operating Procedure.
N. Review of the Automated Significant Event Reporting System.
O. A Critique of How Probable Suicides are Investigated by Defence.
P. Recommendations.

Annex A to
DSA/DMSR_04
Dated 14 Aug 18

TERMS OF REFERENCE FOR A FOCUSED REVIEW OF SUICIDES BY AF PERSONNEL

AIM

1. To identify (additional) measures and mechanisms of preventing suicide in Service Personnel through an examination of Service Inquiries, Learning Accounts and the application of best practice.

PURPOSE

2. In order to improve the effectiveness of mental health provision to Service Personnel (SP) and wellbeing.[43]

OBJECTIVES

3. Determine the governance of suicide prevention across Defence by investigating the ownership of policies, resources and risks.

4. Determine the extent to which published statistics accurately compare the level of suicide in Service Personnel with those in the general and other populations.

5. Determine organisational progress on the implementation of recommendations from past Service Inquiries , Learning Accounts and the recommendations made by Defence Statistics in 2016.

6. Assess the recommendations in recent national publications to identify additional measures to prevent suicide.

7. Determine the utility of creating a Defence Suicide Prevention Plan.[44]

8. Determine new ideas for preventing suicide, by reviewing the scientific literature and by working with the Academic Department of Military Mental Health to identify the risk factors for Deliberate Self-Harm and suicide in SP.

9. Assess the Root Cause Analysis and case reviews of probable suicides on the Automated Serious Event Recording (ASER) system from 2012 to date in order to identify any new lessons.

10. Investigate how the communication of 'at risk' SP could be improved between the Defence Medical Services, National Health Service (NHS), Welfare Services and the Chain of Command (CoC).[45]

11. Analyse how probable suicides are investigated by Defence and the Defence Medical Services in order to identify best practice and a standardised approach to future investigations.[46]

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[43] The Defence Mental Health and Wellbeing Strategy published in Jul 17 is built around the four tenets of Prevent, Promote, Detect and Treat.
[44] Local Suicide Prevention Plans are recommended in https://www.gov.uk/government/publications/suicide-prevention-third-annual-report.
[45] This is a frequent concern for the CoC and an area highlighted for further investigation by SG.
[46] Current practice is variable.

TIMINGS

12. You are to meet the following timings:

a. Assemble the Team and start work on 1 Mar 18.

b. Provide an initial update to Director General Defence Safety Authority (DG DSA) by end Mar 18.

c. Provide a further update to DG DSA by end May 18.

d. Report the findings and make appropriate recommendations to DG DSA by 1 Jul 18.

STAKEHOLDERS

13. You are to consult as required.

RESOURCES

14. Resources will be as follows:

a. A team lead nominated by the SG. (Lt Col [redacted], Head of the Academic Department of Military Mental Health, King's College London)

b. A team member nominated by DG DSA. (WO2(AQMS) [redacted], DAIB)

c. A team member nominated by CDP. (Wg Cdr [redacted], Service Personnel Support Team)

d. Costs will lie where they fall.

GOVERNANCE

15. You will report to DG DSA. The intention is for the focused review to be published on www.gov.uk

Annex B to
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LIST OF SUICIDE REVIEW INTERVIEWEES

Chief of Defence People
Surgeon General
Deputy Chief of the General Staff
Head Royal Navy Medical Services
Senior Health Advisor (Army)
Head RAF Medical Services
Head Future Healthcare/Commander Defence Primary Healthcare (DPHC)
Head Defence Medical Services Regulator
Head of RAF Safety
Defence Consultant Advisor (DCA) Psychiatry
DCA Psychology
Chair NATO Suicide Research and Technology Group (RTG)
Consultant Psychiatrist, Clinical Lead DCMH Plymouth & Consultant Advisor in Psychiatry to MDG(N)
SO1 Executive NPS Navy Command HQ
SO1 AH Health & Wellbeing LAND Command
SO1 RAF Recovery Policy COS Pers-Del Air Command
SO2 SPT PACT NPS-People Navy Command
SO2 Mental Health & Wellbeing Policy LAND Command
SO2 Health and Wellbeing Policy LAND Command
SO2 Casualty and Recovery Management Navy Command
DCMH Psychiatrists x 3
DCMH Clinical Leads x 5
DCMH Mental Health Nurses x 6
Primary Care Medical Officers x 4
SO1 Defence Mental Healthcare
SO1 Patient Safety DPHC HQ
SO2 Healthcare Governance DPHC HQ
Head Personal Support HQ AWS Headquarters Regional Command
RAF PS&SWS (SSAFA)
Senior Police representative
Senior Ambulance representative
Senior Fire Service representative
DCOS 3rd Division
3rd Division PPSI
FTC PPSI
DSA DMSR SO2 Patient Safety
Army PM Inv WO1
APSG PersSvcs SI SO1
APSG PersSvcs SI Lessons SO1
Follow-up investigative procedures following two unexplained deaths were observed

Annex C to
DSA/DMSR_04
Dated 14 Aug 18

REVIEW OF THE CURRENT APPROACH TO SUICIDE DATA ANALYSIS

Introduction

1. The main source of information relating to this topic is the annual report provided by Defence Statistics (DS)[47] with supplementary data contained in an accompanying EXCEL workbook.[48] Both are available as open access documents online; the worksheet should be considered alongside the main report, as it is a rich data source. The report examines death by suicide and open verdict deaths in currently serving UK regular Armed Forces (AF) personnel, and makes comparisons with the suicide rate in the general population of the UK. The study population is tri-Service, but due to the low number of suicides among female Service Personnel, population comparisons have been restricted to males aged 16 to 59 years. The statistical analyses compare age-standardised suicide rates across the three Services; three-year rolling averages are used to minimise the effect of year on year random variation. Using Standardised Mortality Ratios (SMR) to compare the military and general population [49], the document concludes that the number of suicides among serving military males is consistently statistically significantly lower than the number expected, when compared to males in the UK general population. Historically, young Army males were deemed to have significantly more suicides than expected compared to the general population; the report notes that, latterly, the difference is no longer statistically significant. Common methods of suicide among UK AF personnel are summarised.

Limitations of the current approach

2. The calculation of SMR is a widely accepted and robust analytical method used across the world to compare health outcomes between populations. SMR methodology has been used by UK researchers investigating military suicides.[50] The use of the method in the current setting provides context for interpreting military suicide rates. However, as with all analytical approaches, it has limitations. First, and most importantly, variations in suicide rates may be attributable to numerous factors other than age, the principle factor that is currently accounted for in the SMR calculation. There is a possibility that multiple factors such as educational attainment, operational deployment, aversive childhood experiences, employment (arguably the most important factor), physical conditioning, social deprivation and so forth may vary substantially between civilian and military populations and exert a substantial influence on suicide rates. These are not accounted for in the current SMR calculation, although the potential impact of such factors is acknowledged as a limitation in the latest DS report. Secondly, a problem arises when there are substantial incremental changes in annual rates over time which can affect the accuracy of the SMR. This is partially offset using three-year rolling means in the current analyses, although SMR remains a blunt analytical approach. Thirdly, when matching on age, changes in age category proportions in either or both samples can influence the SMR calculation. Random variation can have a particularly powerful effect on

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[47] Defence Statistics Report: Suicide and Open Verdict Deaths in the UK Regular Armed Forces 1984-2017 published 27 March 2018

[48] 20180327_BULLETIN_Suicide_and_open_verdict_deaths_in_the_UK_Regular_Armed_Forces_1984-2016_Tables_and_Figures-O

[49] SMR is calculated as the ratio of the number suicides occurring among military personnel to the number of expected suicides if military personnel had the same age -specific rates as the general population in each specific year of study.

[50] Kapur, N., While, D., Blatchley, N., Bray, I., & Harrison, K. (2009). Suicide after leaving the UK Armed Forces—A cohort study. PLoS medicine, 6(3), e1000026.

statistical significance when comparing low frequency events, which suicide represents. Lastly, the population of interest is also included within general population data, and so can cause bias as it cannot be removed. The analyses presented in the annual suicide reports cannot, and were not designed to, provide information to inform targeted interventions. There is a risk that reassuring outcomes, such as the perceived low rate of suicide among AF personnel in comparison to the general population, might inhibit motivation to further develop suicide prevention programmes. Conversely, when rates are deemed to be elevated, for instance among young soldiers, this might increase preventative activity with no guarantee that the correct causative factors are being addressed.

3. The section of the report dealing with suicide method is very helpful as it could theoretically be used to inform targeted preventative intervention. However, this section is complex and it could be argued that the simple headline figure provided is sufficient for intervention design.

4. The 'strengths and weaknesses' section of the report addresses the validity of the data source, which appears to be robust, being largely coroner-determined. However, the discussion does not give the reader, particularly if not well versed in statistical analyses, a full sense of the potential limitations both of the available data and of the analytic approach. For example, an important additional limitation is the exclusion of women in the population comparisons, due to the low frequency of female suicides in the military sample.

5. Although the report is helpful in summarising military suicide data within one document, comparisons with the general population could be misinterpreted. This is potentially important as the main findings of the annual reports are cited in parliamentary and command publications and appear in official planning documents, such as the Defence Mental Health and Wellbeing Strategy. The latter notwithstanding, sub-sample evaluations published in ad-hoc DS reports have proven useful in providing corrective information when erroneous claims are made about military suicide, an example being the misperception of elevated suicide rates among Op Corporate veterans[51] and Gulf War veterans. [52]

International and occupational group comparisons

6. The study team was additionally tasked to report on any formal comparisons of suicide rates between the UK military and other populations. To date, no such studies have been completed. Such work would need to overcome differences in the coding of suicide and robustness of data sources, along with the structural and cultural differences between international AF; it would also require sufficient numbers of suicides to have occurred among military personnel. DS is currently developing a new methodology to provide comparative data using a World Health Organisation (WHO) classification and reference group. It is likely that the final comparison will be limited to partner nations with sizeable militaries and sufficient numbers of confirmed suicide deaths to provide meaningful analyses. Analyses have been completed and a report is currently being formulated. As part of the current review, the Suicide Review Team collated the available published data which is summarised at Annex D.

7. It is unlikely that comparisons with other UK occupational groups can be carried out as this would require the use of different methodology, such as proportional mortality ratio (PMR)[53] calculations. To do this, researchers would have to access all death records to determine

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[51] Statistical notice: A study of deaths among UK Armed Forces personnel deployed to the 1982 Falklands Campaign: 1982 to 2013 dated 1 May 2014.

[52] https://www.gov.uk/government/statistics/causes-of-deaths-that-occurred-among-the-uk-veterans-of-the-199091-gulf-conflict

[53] The ratio of the number of deaths within a population (in this case, the military versus a comparable occupational group) due to suicide divided by the total number of deaths in the population during a given time period.

occupation, and match military personnel to a partially comparable group, such as the police. Head DS has confirmed that such an approach is not currently practical or achievable.

Alternative methodology

8. Alternative methods for comparing matched population samples have been used in the United States, such as cohort samples or various matching techniques. However, all such methods are likely to be prone to some degree of error, when studying low frequency events such as suicide, and are likely to have prohibitive additional cost and resource implications if implemented in the UK military. It is therefore questionable that the potential benefits, of setting up and maintaining a new study (such as a cohort study) or using a different approach, would justify the cost and resource outlay, as general population and military sample sizes would need to be considerable given the low frequency of suicide in the military. Arguably little benefit would be derived as, if the primary objective is to inform interventions, such studies would probably be unable to achieve this objective. Instead there is good evidence that potentially modifiable suicide risk factors, such as self-harm behaviours, mental disorder symptoms and help-seeking behaviours can be altered, so funding for additional studies might be better spent designing and evaluating supportive interventions which target potentially modifiable risks, rather than developing a new study design to compare rates.

9. DS have recently generated a new methodology, modified statistical process control, which plots suicide events against period between events and calendar time. Using this approach, it is possible to estimate whether rates of suicide are 'unusual' so that action can be taken to examine possible causative factors. Both this and the international comparison approaches will require a separate formal review in due course, to establish whether they add value to the suicide prevention process.

Conclusion

10. The SMR approach makes accurate comparisons of suicide rates between military and civilian populations, based on robust methodology and data collected over a substantial period of time. However, like all statistical techniques, results should be interpreted in light of the limitations of the methods used. The advantage of the method is that it is a standard and widely-used approach which provides helpful context when interpreting military suicide rates, although it does have substantial limitations. New methodologies are being developed by DS which might prove useful in furthering understanding of UK military suicide.

Annex D to
DSA/DMSR_04
Dated 14 Aug 18

COMPARISON OF MILITARY SUICIDE RATES

1. As noted in Annex C, attempting to compare annual rates of suicide between international militaries is highly problematic. Although some nations do publish data, it is often shown in a form that precludes direct comparison, for instance by describing annualised rates, standardised mortality ratios, rates adjusted for confounding factors, and sub-group exclusions such as on the grounds of gender. Many nations do not produce official figures on an annual basis while others make outcomes available through ad-hoc peer-reviewed research publications. The Office for National Statistics (ONS) publishes comparisons between occupational groups in the general population; however, it does not compare civilian and military groups. Although some groups do indeed appear to have a higher rate of suicide than others, the ONS makes clear that no estimation of cause can be made and the reports contain numerous caveats that limit the utility of the research.[54] In order to establish whether comparable data were available, a literature search was conducted by the Suicide Review Team which indicated that some nations have published peer reviewed military suicide outcomes detailing crude rates. Despite searching by nation, the following yielded no data: Belgium, Denmark, Estonia, Italy, Norway, Poland, Germany and Holland (Netherlands). When available in a similar format, published international rates have been compared with the annualised rates provided in the additional datasheets made available online by Defence Statistics. The outcomes suggest that, overall the UK military suicide rate compares favourably with rates in other nation's militaries (see next page).

[54] Suicide by occupation, England: 2011 to 2015. Analysis of deaths from suicide in different occupational groups for people aged 20 to 64 years, based on deaths registered in England between 2011 and 2015.

Published Military Suicide Studies by Nation

Nation	*Rate	Year	***UK Military Males
USA (Male)[55]	33.4	2015	4.7
Canada (Male)[56]	24.8	2016	Not published
Sweden[57]	11.8	2007	5.5
France[58]	18.2	2004	10.7
Ukraine[59]	16.7	2002	7.8
Canada[60]	16.1	2010	6.4
Australia[61]	**13.8	2009	5.7
UK[62]	***9.4***	***2003***	***8.9***
Taiwan[63]	8.2	2018	Not published
Italy[64]	1.1	1998	12.3

*per 100,000 personnel
**age standardised
***corresponding annual rates extracted from DS report supplementary data

The Belgian Military

2. Although peer-reviewed research outcomes were not available, Belgium could provide non-peer reviewed figures for suicide and suspicious death, although the provenance of the data was unclear. The figures suggest that UK military rates of death by suicide are similar to the rate reported in the Belgian military.

Outcome	2014	2015	2016	2017	2018
Suicide	13	9	12	8	1
Suspicious Circumstances	3	1	1	0	0

The Dutch Military

3. The Netherlands military could supply figures for male military suicide and a working male general population comparator sample for the period 2004-12. The analyses were restricted to males and encompassed all military veterans, rather than serving personnel only. The incidence rate of suicide per 100,000 person-years for working men was **11.4**, for veterans who had undertaken deployment the rate was **8.0** and for veterans who had never deployed the rate was **11.2**. Again, direct comparison with the UK was not possible due to sample heterogeneity

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[55] Kang, H. K., Bullman, T. A., Smolenski, D. J., Skopp, N. A., Gahm, G. A., & Reger, M. A. (2015). Suicide risk among 1.3 million veterans who were on active duty during the Iraq and Afghanistan wars. Annals of epidemiology, 25(2), 96-100.
[56] 2017 Report on Suicide Mortality in the Canadian Armed Forces (1995 to 2016). Surgeon General Health Research Program SGR-2017-002 October 2017.
[57] Michel, P. O., Lundin, T., & Larsson, G. (2007). Suicide rate among former Swedish peacekeeping personnel. Military medicine, 172(3), 278-282.
[58] Desjeux, G., Labarère, J., Galoisy-Guibal, L., & Ecochard, R. (2004). Suicide in the French armed forces. European journal of epidemiology, 19(9), 823-829.
[59] Rozanov, V. A., Mokhovikov, A. N., & Stiliha, R (2002). Successful model of suicide prevention in the Ukraine military environment. Crisis, 23, 171-177. doi: 10.1027//0227 5910.23.4.171.
[60] Belik, S.L., Stein, M. B., Asmundson, G. J., & Sareen. G. (2010) Are Canadian soldiers more likely to have suicidal ideation and suicide attempts than Canadian civilians? American Journal of Epidemiology, 172, 1250- 1258.
[61] Hadfield, D. & Sheffield, J. (2009). Suicide in the ADF 2000–2007. Thesis. University of Queensland, Brisbane.
[62] Fear, N. T., & Williamson, S. (2003). Suicide and Open Verdict Deaths among Males in the UK Regular Armed Forces. Comparison with the UK Civilian Population and the US Military. Defence Analytical Services Agency.
[63] Lee, Y. F., & Tzeng, D. S. (2018). Military suicide among Taiwanese soldiers: a comparative study. Journal of Medical Sciences, 38(1), 38.
[64] Mancinelli, I., Lazanio, S., Comparelli, A., Ceciarelli, L., Marzo, S.D., Pompili, M., Girardi, P. and Tatarelli, R., 2003. Suicide in the Italian military environment (1986–1998). Military medicine, 168(2), pp.146-152.

and the use of dissimilar metrics; however, the rate appears to be only slightly higher than that found among UK serving personnel.[65]

The Australian Military

4. The Australian Defence Force (ADF) makes consolidated data available online; however, suicide figures are not annualised and it is therefore not possible to compare with UK military suicide rates. The ADF suicide standardised mortality ratio suggest a similar finding to the UK in that the Standardised Mortality Ratio (SMR) for serving regular males is significantly lower than the Australian general population when matched for age.[66]

UK Police Service

5. In the UK Police Service, there were 22 suicides among 127 485 officers in 2015 and 23 suicides among 124 368 officers in 2016. Although not directly comparable as the police numbers include women, it appears that the rate of suicide in the UK Police Service may be higher than in the UK military.[67,68]

Conclusion

6. Published data suggests that the annual suicide rate in the UK military is lower than that of nations that publish peer-reviewed and ad-hoc military data. Data with lower provenance, or with dissimilar metrics to those used in the UK, suggest a similar pattern. Readers should note that data comparison is problematic as different definitions of suicide, exclusion criteria, sampling strategies and sample compositions were used in the various studies. Furthermore, cultural, military, structural and coding differences between nations' militaries limit the utility of the comparisons; the findings should therefore be considered to be speculative.

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[65] Duel, J. (2017) Suicide among Dutch veterans. A comparison between suicide rates of male servicemen who have been deployed, male servicemen who have not been deployed, and a comparable sample of the male civilian population. STO-MP-HFM-275

[66] Australian Institute of Health and Welfare 2016. Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2014. Cat. no. PHE 212. Canberra: AIHW.

[67] House of Commons Library: Social Indicator 2615 accessed 18 June 2018

[68] Office for National Statistics, Number of Police Officers that died by Suicide in England and Wales, 2015-16. Accessed 18 June 2018.

Annex E to
DSA/DMSR_04
Dated 14 Aug 18

LESSONS IDENTIFIED FROM REVIEWS OF UK MILITARY SUICIDES AND OPEN VERDICT DEATHS

1. In 2016, Defence Statistics (DS) summarised the lessons from UK military Service Inquiries (SI) and Learning Accounts (LA) following suicide and open verdict deaths, in order to consolidate recommendations generated by the various investigations. Lessons learned from 18 post-suicide enquiries were synthesised into seven common 'themes' and the detailed recommendations were listed by theme in three domains; People, Surgeon General and single Service (some with wider application across the three Services). Although the initial generation of themes was comprehensive and appeared practical when grouping recommendations and assigning actions, the Suicide Review Team determined that a critical step had been omitted, namely, subjecting the emergent themes to final critical review by an expert panel before recommending actions; the individual recommendations, although thematically arranged, sometimes appeared to represent direct transcription from individual case enquiry reports.

2. Overall, a total of 54 individual recommendations were made. Eight recommendations (15% of the total) represented duplicates with slight variation; this appeared to be a product of assigning recommendations to three non-exclusive domains (single/tri-Service, Surgeon General and People). Following removal of such duplicates, of the remaining 46 recommendations, 14 (30%) lacked sufficient clarity or were so general that policy makers would be unable to specify precise action(s).[69] In 15 cases (33%), the evidence base underlying the individual recommendation was uncertain; in some cases, the relevance to potential suicide prevention activity was unclear.[70] In four cases (9%), the recommendations appeared to relate to a specific case review, and may therefore have lacked wider relevance.[71]

3. Suicide is a low frequency event in the UK military context. Although it is vital that a detailed post-incident review should continue to be undertaken and lessons learned, it is likely that factors will be identified that are unique to the individual case. Given the weak evidence base of some recommendations, there is a risk of implementing recommendations with potentially little positive effect. Future policy-makers should note that, in the case of low frequency events such as suicide, it is difficult to generate sufficiently dense data to inform robust recommendations; therefore, expert panel review represents a key step in the policy-making process.

4. The Suicide Review Team suggests that it would be helpful to re-institute regular review of learning outputs. This should, furthermore, be undertaken by a group of subject matter experts, so that any potential recommendations can be properly evaluated and turned into actionable recommendations by the Suicide Prevention Working Group (SPWG). It may be helpful to critically evaluate recommendations using the following or similar questions:

   a. Does the recommendation represent a recurrent theme or is it case-specific?

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[69] Examples include a recommendation to focus on specific groups such as those completing pre-departure administration (potentially a large group), living in single service accommodation (another large group), those exposed to potential trauma (large group) and the care of veterans with a history of deployment. In each case, specific activity was not specified.
[70] Examples include the use of TRiM in the non-deployed setting (TRiM does not have a suicide prevention function and has a weak evidence base in terms of prevention), studying the merits of bereavement counselling for all (rather than targeted intervention) and population level stigma reduction (stigma reduction interventions have an uncertain impact; evidence suggests that targeted stigma reduction efforts may be more effective).
[71] For instance, designing a mental healthcare protocol for senior officers, all TRiM leads to be TRiM practitioner trained and conducting a review of a specific DCMH location rather than assessing relevance to wider Defence mental healthcare sites.

b. Is the recommendation likely to be widely relevant such that it could be incorporated into a suicide prevention strategy? Does it have policy implications or can it be dealt with locally?

c. Does the specific recommendation relate to the suicide prevention evidence base? If not, can it be modified so that it is likely to have a positive and measurable effect?

d. Is the recommendation clear and actionable?

e. Does the recommendation detail who should take action?

f. Has a specific outcome been detailed, including how and when it should be measured?

5. The review of the Automated Serious Event Recording (ASER) system, detailed elsewhere in this report, further suggests that combining ASER output with LA and SI outcomes may strengthen both learning and the potential impact of implementing suicide prevention recommendations.

Annex F to
DSA/DMSR_04
Dated 14 Aug 18

SUICIDE AND SELF-HARM PREVENTION IN UK EMERGENCY SERVICES

1. This annex describes suicide prevention provision in the UK Emergency Services; corresponding activity and similarities in the UK military are shown in *italics*. Emergency Services (Police, Fire and Rescue Services (FRS) and Ambulance Services) were asked three questions:

a. Is information about suicide centrally collated and is there a standard approach to learning lessons from the deaths?

b. Is there a service or force-wide strategy for suicide prevention?

c. If an officer is identified as being at risk of suicide and self-harm, how is this dealt with?

2. None of the Emergency Services could identify a unified, national suicide prevention strategy for their service, although some regional services had local policies and procedures. Other than for the Police Service, there is no centralised suicide data capture. None of the three emergency services routinely conduct formal suicide analyses or have a formal learning process. All Emergency Services are currently aspiring to develop, or to begin work on developing, a 'data capture and lessons learned' process in relation to suicide deaths in service. Personnel deemed to be at heightened risk are managed using local resources and procedures; no unified national guidance is currently available.

3. Suicide prevention in the Emergency Services is regionalised and incorporates a broad range of activities that include:

a. Locally generated suicide prevention guidance which provides information on how to approach a conversation relating to suicide. *This is covered by Defence in single Service publications (RN Brd 3(1), Army AGAI Vol 3 Chapter 110 and RAF AP9012 Chapter 6).*

b. Suicide and self-harm component of Mental Health First Aid (MHFA)[72] training. *MoD and the RAF offer MHFA. The Army does not but will be making tailored training available as part of its OP Smart initiative, which is analogous to MHFA. It is notable that MHFA has a weak evidence base and an uncertain impact upon intervention recipients.*

c. Locally organised suicide awareness events. *The MoD and single Services (sS) regularly reinforce key messages throughout service life, provide mental health awareness training, proactive anti-stigma campaigns and specific suicide awareness initiatives in high risk groups.*

d. Suicide awareness incorporated into mental health training for managers. *In Defence, this is provided by unit staffs, sS welfare specialists and Defence Medical Services (DMS) mental health specialists.*

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[72] A two day training programme that teaches members of the public how to help a person developing a mental health problem (including a substance use problem), experiencing a worsening of an existing mental health problem or in a mental health crisis.

e. Signing up to Mind's Blue Light[73] Pledge.[74]

f. Signing up to Time for Change[75] and having local support systems in place. *In Defence, welfare, pastoral and healthcare support is in place at unit level. Welfare registers, monthly welfare/health committees and carer forums are in place to assist at-risk personnel. MoD has signed up to the Stevenson and Farmer Report on improving mental health at work and has produced the Defence People Health & Wellbeing Strategy which sets out the through-life approach and model of Promote, Prevent, Detect and Treat.*

g. Applied Suicide Intervention Skills Training (ASIST)[76] – particularly for high risk units. *ASIST is not evidence-based and has no supporting positive research associated with its use; the MoD has, therefore, chosen not to implement the approach.*

h. Offer of safeTALK in some regions.[77] *There is no evidence of effectiveness for this training and the MoD has chosen not to implement it. As an alternative, the MoD partners with Big White Wall, The Samaritans, Combat Stress and Soldiers, Sailors, Airmen and Families Association (SSAFA), who provide support, helplines and signposting.*

i. Membership of a Regional Suicide Reduction Partnership.[78]

j. Printed or online access to self-help materials, both in relation to general mental health support and specifically relating to suicidal ideation. *Serving personnel are provided with written materials, and briefings relating to mental health and wellbeing, at key transitions such as phase one training, pre-operational briefing, in-theatre training, decompression, normalisation, promotion courses and during resettlement courses; most have a suicide awareness component.*

k. A Wellbeing Hub providing staff support in one region, consisting of self-referral and the facilitation of access to a support pathway. *The DMS provides a dedicated, responsive, flexible and comprehensive mental healthcare service supported by over 200 mental health clinical professionals and further supported by specialist welfare and military social workers. This observation also covers the next emergency services initiative.*

l. Fast track access to Occupational Health support, contracted out in some areas.

m. A confidential 24/7 care line, provided in one region. *Combat stress (current), and the Samaritans (in development) offer 24/7 confidential care lines to serving personnel.*

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[73] The Blue Light Programme seeks to provide mental health support for emergency services staff and volunteers from ambulance, fire, police and search and rescue services across England and Wales.
[74] The Blue Light Time to Change pledge is an aspirational statement with meaning, indicating commitment as an emergency service employer, or voluntary group, to challenge mental health stigma and discrimination within the service.
[75] Time to Change is a mental health campaign in England, launched in 2007 with the objective of reducing mental health-related stigma and discrimination.
[76] Applied Suicide Intervention Skills Training (ASIST) is a two-day interactive workshop in suicide first aid. ASIST teaches participants to recognise when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety.
[77] safeTALK is a half day suicide alertness training which teaches participants to recognise persons with thoughts of suicide and to connect them to suicide intervention resources.
[78] Most partnerships of this kind seek to develop an all-age suicide prevention strategy which acknowledge variations in risk across the life course and incorporate age-appropriate interventions.

Annex G to
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Dated 14 Aug 18

NATO SUICIDE PREVENTION STRATEGY

1. The NATO strategy document[79] details the main findings of Research Task Group (RTG) 218 (Military Suicide Prevention), which canvassed opinion from seventeen member states. The US, UK and Canada were judged to have contributed substantially. The strategy document was updated in Jun 18 with no substantial changes made to the original recommendations.[80] The document contains key recommendations for suicide prevention and many of these have been used by the single Services to underpin a number of their work strands on suicide prevention. The Suicide Review Team provides commentary in *italics* on UK Defence performance in relation to each recommendation. The direction of the working group to member states was to:

a. Design a national military policy on suicide prevention.

b. Develop a strategic framework for suicide prevention.

c. Implement a national military suicide prevention strategy.

d. Systematically evaluate the potential impact of the strategy in the years to come.

e. Regularly review the recommendations of the RTG, identify potential gaps and develop ways to address these in a time-sensitive and systematic manner.

Key NATO Recommendations with Comments

2. **Surveillance of Military Suicide Deaths and Attempts using standardised investigations**: Develop and maintain a standardised surveillance system for the tracking of suicide deaths and attempts, possibly extending the surveillance into the veteran space[81]. *All single Service (sS) use the Automated Significant Event Recording(ASER) system, specific welfare databases and have formal investigative processes backed by detailed written guidance.*

3. **Mental Health Policies Recommendation**: Review the World Health Organisation (WHO) Comprehensive Mental Health Action Plan 2013-2020[82] and be aware of mental health policies that are applicable to the AF. If military policies do not exist, they should be formulated. *The Defence People Mental Health and Wellbeing Strategy contains a number of WHO recommendations including those relating to core determinants of health and is actively influencing these across the UK military population.*

4. **Reduction of Harmful Use of Alcohol**: Review the WHO Global Strategy to Reduce Harmful Use of Alcohol[83]; be aware of national and military prevalence and dependence levels. Alcohol use awareness campaigns may positively impact suicide risk so it is important to ensure that effective treatment options for alcohol-related conditions are available to all military personnel. *As part of the Defence Lifestyles Strategy active steps are being taken to reduce*

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[79] North Atlantic Treaty Organization, Science and Technology Organization, Research Task Group 218 (2016). Military Suicide Prevention: Report Prepared for NATO Leadership (STO-TR-HFM-218). Geneva: STO/NATO.
[80] https://www.sto.nato.int/publications/Pages/Technical_Reports_List.aspx
[81] Item one combines NATO recommendations one and two.
[82] http://www.who.int/mental_health/action_plan_2013/en/
[83] http://www.who.int/substance_abuse/activities/gsrhua/en/

alcohol intake, such as providing Unit Alcohol Advisors and general education programmes incorporating DrinkAware strategies.

5. **Multi-component Interventions:** Pay close attention to multi-component interventions that combine different strategies to target suicide risk. Nation-specific military and/or NATO community approaches to suicide prevention may be developed that encompass multiple levels of universal, selective and indicated interventions. *In the UK military, this is addressed at unit level. Service Personnel identified as being at risk receive Chain of Command (CoC), welfare and clinical support. More serious cases are treated through dedicated specialist medical and psychological treatment provision and rehabilitation, including as inpatients where appropriate.*

6. **Programme Evaluations**: Incorporate an evaluation component into each suicide prevention activity. *The Defence People Mental Health and Wellbeing Plan 2016[84] identifies 8 KPIs against which to measure progress. The Mental Health Steering Group (MHSG) reports this progress biannually to the Defence People Health and Wellbeing Board, with the next full review due in 2022. The MHSG monitors health surveillance data, available research and routine analyses by both clinical and non-clinical steering group stakeholders across the whole of Defence.*

7. **Mental Fitness**: Promote a strong emphasis on mental fitness such that it is viewed as an integral component of military service alongside physical fitness. *Both Defence and the three Services have developed a holistic approach to mental wellbeing and mental fitness. The MoD recently partnered with the Royal Foundation, following the Defence People Mental Health and Wellbeing Strategy's emphasis on forging strong partnerships in order to deliver through life training and mental fitness. Wallet cards are currently being developed that highlight the importance of mental fitness as part of the Change Direction Campaign. In response to the need to promote mental fitness, the Army has adopted an approach looking at the Soldier Athlete, in which mental fitness is viewed as having parity with physical fitness.*

8. **Awareness Campaigns about Mental Health and Stigma Reduction**: Multi-media campaigns, through television, social media or print media, should be delivered to service members and to various individuals (spouses or partners) and/or organisations involved in the service members' lives. The overall objective is to decrease shame, isolation, embarrassment, secrecy and stigmatisation, while increasing prompt help-seeking. If feasible, a division should be created between mental health services delivering treatment, and assessment methods such as screening. *The mental health and wellbeing strategy has established a co-ordinated through-life approach to physical and mental health and wellbeing. As part of this strategy, Defence has launched anti-stigma campaigns ('Don't bottle it up'), runs regular awareness campaigns, has introduced resilience training and has produced policies on workplace and operational stress.*

9. **Access to Care:** Improve access to timely and effective treatments for mental health and substance use disorders among military personnel. *The Defence Medical Services (DMS) has a dedicated mental healthcare service for serving personnel.*

10. **Gatekeeper Training Programmes**: Implement gate-keeper training programmes for military and NATO frontline supervisors, and for those community members well situated to recognise distressed service members and possible warning signs of suicide. Legal problems are an important risk factor for suicidal behaviours. Military legal representatives must be well-trained in recognising distress and connecting service members with appropriate mental health services. Additionally, training programmes need to be designed and implemented that teach every service member to recognise early signs of distress among peers and to identify specific

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[84] 20160608-DPHW Plan 16-18 (3 Star endorsed).

warning signs of suicide, in order to intervene as needed. *There is some disagreement about how helpful these programmes are; research suggests they may have limited value. However, Stress Management Training Courses are offered, and Joint Stress and Resilience Centre (JSARC) was established to ensure that best practice is delivered across the three Services. The sS also run their own bespoke training programmes.* [85]

11. **Crisis Help-lines for Military Personnel**: Provide a telephone and/or chat crisis helpline for suicidal SP. Trained civilian personnel, with no histories of military service, who work at these crisis help-lines may benefit from training in military culture and military-focused community resources. *Combat Stress offers a 24hr Mental Health Helpline for SP and their families and can offer signposting to either The Samaritans Crisis line or to a healthcare provider or Soldiers, Sailors and Families Association (SSAFA). The Big White Wall provides an online early intervention service, although research evidence suggests that this is rarely used by SP.*

12. **Delivery of Evidence-Based and/or Evidence Informed Suicide Prevention Practices which encourage vulnerable groups of service members to seek healthcare services promptly:** Invest in systems of military healthcare that deliver best-practices in suicide assessment, management and prevention; make research effort to develop effective treatments and disseminate them widely. *In-house military healthcare provision is compliant with this guideline.*

13. **Continuity of Care and Engagement in Aftercare**: Consider follow-up and community aftercare support services for SP who are psychiatrically hospitalised due to mental health issues, substance use disorders and/or suicidal reasons. Follow-up services can include case management, postcards or caring letters/text messages, telephone sessions and/or brief in-person visits. *Formal arrangements, including the provision of a Service Liaison Officer are in place to manage post hospital discharge care. This is particularly important when SP are admitted to hospitals outside the current dedicated care provider network. Current medical policy dictates that written and confirmed aftercare arrangements are in place prior to discharge from hospital.*

14. **Reducing the Mental Health Treatment Gap (mhGAP)**: Review the WHO mhGAP Intervention Guide[86] to identify gaps in suicide prevention activity and promote continuing education, consultation and/or supervision for mental health providers. *This is not currently part of Defence planning; however, each sS has committees and specialists that continually monitor and revise current suicide prevention arrangements.*

15. **Targeted Suicide Prevention Training for Primary and Speciality Care Providers**: Provide targeted suicide-specific continuing education, consultation and/or supervision to primary care and mental health providers. The training must emphasise evidence based assessment, management and treatment approaches for suicide prevention. *Defence is compliant with this recommendation. Suicide assessment and risk management is fundamental to mental healthcare specialist training, and strong relationships between primary and specialist care ensure that risk is comprehensively managed.*

16. **Limiting Access to Lethal Means**: Consider options for limiting access to lethal means for suicidal service members and develop Standard Operating Procedures (SOPs) for removing such access (during periods of elevated risk), without promoting stigmatisation. Pay close attention to the decision-making processes, not only for the removal of access but also for the subsequent permission for re-access. *Defence has enforced tighter and more substantial*

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[85] SRTC (START taking Control), RM Op REGAIN, Army Op SMART, RAF SPEAR.
[86] http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/.

controls over access to personal weapon systems especially in the training environment. There is robust direction for medical and welfare staffs to inform the CoC and relevant authorities when SP are unfit for weapon handling.

17. **Management of Suicide-Related Events:** Review policies and procedures related to the management of suicide-related events during deployment and while in-garrison. For instance, when deployed, policies for medically evacuating a suicidal service member, implementing procedures and training for the use of practices such as peer systems to manage suicide risk and/or devising guidance for how to best carry out a memorial service for a service member who dies by suicide during deployment. *The military provides forward deployed medical and welfare personnel, military chaplains and TRiM practitioners.*

18. **Responsible Media Reporting on Military Suicide**. Review recommendations for guiding national press reports of military suicide. *Formal Defence press liaison is in place to provide guidance to media; however, it has to be accepted that the press and wider media are free to publish or represent the military as they see fit.*

19. **Research on Military Suicide Prevention**: Support research programmes on military suicide prevention. Disseminate and share the knowledge gained nationally and internationally. Support research studies, both quantitative and qualitative, on suicidal behaviours among military service members. Support research studies that explore evidence-based treatment for suicide and provide resources for the dissemination of these interventions by well-trained providers to service members. *The UK military has a strong tradition of research into military mental health through commissioning original research programmes and through the provision of the Academic Department of Military Mental Health. In addition, continuous monitoring of suicides, and identified lessons, is conducted by Defence Statistics.*

20. **Military Culture of Caring for the Fallen Service Member**: Advocate for a military culture that values caring for those who are experiencing mental health, substance use disorders and/or suicidal thoughts or behaviours. *This is implicit in the current UK provision for supporting military mental health.*

21. The NATO approach to suicide prevention is not static and a new task group, RTG HFM-277 (Leadership Tools for Suicide Prevention), has been formed to continue the work of the suicide prevention group and has UK representation.

Annex H to
DSA/DMSR_04
Dated 14 Aug 18

THE CANADIAN AF SUICIDE PREVENTION STRATEGY

Overview

1. The Canadian Forces (CF) approach to suicide prevention is held to be an exemplar of good practice. In 2010, CF convened an expert panel whose task was to review current procedures and to generate a suicide prevention strategy. [87] The panel concluded that, with the exception of healthcare assurance, the CF suicide prevention programme compared favourably to those of its closest allies. The panel stated that, in practice, most suicides are not preventable. Quality assurance audits in mental health settings suggested that even for those already in care, only about a quarter of suicides were judged to be preventable. The panel emphasised the need to have reasonable expectations of the CF's suicide prevention programme. In 2017, the panel provided an update related to the implementation of the 2010 strategy.

2. Given that the CF guidelines are lengthy and complex, the Suicide Review Team studied and provided a precis of the main elements of the CF programme and compared the recommendations with Defence practices. In the summary provided below, some elements have been omitted, where they were CF-specific or of low relevance to UK Defence. Both the 2010 recommendations and the 2017 strategy implementation updates are incorporated. Comparative UK comments are provided in *italics.*

Education and suicide awareness programmes

3. **2010 expert panel statement:** The CF panel concluded that there is no evidence of benefit for education and awareness interventions when delivered in isolation. Multi-faceted, community-based prevention programmes with the strongest evidence of efficacy have included an element of mass education. To correct inconsistencies, the Mental Health Education Advisory Committee (MHEAC) which uses the Joint Speakers Bureau (JSB) was established. The two bodies were to be used to integrate suicide prevention training into the mental health education main effort.

2017 update:

a. Existing mechanisms for developing, implementing, and evaluating mental health training using MHEAC and the JSB should continue to be leveraged.

b. Routine suicide awareness and prevention training should be incorporated into the rest of the regular, coordinated mental health training across both the career and the deployment cycle.

c. The US Army's "ACE" programme [88] targets key competencies for suicide prevention and should be strongly considered as part of the main suicide-related education effort.

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[87] http://www.forces.gc.ca/en/about-reports-pubs-health-suicide-prevention/expert-panel-prevention-strategies.page
[88] Ask about suicidal thoughts, Care for those who express them, escort suicidal patients to care

d. Training should incorporate curriculum development and adult education; specifically, it should incorporate opportunities to practice suicide-specific skills, such as asking a friend about suicidal thoughts.

e. For mass education, shorter programmes are favoured over longer until there is evidence that longer programmes lead to superior outcomes.

f. Quotas for personnel to receive suicide prevention training by a certain date were not mandated.

4. *UK Defence is compliant with this recommendation, although specific suicide awareness and intervention training is offered on an ad-hoc, rather than mandated basis, and is supplemented by training delivered at key career transition points and deployment transitions. Mass education programmes are delivered in line with the Defence People Health and Wellbeing Strategy and are of the brief, awareness promotion, type recommended in the CF guidelines. Defence does not currently have a speaker bureau and there are no plans to develop one; the Joint Stress and Resilience Centre co-ordinates this activity.*

Gatekeeper Education

5. The relationship between good leadership, work stress, and mental health problems should be incorporated into wellness education programmes, as should the leader's role in overcoming barriers to mental healthcare. General leadership skills are likely to be more important for suicide prevention, than specific suicide prevention skills. However, there is enough evidence for potential benefit from suicide prevention training that it should be incorporated into leader training. Educational programmes for leaders should specifically address ways of managing disciplinary processes, in ways that mitigate suicide risk. The need for specific suicide prevention training for certain occupational groups (such as Military Police personnel) should be considered.

6. *UK Defence does not offer specific gatekeeper training as its effectiveness is far from clear; rather, it relies on effective leadership at all levels. Given the lack of clear evidence of effectiveness for gatekeeper activity, Defence should continue to monitor developments in this area. The TRiM programme, though not specifically designed for suicide prevention and having a relatively weak evidence base, nonetheless helps to mobilise peer support at times of crisis and trauma.*

Education of Clinicians

7. Health educators should consider offering training in depression and suicide as part of regular educational activities and consider incorporating this into the clinician's Personal Learning Plan. The ability to establish trust and rapport with a suicidal patient is fundamental to the assessment of suicidality. As such, evaluating and, if needed, enhancing these skills should be a focus of suicide prevention education for clinicians.

8. *Medical and nursing practitioners, interviewed during the suicide review, were clear that this form of training is regularly undertaken within military medicine and within military mental health, where there is a close working relationship between primary and mental healthcare. This recommendation probably relates to the unique circumstances in the CF and is provided for, in the UK context. Specific recommendations have been made in the suicide review to improve the working relationship between military mental health clinicians and welfare workers.*

Screening and assessment

9. **2010 expert panel statement:** The CFs already screen for suicidal thoughts during regular Periodic Health Assessments and pre- and post-deployment screening. Additional

screening for suicidal thoughts was not recommended. Additional screening for depression in primary care was, however, recommended.

2017 update:

a. Additional mass screening for suicidal ideation was again not recommended; existing screening for depression (which utilises the self-harm question in the nine-item Patient Health Questionnaire[89] (PHQ-9) during the Periodic Health Assessment and pre- and post-deployment screening should continue.

b. Increasing the frequency of depression screening should be considered, but only if it forms part of a systematic approach to primary care management of depression.

c. The emerging literature on the benefits of more frequent PTSD screening in primary care should be monitored and such screening be implemented only when there is sufficient evidence of benefit.

10. *The UK Armed Forces do not currently conduct mental health screening as it has been shown to be largely ineffective in a UK military context. There are currently no plans to develop programmes of this kind. This point is addressed in the main body of the review.*

Assessment of Suicidality

11. The American Psychiatric Association (APA) guidelines on assessment of suicidality should be widely disseminated and implemented. Assessment of suicidality should occur at the first encounter for evaluation of patients with symptoms of mental health problems in both mental health and primary care settings. Suicidality should be reassessed during care for patients who have deteriorated, have developed new symptoms or co-morbidities, have failed to improve as expected, or are experiencing a crisis or significant new stressors. Assessment of suicidality at each mental health encounter is not required and may be counterproductive. However, this last finding may not apply to computerised mental health outcomes management systems. There is limited value in evaluating risk factors for predicting suicide on a case-by-case basis; instead, suicide risk assessment should be predicated on the precise content of an individual's suicidal ideation and plan. Given its central role in suicide prevention, the assessment of suicidality should be a target for quality assurance audits.

12. *The systematic review provided by the Suicide Review Team suggested that carrying out and documenting suicide risk assessment in healthcare is a potential area of vulnerability in the suicide prevention effort. UK military mental health is compliant with NICE guidelines for self-harm management[90] and uses electronic health record (DMICP) templates to ensure that risk is properly documented following formal assessment. Practitioners cannot close the clinical record until risk has been documented. Audit suggests that this does not necessarily guarantee full compliance with risk recording, and this is an area that is regularly reviewed by SO1 Mental Health.*

Treatment of Suicidality

13. A distinct group should develop best practice for outpatient management of individuals at high risk for suicidal behaviour (such as those discharged from an inpatient facility following a serious suicide attempt). CF should specifically address the issue of when a unit "buddy watch" is indicated, as well as how precisely the watch is to be carried out. Because resources are likely to vary from region to region, a mixture of both national and regional solutions will be

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[89] The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
[90] https://pathways.nice.org.uk/pathways/self-harm

required. A unit "buddy watch" should be reserved for short-term use in truly exceptional circumstances, such as a serious suicide attempt in an austere location.

14. *Suicide risk, following discharge from hospital following mental healthcare, is addressed in the UK military, where hospital care is provided by a dedicated NHS network provider that is required to discharge military personnel only when an aftercare package has been formulated, documented and communicated to the receiving Department of Community Mental Health (DCMH)/primary care facility. 'Buddy watch' is not routinely used in the UK military and is considered to be problematic. Such supervision is co-ordinated on a case-by-case basis and in a needs-led way by the Unit Health Committee or equivalent. When peer support is used, this is incorporated into the written Care Action Plan (CAP) as part of the Suicide and Vulnerability Risk Management (SVRM) process or tri-Service equivalent. Peer support is often used to provide safety prior to aeromedical evacuation in deployed settings.*

Pharmacotherapy (Pharmaceutical drug therapy)

15. **2010 expert panel statement:** The balance of evidence suggests that antidepressants lower suicidal risk. Conventional guidelines should be followed for drug treatment of individuals with mental disorders and for suicidal patients in particular.

2017 update:

a. Conventional, evidence-based guidelines for the drug treatment of mental disorders should be followed.

b. APA guidelines should be followed with respect to drug therapy for suicidal patients. These guidelines provide instruction on how to mitigate the increased risk of suicidal behaviour that can occur in the first weeks to months after the initiation of antidepressants.

16. *This is a well-known risk factor and forms part of the care plan in the DCMH. Both DCMH and military Primary Care practices are NICE guidance compliant in this regard.*

Psychotherapy (psychological or talking therapy)

17. **2010 expert panel statement:** Access to psychotherapy is important because optimal treatment, for the common mental disorders that drive suicidal behaviour, should include some evidence-based psychotherapy. Conventional guidelines for psychotherapy of individuals with mental disorders and focused suicidality psychotherapy should be applied.

2017 update:

a. Suicidality should be identified and addressed as a separate problem in mental health patients. Patients with suicidal ideation, intent, or behaviour should receive evidence-based psychotherapy specifically targeting the suicidality and the interpersonal problems that are driving it.

b. Cognitive-behavioural approaches targeting impulsiveness, problems regulating emotions and hopelessness or pessimism may be particularly useful in psychotherapy for suicidality because of their strong evidence base.

c. The decision to augment (or replace) suicidality-specific cognitive-behavioural approaches with interpersonal therapy, purely cognitive therapy, problem-solving therapy and insight-oriented approaches should be made by the treating clinician, in consideration of the totality of the clinical circumstances.

d. Where clinically appropriate, using manualised approaches of proven benefit should be strongly considered (given that these have the strongest evidence behind them).

18. *Cognitive behavioural therapy (CBT) and other evidence-based care approaches are catered for in all DCMH; in addition, higher level stepped care and specialist CBT are delivered by nurse practitioners and consultant psychologists.*

Follow-up Care for Suicide Attempters/High-risk Patients

19. **2010 expert panel statement:** Robust follow-up of high-risk patients decreases the risk of suicidal behaviours and promotes other favourable outcomes, particularly for depressed patients in primary care settings. The US Army's RESPECT-Mil[91] programme should be considered as it based on evidence of effectiveness. High-risk patients are sometimes managed in their units, watched over by their co-workers. The Panel found this practice to be well-intentioned but problematic, noting the enormous breach of patient confidentiality that it requires. Best practices for outpatient management of high-risk patients should be developed using unit "buddy watch" only as a last resort. The existing Case Management Programme[92] is recommended as a mechanism to improve follow-up for higher-risk mental health patients.

2017 update:

a. A single, system-wide process for assuring follow-up for patients receiving care for mental disorders in both primary care and speciality mental healthcare settings should be developed and implemented.

20. *The SVRM process and tri-Service equivalents are wholly compliant with this recommendation. The care action plan is analogous to the key component of the Case Management Programme and takes the form of a written care plan for at-risk personnel overseen by Unit Health Committees.*

Restriction of Access to Lethal Means ("Means Reduction")

21. **2010 expert panel statement:** Restriction of access to lethal means can decrease the risk of suicide. However, the means of suicide is often procured externally. Suicide surveillance systems should better capture information on the means of suicide, impact of packaging and dispensing of medications commonly used in suicide (e.g., over-the-counter pain relievers).

2017 update:

a. Suicide surveillance data should capture the source of any firearm involved in suicide (service vs. personal), as well as enough information to determine whether policies and procedures for firearm access were followed. This surveillance data should inform any required changes in firearm control policies.

b. Suicide surveillance data should capture the agent used in drug suicides, as well as the source of the agent if known. Existing dispensing/packaging practices for high-risk drugs should be continually reviewed.

c. Restriction of access to lethal means, at the individual level, should be part of the plan for the management of suicidal patients in the outpatient setting.

22. *Access to weapons is provided for in the occupational medical grading system (PULHHEEMS) administrative pamphlet. Formal, ongoing suicide surveillance is undertaken for all SP identified as being suicide-vulnerable; Unit Health Committees act to place restrictions on*

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[91] The Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT-Mil) Programme is a system of care designed to screen, assess, and treat posttraumatic stress disorder (PTSD) and depression among active duty service members in US Army's primary care settings

[92] The Case Management Programme is a nurse-led, collaborative, client centred process for providing services associated with the coordination of health care, health care related activities and welfare benefits for ill and injured CF members

personnel deemed to be suicide vulnerable until such time as the individual receives a formal medical assessment.

Media Engagement

23. **2010 expert panel statement:** There is some evidence that media reporting of suicides can serve as a suicide trigger for suicide-prone individuals. Suicides are newsworthy, particularly when there is a perceived connection to a deployment. Media engagement should follow conventional guidelines on the reporting of suicide in the media (i.e. US Centre for Disease Control guidelines).

2017 update:

a. Opportunities to proactively engage with the local, regional, and national media in order to educate them on suicide and mental health should be explored with the goal of encouraging responsible reporting of military suicides and enhancing confidence in military mental healthcare.

24. *UK Defence has dedicated press response arrangements. It seeks to influence media reporting whenever possible, but cannot always guarantee input to the reporting process.*

Organisational Interventions Intended to Mitigate Work Stress and Strain

24. **2010 expert panel statement:** Work stress is a risk factor for mental health problems and it is a common contributor to suicidal behaviour; attempts at mitigation include specific workplace interventions and effective leadership. Failed intimate relationships are a common trigger for suicidal behaviour. Given that supervisors and others in the unit are likely to know about failed relationships, this might be a potential point of intervention for suicide prevention.

25. Disciplinary action and/or legal problems are another common factor in military suicides. Leader education should include guidance on managing the disciplinary process in ways that mitigate suicide risk. The US Air Force's "hands-off" policy for members under investigation should be evaluated. This policy requires that members be "handed off" to their leadership immediately after any serious investigative disciplinary interview. Leaders then assess how the member is coping, and refer for evaluation or healthcare as needed.

2017 update:

a. Policies and programmes designed to mitigate stress and strain in the workplace should be developed and evaluated, with the expectation that these may advance a suicide prevention agenda, while at the same time offering many other military advantages.

b. Disciplinary and investigative policies and procedures should be reviewed with an eye towards identifying any additional opportunities for changes that will mitigate stress and lower suicidal risk (such as the hands-off policy). In order to be effective, such a policy would need to be supported by training and development of tools and resources for all.

26. Being investigated for a potential criminal offence, particularly a sexual offence, is listed as a risk factor for suicide in the UK. The guidelines recommend early engagement with the chain of command when SP are initially investigated for serious offences or allegations. The Suicide Review Team confirmed that military police personnel are aware of this specific risk.

Selection, Resilience Training, and Risk Factor Modification

27. **2010 expert panel statement:** Suicide screening for those with minor psychopathology or those who have risk factors is appealing on principle, but unreliable in practice. Resilience interventions must be evaluated for effectiveness. Evidence-based primary risk factor reduction is already offered through a health promotion programme which targets risk factors such as alcohol use disorders, relationship conflict, psychological stress and anger.

2017 update:

a. Continue to evaluate the resilience aspects of mental health training programmes.

b. Continue to monitor the scientific literature in the area of resilience training, modifying programming to reflect best practices.

c. Risk factor modification efforts should continue; such as Strengthening the Canadian Forces programmes on anger management, stress management and promoting healthy relationships.

28. *The Defence People Health and Wellbeing Strategy is wholly compliant with this specific recommendation, and has several resilience-based programmes in place. The only potential area of weakness is the relative lack of outcome data, to allow full assessment of programme effectiveness.*

Systematic Efforts to Overcome Barriers to Mental Healthcare

29. **2010 expert panel statement:** Nearly all suicidal individuals have mental health problems, but more than half are not in care at the time they commit suicide. Barriers to mental health care reduction efforts include:

a. Strengthening confidentiality and career protection for help-seekers.

b. Operational Stress Injury Social Support (OSISS), a national peer support network for serving members, veterans and their families.

c. Expanding the number of mental health professionals.

d. Offering up to 10 sessions of counselling to serving members and their families through civilian providers.

e. Reinforcing screening for mental health problems during the regular Periodic Health Assessment and routine pre- and post-deployment screening.

30. In Canada, a robust surveillance system for monitoring barriers to mental healthcare in garrison is in place using the periodic Health and Lifestyle Information Survey. In-theatre mental health needs assessment was recommended and subsequently carried out to identify the needs and barriers to care in deployed settings.

2017 update:

a. Efforts to identify barriers to mental healthcare (both in garrison and on deployment) should continue and any needed changes made to address these.

b. Confidentiality, with respect to suicidal thoughts and behaviour, offers both advantages and disadvantages. Military mental health specialists believe that the effects of the military policy of strong confidentiality protection surrounding suicidality are, on balance, far more positive than negative. Nevertheless, military clinicians should engage in meaningful dialogue about medical employment limitations with the operational chain of

command. In addition, clinicians should encourage members to disclose details about their mental health problems when doing so can contribute to their recovery.

c. The military should continue to drive down waiting times for mental health services to as low as is feasible.

31. *Academic Department of Military Mental Health (ADMMH) and King's Centre for Military Health Research (KCMHR) have provided extensive data on deployment mental health, health and wellbeing in the non-deployed setting; both have an extensive programme of work evaluating stigma and stigma-reduction interventions. DS continually monitors military mental healthcare and provides feedback in the form of a dashboard. Mental healthcare usage data is published in the public domain. Several academic studies have evaluated both deployed and non-deployed mental healthcare outcomes and all contain an assessment of barriers to care. Defence offers a number of interventions which seek to reduce barriers to care such as the Army's 'Don't bottle it up' campaign. Defence publications address the need for effective communication between healthcare and the Chain of Command; these are described in the main report.*

Systematic Clinical Quality Improvement Efforts

32. **2010 expert panel statement:** Conventional suicide prevention models focus on finding ways to identify suicidal individuals and get them into care (arguably the key ingredient of an effective programme), with the assumption being that, once there, they will receive optimal treatment. Hard data on the quality of care in Canadian Forces is lacking; the most pivotal recommendation was that steps be taken to reinforce infrastructure for quality improvement in mental healthcare.

33. Current Canadian Forces policy requires a Board of Inquiry (BOI) for every member suicide: however, the BOI process is a weak and inefficient tool for clinical quality assurance. For this reason, it recommended that a rapid, standardised health care quality assurance investigation occur after each suicide.

2017 update:

a. Capabilities in clinical quality improvement in mental healthcare must be reinforced. The improvement process must capture enough data on the processes and outcomes of care to permit identification of potential problem areas and to evaluate the effect of any countermeasures.

b. After each suicide, a clinical suicide investigation should take place as soon as possible.

c. The information required for suicide surveillance activities should be reviewed, making sure that there is a reliable mechanism for capturing the information that is most likely to be helpful for quality assurance. More detail is required on means, triggers, mental healthcare and communication/collaboration with the chain of command.

d. The US Department of Defence Suicide Event Report may serve as a useful template for suicide surveillance data.

e. The clinical suicide investigation should be used to capture the data needed for suicide surveillance; investigators should be trained in the use of the suicide event report.

f. For the present, the focus should be on completed suicides as this fine-tunes the suicide surveillance system. However, in the future, finding ways of capturing similar information on serious suicide attempts should be incorporated.

g. Suicide risk factors (including barriers to mental healthcare) should continue to be monitored using the periodic Health and Lifestyle Information Survey.

h. Suicide rates in currently serving and former members should be included in the planned cancer and mortality linkage study.

i. A set of performance measures (and ways to capture these) should be developed for the suicide prevention programme. The completed suicide rate will have limited value as a performance measure because the numbers are expected to be so low that detecting important changes will be difficult. Thus, other performance measures will be needed (such as the fraction of those with mental health problems who are in care, the prevalence of suicidal ideation, and the fraction of mental health patients with a complete suicidality assessment documented in their medical record).

34. *The suicide review team established that there may be potential for improvement in this area; details are provided in the main report. At present, there are no performance outcome measures for suicide prevention in UK Defence.*

Annex I to
DSA/DMSR_04
Dated 14 Aug 18

THE NATIONAL SUICIDE PREVENTION STRATEGY FOR ENGLAND

1. Progress towards implementing the UK national strategy for suicide prevention was detailed in a third report[93] published in 2017, following initial roll-out of the strategy in 2012. This is a lengthy and detailed document, but represents a standard against which Defence efforts in suicide could be benchmarked. Commentary about the relevance of the national recommendations to Defence and current Defence suicide prevention activity is provided by the Suicide Review Team in *italics.*

The key deliverables generated by the national strategy are:

2. **Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan with agreed priorities and actions that is updated annually.** This is to be achieved by improving implementation through strong leadership, clear accountability and improved transparency and scrutiny. *Defence does have a clear mental health and wellbeing strategy, but there is no unified UK military suicide prevention plan, although provisions made in single Service guidance and policy documents are largely in keeping with this recommendation. During the Suicide Review, opinion was divided amongst interviewees as to the need for a specific suicide prevention plan. However, there may be some benefit in harmonising policy, procedures and guidance across the three Services, wherever possible, and consolidating all current policy and guidance in one place.*

3. **Enhanced targeting of suicide prevention to high risk groups**. The national strategy is specific about the need to target high risk groups. *Many such groups are not relevant to Defence. Although a myriad of suicide risk factors has been identified in military groups, most are non-specific or non-modifiable, such as age, sex and role. The latter includes suicidal thoughts, psychological processes and factors such as adverse childhood experiences. The literature review and academic paper that accompany this document suggest that the key risk factor for suicide in military personnel is mental ill-health. Some mental disorders, such as bipolar disorder and depressive illness, carry greater risk than others. There is limited evidence to suggest that preventative measures are effective in averting suicide or reducing risk. The principle intervention is therefore to ensure that <u>all</u> military personnel can gain easy access to good quality, evidence-based mental healthcare and/or support when required.*

4. **Improving data at national and local level, using it to help take action and target efforts more accurately.** The national review makes broad recommendations about improving data collection across the NHS and addressing shortcomings in the investigation of completed suicide. *In the UK AF, suicide data is currently held in a number of places. Clinical data is dealt with in a different way to that from cases where the deceased was not in contact with primary care or mental health services. Across the three Services, <u>all</u> suicide data could be merged, anonymised using a reversible key and held in a central repository. This includes output from Service Inquiries (SIs), learning Accounts (LAs) and the Automated Significant Event Recording (ASER) system. Using a standardised psychological autopsy approach in all cases of suicide, irrespective of whether there has been clinical contact, would also help in this regard. Amalgamating data would help to maximise numbers, increase the availability and utility of data, and allow for a better understanding of the*

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[93] https://www.gov.uk/government/publications/suicide-prevention-third-annual-report .

precursors and precipitants of completed suicides. This approach would additionally allow analysts to develop a consistent strategy with standardised outputs. The national review recommends presenting data under three domains: suicide data, related risk factors and related service contacts. Subject to the views of Defence Statistics (DS), military suicide data could be organised in this way to enable benchmarking against non-military populations.

5. **Improving responses to bereavement by suicide and providing support services.** *The academic work that accompanies this review suggests that suicide and self-harm risk is heightened in military units that experience a suicide event. Furthermore, there is substantial research evidence to suggest that those bereaved by suicide, be it family, friend or partner, are at heightened risk of suicide themselves. It would therefore be helpful to institute a 'watchful waiting' approach in units where suicide occurs; unit members who experience bereavement by suicide may benefit from a compassionate inquiry into their welfare and, potentially, a targeted offer of more formal bereavement services. Defence already has well developed welfare structures, support networks, guidelines and policies[94] which aim to support the families of Service Personnel who die by suicide; this is a key part of the National Strategy.*

6. **Expanding the scope of the National Strategy to include self-harm prevention.** *In the UK Armed Forces (AF), for serving personnel, there are currently two contemporary sources of relevant information. Reports generated from medical and administrative record data are compiled by DS, and original research is conducted by King's Centre for Military Health Research and Academic Department of Military Mental Health (KCMHR/ADMMH). The DS study found a self-harm rate of 2.8 per 1000 in 2016/17.[95] The second piece of research estimated a lifetime self-harm prevalence rate of 4.2% in serving personnel in 2014-16. Although both studies have strengths and weaknesses, they could be used to inform strategy. A summary of the KCMHR/ADMMH study is provided within this review. Although comprehensive policy, and guidance for assisting SPs who attempt suicide or self-harm, is available, specific self-help and programmes and resources for those who self-harm while serving in the military are currently lacking.*

7. *Self-harm is noted in the national review as being amongst the most significant predictors of suicide; this is consistent with findings from military research. The national review recommends that every known self-harm case must have a psychological assessment. It further recommends that a care pathway for those who self-harm be developed, and educational materials of a written or audio-visual nature be made available to those that self-harm. Work is underway in the NHS to develop clinical hubs where physical health, mental health and social care services are connected through a shared resource to navigate people to the right services, so that A&E is not the default choice for patients, particularly out-of-hours. New initiatives, such as the Royal Foundation health and wellbeing support programme and Samaritans assistance resource, are being developed. It may be helpful for a clinical working group to develop a clear care pathway that encompasses out-of-hours arrangements; the unified care pathway document that accompanies this report goes some way to achieving this. Regularly updated guidance for self-harm is provided by the National Institute for Health and Care Excellence.[96] All current material could be reviewed by the proposed Suicide Prevention Working Group (SPWG) and, where appropriate, incorporated into unified care pathway standard operating procedures and broader management guidance.*

8. **Mental health crisis resolution home treatment teams in the community to be made more widely available and improved in quality.** *For Defence, Service Personnel*

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[94] JSP 751 Joint Casualty and Compassionate Policy and Procedures.
[95] https://www.gov.uk/government/collections/deliberate-self-harm-in-the-uk-armed-forces-index
[96] https://www.nice.org.uk/guidance/qs34/resources

have rapid access to mental healthcare; all military mental health departments have a duty clinician available during office hours from Monday to Friday, access to in-patient care within four hours, and routine appointments offered within 15 working days of referral. For crisis cases, a Defence Mental Health (DMH) on-call practitioner co-ordinates out-of-hours care by interacting with the MoD/Combat Stress 24-hour helpline, along with providing support and facilitating emergency care for SP, if required. All Service Personnel are entitled to NHS crisis services out-of-hours. In-patients discharged from the military Independent SP hospital network have access to a review within seven days as required by the national strategy. All primary care providers and key commanders should have a detailed understanding of crisis services available to Service Personnel, whether accessed through the MoD/Combat Stress 24-hour helpline, dialling 111 or directly, and this information should be widely available to Service Personnel. Among several suicide review interviewees, there was a lack of awareness of resources available to those that self-harm particularly out-of-hours and on operations.

9. **Liaison and diversion services to manage the interface with the criminal justice system**. *Research evidence suggests that military personnel charged with serious offences, particularly sexual offences, are at heightened suicide risk. To manage this, the Canadian AF expert panel on suicide*[97] *suggests that the US military system of immediate 'hands-off' to the unit chain of command be undertaken when a serious charge is brought against an individual, so that a needs assessment can be undertaken and an appropriate care package put in place. The UK national review recommends a formal risk assessment for those in custody who are accused of serious offences. The review notes that heightened support for the latter is recommended in the sS suicide risk policies. Defence is largely compliant with this aspect of the national strategy. Future work may consider whether the US 'hands-off' approach could be further developed and incorporated into care planning for UK SPs charged with serious offences.*

10. **Online support.** *The national strategy review document highlights potential sources of support and other resources for those who self-injure; these can be accessed via hyperlinks contained in the final section of the National Strategy document. There may be some merit in the proposed SPWG reviewing this material to assess whether it might be useful within Defence and whether it could be incorporated into the various programmes which are currently being developed such as the Royal Foundation and Samaritans initiatives.*

11. **Consensus statement for sharing information**. The national review provides some guidance on information sharing. With prior discussion and respecting the wishes of the patient, health professionals are encouraged to obtain information from and listen to the concerns of family members and friends. If possible, this should include what should happen if there is serious concern over suicide risk. Professional judgement is required to determine what is in the person's best interest in cases where the patient is judged to lack capacity to provide consent. The statement fits with good clinical care and general support. *In the military context, this is covered by current guidelines and policies. However, most clinicians interviewed in the current review remain uncertain about the level of detail that can be disclosed at the clinical/welfare/Chain of Command interface, within the unit health committee or sS equivalent. The latter represents a potential point of vulnerability. The Army guidance note dealing with disclosure is valuable, and is commended for use. The review team established that communication between NHS services that treat SPs when they self-harm or attempt suicide 'out-of-hours', the parent unit and military healthcare practitioners can be problematic. Service Personnel who seek help from private healthcare sources may be particularly vulnerable in this regard. A solution to close this gap is not*

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[97] http://www.forces.gc.ca/en/about-reports-pubs-health-suicide-prevention/expert-panel-toc.page

readily apparent and should be further considered.

12. **The expansion of the Improving Access to Psychological Therapies (IAPT) programme**. *This recommendation is potentially less relevant to the UK AF as the recently implemented unified care pathway SOP has, at its core, a stepped care approach which incorporates the key principles of IAPT. However, senior health advisors from the three Services expressed some concern that the delivery of level 1 interventions in primary care, which is recommended in the unified care pathway SOP, can be accommodated by Defence's current capacity and capability.*

13. **Addressing in-patient suicides**. *Inpatient mental healthcare is currently provided by a contracted NHS network. In order to promote a seamless link between community and hospital care, the DMH services provide a Service Liaison Officer who manages the interface for those admitted to hospital for mental healthcare. The NHS providers are subject to regular assurance processes and were selected by the MoD, as they met or exceeded pre-determined quality standards. This recommendation has been delivered, as the NHS provider is required to comply with the national guidelines for suicide prevention.*

14. **Addressing the needs of potentially at-risk occupational groups**. *Much of the national review document describes interventions for at-risk groups. Defence is not listed as being at heightened risk. However, it is clear that Defence is structured in a different way to many of the listed at-risk groups, and undertakes the unique activity of military deployment. It is, therefore, considered important to continue to monitor the mental health and wellbeing of SP in order to identify potential opportunities to intervene when suicide risk is judged to be elevated in certain sub-groups. The national review specifically recommends that heightened attention be given to black and ethnic minority, and to lesbian, gay, bisexual and transgender, groups.*

15. **Drugs and alcohol**. The review makes specific mention of drug and alcohol misuse and suggests this is particularly important when associated with mental disorders. *The lifetime self-harm research paper produced by ADMMH/KCMHR within this review suggests that alcohol does not function as a primary risk factor for suicide attempts and self-harm in a military context. Nonetheless, Defence is developing a Defence Alcohol Treatment Pathway; the work is being carried out in line with efforts of a similar NHS scheme and other mental health treatment pathways, to reduce alcohol use. The association of alcohol and suicidality should continue to be monitored.*

16. **Perinatal mental health**. Suicide is now one of the leading causes of death in pregnant women and new mothers. The bulk of the recommendations contained in the National Strategy relate to healthcare services for pregnant women and mothers with new babies. *The implications for Defence is that it is necessary to monitor the mental health of military mothers immediately before ceasing, and after returning to, work so that they can be offered mental health support or treatment when, and if, required. The Defence Mental Health Services do not currently comply with the NICE guidelines in relation to maternal mental health. At the time of this military review, a military pilot project co-ordinated by Department of Community Mental Health (DCMH) and Primary Care staffs is being launched in the Portsmouth area to assess ways of overcoming this deficit.*

17. **Reducing access to means**. The national review details strategies to close-off vulnerable points in the transport network and to restrict access to large amounts of over-the-counter medication. The recommendations relating to this area are summarised in Public Health England's preventing suicide in public places resource[98] which details a range of

[98] https://www.gov.uk/government/publications/suicide-prevention-suicides-in-public-places

effective steps that might help to prevent public places being used for suicide and potentially increase the chances of last-minute intervention. *In a military context, the main implication relates to the need for clear communication of restrictions placed on the access to an issued weapon or on the performance of a safety critical task, which might be affected by cognitive impairment arising from mental disorder symptoms or suicidality. This is covered in current Defence guidelines and policy.*

18. **Learning and investigations within NHS settings.** The Care Quality Commission (CQC) has published a report[99] detailing several actions to be taken to improve the understanding of and learning arising from suicide deaths:

a. Review the CQC report within local services, and publish a full response.

b. Develop a new single framework defining good practice in relation to identifying, reporting, investigating and learning from deaths in care and provide guidance to determine when an independent investigation may be appropriate.

c. Define what families and carers can expect from healthcare providers when they are involved in the investigation process.

d. Provide solutions to improve consistency, definitions and practices that support suicide prevention among people with mental health conditions.

e. Develop reliable and timely informatics, so that information is available to all providers recently involved in a patient's care. Provide guidance on a standard set of information to be collected by providers on all patients who have died.

f. Develop approaches to ensuring that staff have the capability and capacity to carry out comprehensive investigation of deaths and write good reports, with a focus on those leading to improvements in care.

g. Organisations to work together to review and improve their local approach following the death of people receiving care. Ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated when appropriate, and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers.

19. *Tri-Service guidance and policy details the process of post-incident investigation and learning following a suicide death. This is dealt with in detail elsewhere in this review document. The military suicide review process suggested that military mental healthcare workers, who provide critical input to suicide reviews, were uncertain about the focus of their investigations and the level of detail required in subsequent reports. SO1 Defence mental healthcare Services is currently developing clear guidance which will be published soon. Learning account and SI data are not currently combined with ASER outputs; furthermore, the review team established that the method of confirming that lessons had been learned and recommendations implemented following suicide was currently unclear. Formal audit at a pre-specified point to ensure that implementation has occurred is therefore lacking. Consolidating SI, LA and ASER outputs and putting in place a robust assurance procedure are arguably the two most helpful actions that could be taken, to ensure compliance with this aspect of national guidelines; this should be a Defence Safety Authority (DSA) responsibility.*

20. **Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour**. *The academic work undertaken alongside this review suggests that media reporting*

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[99] https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

of military suicide is often qualitatively different to civilian suicide reports. Military suicide reports often highlighted perceived care shortcomings and used pejorative language.

21. **The National Suicide Prevention Alliance (NSPA**) is highlighted in the review as the leading England-wide, coalition for suicide prevention organisations across the public, private and voluntary sectors. *There is currently no military representation on this body.*

Annex J to
DSA/DMSR_04
Dated 14 Aug 18

THE NATIONAL SUICIDE PREVENTION STRATEGY FOR SCOTLAND[100]

1. Although it lacks some of the detail of the English report, the Scottish Government has produced its own strategy[101] which has the following key features that map across to the strategy for England:

a. Guidance for responding to people in distress, which is about how caring services interact with people who self-harm or are vulnerable to suicide.

b. Talking about suicide, which is largely about initiating conversations at individual through to national levels and protecting vulnerable people from the potentially negative effects of social media.

c. Improving the NHS response to suicide, such that people who are at risk of suicide and self-harm are provided with a safe and optimal care environment.

d. Developing the evidence base to improve suicide prevention efforts.

e. Supporting change and improvement through raising awareness, various population level and community activities, developing and making available to communities various resources and through training and research.

[100] There is no specific plan for Northern Ireland or Wales.
[101] http://www.gov.scot/Topics/Health/Services/Mental-Health/Suicide-Self-Harm

Annex K to
DSA/DMSR_04
Dated 14 Aug 18

DELIBERATE SELF-HARM IN THE UK MILITARY – A NEW STUDY

1. As a component of the review process, the academic member of the Suicide Review Team conducted a novel piece of research assessing self-harm in the UK Armed Forces (AF).

2. The rate of deliberate self-harm (DSH) in the UK AF was compared at three independent measurement points between 2004 and 2016. Additionally, a range of factors, potentially associated with lifetime Suicide Attempts (SA) and DSH, were explored. The rates of DSH and SA were estimated using data derived from three phases of a cohort study,[102] which had 10272, 9990 and 8581 respondents at each of the three measurement points. A telephone interview study assessed SA and DSH among 1448 serving and ex-serving individuals who, in the latest phase of the cohort study (2014-16), endorsed experiencing a mental health, stress or emotional problem during the last three years.

3. Individuals in the telephone interview component were asked about suicidal ideation, acts and DSH. Mental health measures estimated depression, anxiety, PTSD symptoms and alcohol use. Mental health-related stigmatisation and attitudes, perceived barriers to mental healthcare, social support and help-seeking for mental health problems were assessed.

4. In the main cohort study, the rate of lifetime DSH remained relatively constant at the first two measurement points: 2% among serving personnel and 4% in ex-service veterans in 2004-06 and 2% and 5% respectively in 2009-10. In 2014-16, the rate rose to 4% and 7% in the two groups of respondents respectively. The rates among telephone interview study participants were 17% among serving personnel and 19% among ex-serving veterans.

5. In the telephone interview study, factors significantly associated with lifetime SA and DSH were: experiencing current symptoms of mental disorder, holding greater levels of stigmatising beliefs and negative attitudes relating to mental illness, having lower levels of social support, experiencing suicidal thoughts and seeking help from medical and mental health practitioners. Commissioned officers and members of the RAF were significantly less likely to report lifetime suicide attempts, while women were significantly more likely to report lifetime self-harm events. Alcohol misuse had no significant association with either SA or DSH.

6. The implications of this study are discussed in the main report; the full study paper will be submitted for peer-review and will be published in an academic journal.

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[102] The cohort study is a large, representative sample of the UK Armed Forces who provided health, wellbeing and lifestyle information as part of an ongoing programme of research. Research findings derived from the cohort can be used to reliably estimate outcomes in the whole UK Armed Forces.

Annex L to
DSA/DMSR_04
Dated 14 Aug 18

SUICIDE AND SELF-HARM IN MILITARY ORGANISATIONS – A LITERATURE REVIEW

1. A literature review was conducted which focused on Military Deliberate Self-harm and suicide research. The review contained 169 peer-reviewed academic studies that met a pre-determined quality threshold for inclusion. The majority of the academic papers identified in the literature search originated in the United States (US) which, because of considerable procedural and cultural differences between US and UK forces, meant that some of the papers were not deemed directly relevant to the United Kingdom AF (UK AF) context. However, many factors were applicable to suicide prevention[103] in the UK military and elsewhere.

2. The available evidence suggests that predicting the risk of suicide is a complex task. The risk is often difficult to quantify and incorporates many disparate factors that frequently work in combination. In addition, several studies concluded that, given the random nature and low incidence of military suicide, it is often misleading to draw clear conclusions from investigations and make firm practice recommendations based on limited evidence. In an attempt to compensate for small samples, researchers often link death registries, clinical and administrative datasets to increase the numbers of suicides available to analysts. Although this may be an efficient way to use data, this approach is limited by differences in data coding, study methodology, completeness of data and so forth. This needs to be considered when interpreting the findings of the review. Although a moderately high quality threshold was set for including papers, the reviewed studies varied in quality and as, with much research, the majority were subject to varying levels of bias.

3. Key risk factors for completed and attempted suicide were identified, chief among which were emerging or established symptoms of mental disorder, and recent receipt of a psychiatric diagnosis. Given the importance of mental disorder symptoms in suicide, the need to provide timely, evidence-based, quality mental healthcare has been emphasised in a number of studies. The provision of good quality mental healthcare, for personnel identified as being at significant risk of suicide, should incorporate a formal crisis response plan agreed between recipient and provider. The requirement to conduct and document comprehensive risk assessment also featured in a number of studies. Some US studies suggested that it is not necessarily safe to assume that clinicians robustly assess and document suicide risk. Therefore, the clinical component of any suicide prevention strategy should include assurance processes and governance procedures to ensure that risk is properly assessed and recorded, that care packages agreed by multi-disciplinary care teams are adequately described and implemented, and that care plans and outcomes in suicidal personnel are regularly audited.

4. Features of care such as hospitalisation for mental disorder are associated with a markedly heightened risk of suicide, while discharge from hospital represents a critical transition that is potentially hazardous if not well managed. Ensuring that communication about aftercare arrangements is fully understood and implemented by patients and carers, appears to be important in managing this critical period.

5. Specific mental disorders were assessed as risk factors for suicide. Although most had a significant association with completed suicide, bipolar disorder and depressive illness emerged as important associates or predictors. Synthesis of the PTSD and suicidality research included

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[103] Total suicide prevention is an aspiration for the UK military; the use of this term can however be misleading as whilst many interventions claim to prevent suicide, there is a dearth of evidence supporting such assertions.

in the review suggested that PTSD represents a risk factor for suicidality. This is relevant to the military as PTSD can arguably be attributed to deployment and combat exposure in around half of military PTSD patients. PTSD appeared to be most significantly related to suicide when it co-occurred with depressive illness or moral injury[104]. Although mild traumatic brain injury (mTBI) was assessed as a risk factor for suicide, increased suicidality was predominantly explained by the presence of co-occurring mental disorder symptoms, rather than mTBI per se.

6. Despite being widely cited as an important factor in completed suicide, there were few published studies suggesting that alcohol misuse functioned as a primary risk factor. It appeared to facilitate impulsivity, which in the context of life crises, increased the likelihood of acting upon suicidal thoughts. Sleep problems are a substantial feature of many mental disorders; several academic papers suggested that poor sleep in the presence of mental disorder symptoms was associated with increased suicide risk. Enquiring about sleep problems is potentially a less stigmatising way of opening discussions about suicidality rather than asking about it directly.

7. Many research studies examined socio-demographic factors in relation to suicide. Many cited young age, male sex (although women were at increased risk in some studies), low rank, lower educational attainment and exposure to early adverse life events as significant predictors of suicide. However, it was not made clear how these could be incorporated into robust risk assessment, given the high probability of both false positive and false negative predictions of future suicide in a military context where these factors predominate. Many of the factors identified were not modifiable and studies suggest that it might be more helpful to concentrate efforts on potentially modifiable risk factors such as mental disorder symptoms, unhelpful thoughts and distorted perceptions related to suicide. It may also be helpful to conduct research to assess whether individuals with severe childhood adversity histories (a significant risk factor for suicide and self-harm) are suitable for military service.

8. Instances of deliberate self-harm or suicide attempts were strongly linked with completed suicide. However, debarring military personnel from further service on these grounds alone may not be either feasible or desirable. It may be helpful to assess in future studies whether certain forms of self-harm are more or less predictive of further self-injury or even suicide.

9. There was little evidence to suggest that deployment alone was associated with heightened suicide risk, although suicides that occurred during deployment often involved the use of an issued weapon. Sexual assault and bullying were both associated with substantially increased suicide risk irrespective of the context in which they occurred, be it pre-military, during deployment or during service life more generally.

10. In keeping with the findings of broader research in mental health, social support and access to a tangible, supportive social network were both associated with suicide risk. Strong evidence was presented to suggest that both supportive and accessible networks functioned as a buffer against suicidality, the negative effects of traumatic exposure, aversive childhood experiences and negative aspects of deployment. The ability to derive positive experience and personal development out of potentially negative or traumatic experiences (often referred to as post traumatic growth (PTG)) also emerged as a buffer against suicidality whereas in a military context, greater levels of spirituality did not. Further developmental work is required to operationalise PTG to assess whether it can be 'trained'. There was little evidence to suggest that resilience-promoting interventions contributed to reduced suicidality, although this may be related to the small number of resilience studies conducted during the literature review period.

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[104] An injury to an individual's moral conscience resulting from an act of perceived moral transgression which produces profound emotional shame.

11. Stressful life and occupational events and other forms of crises, financial and relationship-related for instance, often precipitated suicide attempts and completed suicide in military personnel and veterans. Exposure to suicide appeared to increase suicide risk amongst bereaved military personnel and veterans, particularly when the deceased was a significant other or friend. Increased suicide risk was also found in military units where a member died by suicide, particularly in combat units.

12. Various psychological factors appeared to be substantially linked with all forms of suicide-related behaviours and completed suicide, in particular guilt, shame and hopelessness. Three additional factors appear to be gaining traction in military suicide research, namely, 'perceived burdensomeness' (perceptions of being a burden to others), 'thwarted belongingness' (defined as an incapacity to obtain or perceive a sense of belonging or being rejected) and 'acquired capability for suicide' (experiencing a reduced desire to live and increased desire to die). These 'hidden' factors could potentially be explored in suicide risk assessments. Additionally, anger, aggression and violence were significantly linked to suicidality; these too could form part of a suicide risk assessment.

13. A number of studies recommended efforts to reduce mental health-related stigmatisation and the introduction of processes to foster help-seeking for mental disorder symptoms. Where these are introduced, it was recommended that they should be subjected to rigorous and robust assessment of impact and outcome. A small number of military suicide prevention interventions were evaluated. One highly structured programme was the US Air Force Suicide Prevention Programme, which is widely cited as a benchmark against which other programmes can be compared. The programme is largely about facilitating mental healthcare and support, responding to crises, bereavement support following suicide, reducing access to means and fostering social support. However, convincing evidence for a positive effect arising from the programme is currently lacking. A second programme, After Deployment Adaptive Parenting Tools (ADAPT) was associated with a reduction in suicidality in military parents. The provision of training in suicidality management for peers and unit support providers was assessed. Although such training was perceived as helpful and potentially useful when dealing with potential suicide cases, no evidence about the impact on recipients of the intervention was provided. When caring for suicidal military personnel in the clinical environment, adapted motivational interviewing, to increase the desire to live and reduce the desire to die, appeared to have a positive effect.

14. The literature review therefore must conclude that the causes of suicide and suicide prevention efforts and interventions are complex and multifaceted. There is no simple solution for suicide prevention or management, and it is likely that a multi-component strategy is required which contains clearly articulated actions for both clinical and non-clinical staffs with a single point of accountability for each action.

15. The full literature review will be submitted to Surgeon General (SG) and will be widely circulated following the completion of the Suicide Review Team's work.

Key learning points:

16. **Risk**

a. Historically, certain risk factors are regularly identified as being associated with completed suicide; the current review findings are in keeping with past research. Many of the risk factors are not modifiable, such as age, sex, rank and so forth. In the current review, mental disorder symptoms emerged as a key risk factor for suicide. In order to manage this effectively, timely and easy access to high quality mental healthcare is arguably the most important factor in any suicide prevention strategy.

b. The review outcomes suggested that risk assessments are not always performed adequately and/or documented by assessing clinicians. Ideally, every case of self-injury and referral for the assessment of suspected mental disorder should result in a documented, comprehensive risk assessment.

c. DSH does not, and arguably should not, result in discharge from service given that continued occupation and access to meaningful support are both suicide prevention factors. However, short and medium-term risk will be carried by the military when individuals self-harm and remain in service, as DSH is a significant risk factor for future self-harm.

d. Hospitalisation for mental disorder treatment represents a period of severely heightened suicide risk; hospital aftercare arrangements must always be properly articulated, preferably in written form, and should be fully understood and implemented by patients, carers and support networks.

e. Alcohol misuse does not appear to be a primary risk factor in military suicide; however, it is an important facilitator of self-harm and suicide attempts. Given that alcohol misuse is highly prevalent in Defence, any suicide prevention plan should continue to emphasise alcohol reduction using evidence-based means.

f. Three psychological factors were identified as substantial risk factors for suicide and self-harm; these could be incorporated into formal risk assessments. The factors were; 'perceived burdensomeness'; 'thwarted belongingness' and 'acquired capability for suicide'. Although these factors are most relevant to clinical assessment, they could potentially be enquired about in any form of risk assessment.

g. Sleep problems (initiating, maintaining and early wakening) were linked to heightened risk of suicide. Enquiring about sleep problems is recommended as a potentially less stigmatising and indirect way of opening enquiries about suicidality.

17. **Interventions**

a. Reducing mental health-related stigmatisation is a feature of many suicide prevention strategies. However, research outcomes suggest that self-stigmatisation, among those with emerging or established mental disorder symptoms, rather than public stigma should be the key focus of stigma reduction activity.

b. Providing at-risk personnel with crisis response plans, preferably in written form, are a key component of suicide prevention activity (stressful life and occupational crises often precipitated suicide attempts and completed suicide in the literature review).

c. Targeted bereavement support following suicide may well be required as proximity to suicide death, particularly in a significant other, increases suicide risk. There was no strong evidence to suggest that blanket bereavement counselling is helpful.

d. Suicide prevention activity that limits access to lethal means for those at heightened risk should continue to be incorporated into policies and plans. For instance, managing access to weapons and stockpiled medication, particularly when acquired through unsafe prescribing practices.

e. The consensus appears to be that peer-delivered and resilience building interventions require further validation in military personnel before they can be recommended for routine mental health support.

18. **Protective factors**

a. Post Traumatic Growth (PTG) is a protective factor which is highly relevant to organisations that expose their workers to potentially traumatising events. It is receiving increased attention in scientific literature; however, further developmental work is required to establish exactly what PTG is, and to assess whether it can be 'trained'.

b. Fostering accessible and meaningful social support networks can help to reduce suicide risk and should continue to be a key focus of command and leadership activity.

Annex M to
DSA/DMSR_04
Dated 14 Aug 18

UNIFIED CARE PATHWAY FOR MENTAL HEALTH STANDARD OPERATING PROCEDURE

1. A review of UK military mental healthcare concluded that provision was sub-optimal. Therefore, the Defence Consultant Adviser in Psychiatry generated a unified care pathway for mental health proposal to attempt to close gaps in mental healthcare delivery. The pathway document is comprehensive and lengthy. This precis provides a brief overview of the care pathway guidance for mental healthcare in primary care settings and Departments of Community Mental Health (DCMH). This is a live document that will undergo regular review.

2. The mental health care pathway model that underpins the guidance is predicated on the assumption that the management of Common Mental Health Disorders (CHMD) starts in primary care before referral to military mental health services. The model seeks to maximise effective use of resources and to promote evidence-based care.

3. Current drivers for a unified care pathway SOP:

   a. Annual increases in demand for DCMH services.

   b. Current resources to be deployed effectively and consistently across all DCMHs using evidence-based care with proper governance and assurance.

   c. Optimising mental healthcare interventions in primary care.

   d. Accounting for recurrent staff shortfalls and the use of locum clinicians.

   e. Managing risk in both referred, yet to be assessed and assessed patient populations.

   f. Through early assessment and allocation to stepped care (described below), ensuring that risk management is the responsibility of the whole medical system, not just focused on clinicians in one area of the care pathway.

4. **Principles of the CMHD care pathway model**

   a. Appropriate guidance and support will be provided to primary care doctors (PCDs) to manage a proportion of low risk patients in primary care using Step 1 interventions.[105]

   b. Patients who have not responded to Step 1 primary care interventions will receive early DCMH assessment.[106]

   c. DCMH patients with moderate to severe risk profiles will receive immediate stabilisation via the DCMH multi-disciplinary team (MDT).

   d. Low risk DCMH patients will be placed on a therapeutic waiting list with robust safety-netting instructions; primary care and DCMH staffs will share responsibility for waiting list management.

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[105] Patient-led, self-help interventions that require no specialist mental health support skills.
[106] Key performance indicators for new patient assessments are: urgent (currently 1 working day) and routine (currently 15 working days).

5. **Pathway assurance and governance policies.** There are three key principles:

a. A detailed and explicit care pathway for CMHDs which includes primary care and DCMH actions to be adopted to ensure that all personnel are offered evidence-based interventions.

b. A detailed supervision policy for DCMH staffs will be followed which seeks to:

i. Ensure patients are provided with monitored, evidenced-based interventions.

ii. Enable early recognition of lack of progress that will trigger a review or step-up in care.

iii. Ensure that patients move efficiently through the care pathway.

c. A robust, thorough and complete record keeping policy will be followed by all DCMH staffs.

6. **Five red lines** are articulated which govern care in the DCMH:

a. All patients will be assessed inside 15 days (a 90% key performance indicator target will be set).

b. Evidenced-based interventions will conform to National Institute for Health and Care Excellence (NICE) guidelines (principles for making exceptions are detailed).

c. The split between Direct Clinical Care (DCC) and Supporting Professional Activities (SPA) of 75% and 25% respectively will not be violated.

d. PCDs must be supported in delivering the CMHD care pathway primarily by offering Step 1 interventions.

7. Each DCMH will need to establish <u>therapeutic</u> waiting lists that <u>could</u> include the following:

a. Step 2 Cognitive and Behaviour Therapy[107] (CBT).[108]

b. Step 3 CBT.[109]

c. Step 2 Group CBT for depression.

d. Step 3 Eye Movement Desensitisation and Reprocessing (EMDR).

e. Clinical psychology (in some departments this may be merged with high intensity CBT activity).

f. Consultant psychiatrist care.

8. The care approach will not be wholly reliant on intensive individual therapy and could potentially include:

a. Group behavioural activation therapy for depression.

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[107] CBT is a talking therapy that targets both thoughts and behaviour. It is most commonly used to treat anxiety and depression and is useful for other mental and physical health problems.
[108] Defined as CBT that can be provided by a clinician with basic training in CBT.
[109] Defined as CBT that must be provided by a clinician with formal training in CBT or under the direct supervision of such a qualified clinician.

b. Emotional coping skills group for stabilisation and symptom management.

c. Group CBT for anxiety.

d. Group CBT for coping skills for substance misuse.

e. Group CBT for insomnia.

9. Step 1 interventions already provided by primary care can be augmented during DCMH assessment (specialist leaflets, further sources of self-help, psychosocial interventions and brief interventions for alcohol).

10. **Safety-nets for patients on waiting lists.** The pathway document states that it will be policy to carry risk in the assessed patient group. DCMH clinicians will not routinely review patients placed on a waiting list as they will have been deemed low risk. Waiting list members will be encouraged to contact DCMH staffs if they deteriorate following advice provided by clinicians; a template for a standardised safety-netting letter for patients placed on waiting lists is provided in the pathway document. Patients who are sick at home in a P0S0[110] medical category are highlighted as being vulnerable. Such patients will receive primary care review every 4-6 weeks and will receive appropriate command and welfare support if they have not been assigned to a specialist rehabilitation unit. If a patient is made sick at home for more than 2 weeks, a case conference with the Chain of Command must be called within the first two weeks of sick leave.

11. The care pathway model gives detailed guidance about the management of CMHDs and describes additional pathways for:

a. Major psychiatric events (serious suicide attempts, serious mental illness).

b. Transsexualism (Gender Identity Disorders).

c. Cases of diagnostic uncertainty.

d. No mental health disorder but reports low mood and unhappiness.

e. Mild to moderate anxiety or depressive disorder.

f. Adjustment disorder.

g. Eating disorder.

h. Substance misuse disorder.

i. "Corridor Consultations" between primary care and DCMH staffs.

12. **Clinical supervision and record keeping**. Supervision arrangements for all DCMH clinicians and for certain therapies are addressed in full within the pathway document with supporting recording templates, in addition, comprehensive guidance for record keeping is provided.

13. **Support for primary care providers delivering mental health support**. The essence of the pathway is that primary care doctors (PCDs) will provide Step 1 interventions for eight weeks for low risk, mild to moderate CMHD cases before DCMHs will accept a referral. In cases where moderate to high risk patients are referred for urgent assessment and judged to be

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[110] Non-effective on medical grounds

at low clinical risk by DCMH staffs, they will be returned to the PCD for the Step 1 care pathway to be undertaken. PCDs will be supported in this following guidance given in the pathway document.

14. ***Suicide Review Team Comment.*** *During the review process, potential weaknesses in the proposed unified care pathway SOP were highlighted by senior military health advisors. Chief among their concerns was the capability and capacity of military primary care physicians to deliver step 1 psychological interventions (as recommended in the care pathway SOP). This was felt to be particularly difficult where locum or civilian GPs were employed. In addition, concern was raised about the ability of junior military mental health nurses to conduct robust risk assessments when working alone and, given current staff shortfalls, the capacity of consultant psychiatrists to provide comprehensive supervision to junior staff carrying out these activities.*

Annex N to
DSA/DMSR_04
Dated 14 Aug 18

REVIEW OF THE AUTOMATED SIGNIFICANT EVENT REPORTING SYSTEM (ASER)

1. The ASER System is primarily a patient safety tool; the report is 'owned' and initiated by the patient's medical centre but can be submitted by any medical staff. ASER reporting is standardised but can accommodate additional documentation. Many ASER reports are trivial and are closed off immediately while others are escalated with rapidity as they are titrated against potential patient harm. Suicide cases are abstracted from the steady flow of ASER reports that come through the system. All reports are graded according to the level of harm that might befall the patient, even if it is 'None'. Suicides are automatically annotated as SENTINEL[111] events which means that all levels of the ASER reporting and learning process are opened. It should be noted that not all suicides will generate an ASER. The serious event report is usually generated where the individual has received recent, or is currently in receipt of care from a Department of Community Mental Health DCMH or medical care facility. Therefore, there may be substantial lessons for medical personnel to learn. There is a three-step investigation and learning process associated with each ASER report relating to suicide:

a. Case review by DCMH/primary healthcare staff.

b. External review by a consultant psychiatrist or PHC clinician. This is usually a clinician from within Defence Medical Services (DMS), but can be a non-DMS clinician if there is a conflict of interest.

c. A formal, written lessons learned document is issued.

2. Currently, there is written guidance for DCMH staff who are carrying out this process; however, it is not standardised. The single Services conduct investigations differently. The Royal Navy carry out a 'Psychological Autopsy' whereas the Army and the RAF conduct an Organisational Analysis. This is likely to be an area that can refined and standardised within a written, inclusive suicide management/prevention plan.

3. A second area of potential weakness is the absence of a consolidation exercise where all suicide-related ASER outcomes are pooled and critically analysed so that patterns and regularities/recurrence are identified. If instituted, this could potentially result in a richer dataset, along with more substantial and potentially impactful recommendations for Defence.

4. A third potential shortcoming is the dissemination of learning. At present, the ASER is closed by issuing a 'lessons learned' document. In the case of suicide, SO1 Mental Health writes a guidance note that is distributed to all DCMH staffs. This is currently an informal arrangement that would benefit from being put on an official footing with clear guidance. The review team has established that the Defence Statistics document detailing lessons learned from official inquiry and learning sources has not been implemented. There is, therefore, an opportunity to improve the management of suicide by amalgamating the ASER/SI/LA process.

5. Lastly, there is no assurance process to confirm that any recommendations arising from the ASER process for suicide have been implemented.

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[111] Suicide is characterised as a Sentinel event. A Sentinel Event is defined as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.

6. Further areas of uncertainty were identified. Deaths, where harm is not associated with Defence Primary Care contact, are not captured. The reporting of deaths not associated with mental healthcare is challenging, as the World Health Organisation classification of events only allows for reporting when a cause is known or suspected; therefore, further processing of such events following case review is not always possible. In these circumstances, the event is progressed to closure as a Locally Managed Issue or is deleted from the ASER system with supporting evidence (although it can be recalled and re-opened). System administrators are not convinced that parallel recording of non-healthcare events is necessary, but questioned whether an opportunity to capture potential triggers for suicide might be missed if this information is not assimilated. System administrators were clear that being overly prescriptive about which class of events should be captured might close off a possible source of material for further learning.

Annex O to
DSA/DMSR_04
Dated 14 Aug 18

A CRITIQUE OF HOW PROBABLE SUICIDES ARE INVESTIGATED BY DEFENCE

Army

1. Following receipt of a notification of attempted or completed suicide, the unit initiates a reporting procedure which triggers activity by multiple agencies.[112] The subsequent investigation is coordinated by the Army Personnel Services Group (APSG).[113] The APSG receives a casualty report (NOTICAS) or a Land incident report (INCREP), and instructs the unit to initiate the Learning Account (LA).[114] The LA investigation is directed by the Permanent President Service Inquiries (PPSI) and their team. The PPSI team, in turn, create a Learning Account Review (LAR) and can request additional information if required. Once the LA has been agreed by the PPSI, it is fed into the central APSG master tracker. Information may then be added to the tracker by several external agencies including Chief Environmental and Safety Officer (CESO), Defence Accident Investigation Branch (DAIB), Defence Safety Authority (DSA) and Permanent Joint Headquarters (PJHQ). The consolidated information is then analysed and actions or recommendations are generated. Ownership of the recommendation is assigned and the identified lessons or recommendations are added to Defence Lessons Identified Management System (DLIMS). Lessons and actions can only be closed once sufficient evidence of completion has been presented to APSG. If a Service Inquiry (SI) or Non-Statutory Inquiry (NSI) is convened, then JSP 832 is followed. This policy is followed by all three Services.

Royal Navy

2. Royal Navy Book of Reference 3(1) contains RN suicide prevention policies. It details background information relating to suicide, risk factors for suicide and provides details of pre- and post-event management procedures including actions to be taken by all involved in the event. Suicide or self-harm reporting procedures are clearly described and the documentation and information required by the Chain of Command (CoC) are set out. Reference is made to multidisciplinary care and the divisional systems to be followed in order to achieve a joined-up care approach. Unit investigations and Service Inquiry procedures are described in full in Joint Service Publication (JSP) 832 and BRd 172. BRd 172 Ship Investigation/RM Unit Inquiry Process documents provide specific advice for carrying out investigative processes. BRd 172 provides clear guidance to follow during an incident, the structured reporting process, key points of contact and how to format and write the final report.

3. Upon receipt of notification of a suicide or attempted suicide, Navy command forms a PPSI team to investigate the event; the team uses specialist legal advice and JSP 832 to guide them through the process and ensure the accuracy and completeness of the final report. The unit/ship will also form a team to investigate the incident and produce a LA. This team will be the first on scene and may conduct evidence gathering in preparation for PPSI team activity. The suggested composition of the team and its TORs are all detailed in RN BRd 172.

Royal Air Force

4. Royal Air Force suicide prevention policy is contained in AP9012 Chapter 6. In addition to the management of self-harm and attempted suicide, the policy details step by step guidance

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[112] Land Forces Standing Order 3207.
[113] The APSG have teams to deal with non-statutory inquiries and will provide the guidance and advice to an Service Inquiries.
[114] ACSO 1118 Learning Lessons in the Land Environment.

for informing the Chain of Command (CoC) and post-incident actions to be taken. The Post Incident Report (PIR) structure and guidance is detailed in AP800, leaflet 8027, Annex B, App A. This includes a structured report template and stepwise completion guidelines.

5. Service Inquiry procedures are governed by JSP 832, however if a NSI, or unit LA is to be set up, guidance is provided in AP 3392 Vol 4, leaflet 1514. This details the investigation process, team composition, recommended TORs and additional specific guidance. The investigation process and report template are both similar to those adopted by the Army and RN. The RAF policy document is very clear on the processes to be followed (including time lines and ownership). Overall, the clarity of the guidance is likely to ensure informative accounts and provide for detailed learning. Information and lessons learned from incidents are uploaded and held on both the DLIMS and Air Safety Information Management System (ASIMS).

Management of lessons learned post-investigation.

6. DLIMS is the single tri-Service repository for lessons learned. Lessons are entered into the system, are actioned and closed, or immediately closed if the information/process already exists. There are a number of key milestones in the closure process:

7. The Gatekeeper is a designated individual who can close a lesson if they are assured that recommendations have been implemented. The Gatekeeper is assisted by:

a. Senior Point of Authority (SPA) – the owner of the lesson with responsibility for its progress through the system.

b. Support Action Manager (SAM) – the subject matter expert for the specific lesson.

8. The system allows for external files and documents to be attached as supporting evidence and can provide a direct link back to the Army Incident Notification Cell (AINC); this feedback loop is less clear for the other services.

Annex P to
DSA/DMSR_04
Dated 14 Aug 18

RECOMMENDATIONS

Serial	Paragraph	Recommendation
1	12	Reinvigorate the Suicide Prevention Working Group to drive the implementation of suicide prevention measures and to share best practice across Defence.
2	12	Confirm the terms of reference and membership of the Suicide Prevention Working Group.
3	12	Review the Royal Navy policy document RN BRd 3(1) and clarify strategic ownership of safety, healthcare, welfare policies, practices and reporting.
4	18	Defence to continue to monitor suicide rates in Service Personnel and to publish an annual statistical note on suicide that highlights the limitations of the current methodology.
5	18	Confirm the value of the new suicide rate monitoring methodology at 12 months post introduction.
6	18	Suicide Prevention Working Group to explore the collection of alternative or additional statistics by Defence Statistics in order to identify additional measures for preventing suicide in Service Personnel.
7	19	Suicide Prevention Working Group to review the lessons identified from previous investigations into military suicides for implementation across Defence
8	19	Mental Health Steering Group to review the 2016 Defence Statistics loose minute and prioritise recommendations for implementation across Defence.
9	23	Mental Health Steering Group to review currently available self-help resources for deliberate self-harm and oversee the development of a resource package for Defence.
10	23	Mental Health Steering Group to consider the benefits of joining the National Suicide Prevention Alliance.
11	28	Develop a Defence Suicide Prevention Plan in line with Government recommendations.
12	33	Academic Department of Military Mental Health to expand the current military suicide literature review to include civilian studies and increase reporting frequency to biannually.
13	33	Review the unified care pathway for mental health in 12 months' time to ensure that it is being delivered and that it is effective.
14	35	Defence Primary Healthcare to publish guidance on best practice for Department of Community Mental Health internal case note reports, psychological autopsies and the external investigation of suicides.
15	35	Internal reviews, psychological autopsies and external reviews to be collated by the Defence Medical Services Regulator on at least an annual basis.
16	35	Suicide Prevention Working Group to review collated reports, Service Inquiry recommendations and Learning Accounts in order to identify new measures to prevent suicide of Service Personnel.
17	35	Defence Medical Services Regulator to audit the implementation of recommendations to prevent suicide in Service Personnel.
18	38	Consider Army guide to medical confidentiality for adoption across Defence.
19	38	Defence Health and Wellbeing Board to consider embedding welfare support in Departments of Community Mental Health.
20	42	Defence Lessons Identified Management Systems to be the single repository for Lessons and Learning Accounts.
21	42	Suicide Prevention Working Group to have full access to information held on Defence Lessons Identified Management Systems regarding suicide.
22	42	Defence Safety Authority to assure that Learning Accounts and Service Inquiry recommendations are shared across Defence to ensure implementation of best practice.