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[redacted]

13 July 2021

Dear [redacted]

Thank you for your email of 15 June in which you requested the following information:

AGAI Vol 3 Ch 110 - Army Suicide Vulnerability Risk Management (SVRM) Policy

I am treating your correspondence as a request for information under the Freedom of Information Act 2000. A search for the information has now been completed within the Ministry of Defence, and I can confirm that information in scope of your request is held.

The information you have requested can be found attached below, but some of the information falls entirely within the scope of the absolute exemption provided for at sections 40 (Personal Data) of the FOIA and has been redacted. Section 40(2) has been applied to some of the information in the requested document in order to protect personal information as governed by the Data Protection Act 2018. Section 40 is an absolute exemption and there is therefore no requirement to consider the public interest in making a decision to withhold the information.

If you have any queries regarding the content of this letter, please contact this office in the first instance. If you wish to complain about the handling of your request, or the content of this response, you can request an independent internal review by contacting the Information Rights Compliance team, Ground Floor, MOD Main Building, Whitehall, SW1A 2HB (e-mail CIO-FOI-IR@mod.gov.uk). Please note that any request for an internal review should be made within 40 working days of the date of this response.

If you remain dissatisfied following an internal review, you may raise your complaint directly to the Information Commissioner under the provisions of Section 50 of the Freedom of Information Act. Please note that the Information Commissioner will not normally investigate your case until the MOD internal review process has been completed. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF. Further details of the role and powers of the Information Commissioner can be found on the Commissioner's website at https://ico.org.uk/.

Yours sincerely,

Army Policy & Secretariat

August 2020
(Replaces AEL 64 dated Aug 12)

ARMY

ARMY GENERAL AND ADMINISTRATIVE INSTRUCTIONS

VOLUME 3

CHAPTER 110

VULNERABILITY RISK MANAGEMENT

This Chapter is sponsored by the Senior Health Advisor (Army) and contains the regulations for the Army's Vulnerability Risk Management process.

It is applicable to all Regular and Reserve Army personnel including all Officer Cadets and Soldiers under Training, units and formations and should be applied to all personnel in Tri-Service units where the Army is the lead Service.

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RECORD OF AMENDMENTS

AEL Number	Amendment Date	Authority	Amendment
AEL 064	Aug 12	SHA(A)	General review and update
AEL 127	28 Aug 20	SHA(A)	General review, updated and re-templated

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CHAPTER 110
VULNERABILITY RISK MANAGEMENT

Part 1 - Introduction

110.001. S cope. This Chapter contains the regulations for the Vulnerability Risk Management (VRM) process. VRM is a leadership function and a command-led activity and is part of the Army's preventative strategy to minimise the vulnerability to, and incidence of, suicide[1] and self-harm[2] behaviours across the whole force.

110.002. The early identification and management of suicide and self-harm behaviours is a leadership function that directly affects the health, employability, deployability and operational effectiveness of individuals and units. Suicide and self-harm behaviour is rarely the result of a single factor or incident; it usually follows a combination of previous vulnerability and recent life events. Individuals may find themselves in difficult situations for a range of reasons, some of which may be beyond their control, so it is essential to identify them early and put in place effective care assessment plans. Prompt, appropriate management and support by the Chain of Command (CoC), with the assistance of pastoral, welfare and healthcare personnel as necessary, is essential to minimise the potential risk of self-harm and/or suicide.

110.003. Suicide is a major health problem and a leading cause of death worldwide[3,4]. Recent reports inform that around a million people die by suicide annually, representing an annual global age-standardized suicide rate of 11.4 per 100,000 populations (15.0 for males and 8.0 for females). Considering a time perspective from 2000 through 2016, the age-adjusted suicide rate has grown by 30%. Within the UK Armed Forces suicide remains a rare event[5]. Whilst it is unlikely that the Army will ever be able to entirely prevent such tragic events, there is much that can be done to reduce the current levels of suicide and self-harm[6].

110.004. Suicide and self-harm behaviours are complex and are not always associated with mental illness; they often occur when life stressors converge to overwhelm the individual. Individuals vary with different "coping" thresholds but some, may be at risk of suicidal behaviour at times of psychological difficulty arising from the cumulative impact of generic risk factors and the circumstances at that time. The key to suicide prevention is to recognise the warning signs, identify and mitigate the risk factors, initiate protective measures and assist the individual to resolve the underlying issues as detailed in this AGAI and Annexes. There is substantive evidence to show that active suicide prevention policies can decrease the incidence of suicide[7,8,9,10].

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[1] Suicide is the act of intentionally ending one's own life. The National Statistics definition of suicide includes all deaths from intentional self-harm for persons aged 10 and over, and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 and over **(ONS,2018).** Only the Coroner's Court can determine that a death be classified as "suicide".
[2] Self-Harm refers to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. NICE QS34 dated June 2013
[3] Curtin SC, Warner M, Hedegaard H. Increase in suicide in the United States, 1999–2014. NCHS Data Brief (2016) 241:1–8. **[PubMed]**
[4] World Health Organization Preventing suicide: a resource for media professionals, update 2017. Geneva: WHO; (2017). Retrieved from **apps.who.int/iris/bitstream/10665/258814/1/WHO-MSD-MER-17.5-eng.pdf. [Google Scholar]**
[5] **https://www.gov.uk/government/statistics/uk-armed-forces-suicides-2019**
[6] **https://www.gov.uk/government/collections/deliberate-self-harm-in-the-uk-armed-forces-index**
[7] Workplace suicide prevention: a systematic review of published and unpublished activities. Milner. A, et al. Health Promotion International, Volume 30, Issue 1, March 2015, Pages 29–37, Published: 25 September 2014 **https://doi.org/10.1093/heapro/dau085**
[8] Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: a systematic review. *JAMA*. 2005;294(16):2064-2074. doi:10.1001/jama.294.16.2064
[9] Zalsman G, Hawton K, Wasserman D, et al. Suicide prevention strategies revisited: 10-year systematic review. *Lancet Psychiatry*. 2016;3(7):646-659. doi:10.1016/S2215-0366(16)30030-X
[10] 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.

110.005. Definition of Vulnerability Risk Management (VRM). VRM is a measured, individual assessment by the CoC with the assistance of pastoral, medical and welfare support and is designed to identify those with a vulnerability to suicide or self-harm behaviours and provide structure to subsequent management and support. VRM is therefore a G1 Management Tool, at the heart of which is the most basic leadership tenet of "knowing your people".

110.006. Aim. The aim of VRM is to minimise the vulnerability to, and incidence of, suicide and self-harm in the Army and provide guidance for Commanders and the CoC to:

a. Assist them to identify personnel who may have a vulnerability to, and be at risk of, suicide and self-harm behaviours, and,

b. Signpost appropriate responses to actively manage and support individuals at risk.

110.007. Applicability. Application of VRM policy is mandatory for all Army personnel (Officers and Soldiers, both Regular and Reserve, and regardless of whether they are in a Tri-Service, Naval Service (including Royal Marines) or RAF[11] unit/establishment[12]), including all Soldiers under Training (SuT)[13,14] and on "Holdover", including Royal Military Academy Sandhurst (RMAS) Officer Cadets[15] and University Officers' Training Corps (UOTC) Cadets, and to include Naval Service or RAF personnel in Tri-Service units when the Army is the Service Lead. The policy is to be adopted overseas (not just on operations) for all who come under Service law[16] where practicable.

110.008. Stigma. Stigma is a cultural issue and it is the responsibility of every commander and individual to address it. Men in general, and male Army personnel in particular, have been shown to delay seeking help due to lack of insight, stigma and fear that disclosure of their personal circumstances will be seen as a sign of weakness and/or have an adverse effect on their military career[17]. Early recognition and intervention can reduce risk of suicidal behaviours, allow time to recover and improve outcomes.

110.009. **Responsibility.** Personnel must be encouraged and empowered to take responsibility for their own wellbeing. The Commanding Officer (CO) and the CoC must put in place the necessary enablers to support individuals and the collective effort to improve health and wellbeing and prevent harm[18]. The CoC must know and understand their personnel and support those who, for whatever reason, are unable to cope. This is the role of leadership and is vital to maintaining operational effectiveness and unit cohesion. The most effective way of reducing the incidence of suicide and self-harm behaviours in the Army is to overcome stigma and create a positive and sympathetic environment where all individuals, regardless of rank, can face their problems, ask for support or help others to do so.

110.010. Governance. The Senior Health Advisor (Army), on behalf of the Deputy Chief of the General Staff (DCGS) as the Army's Principal Personnel Officer and the Director Personnel (D Pers), sets the policy to ensure that those personnel at risk of suicide and self-harm behaviours, are supported.

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[11] RAF Policy AP9012 Chapter 6
[12] Navy Policy BRd 3(1) Chapter 24
[13] Army Recruiting and Initial Training Command Handbook Supervisory Care Directive
[14] **JSP 822** Chapter 2.3 - Supervisory Care for Phase 1 Recruits and Phase 2 Trainees
[15] Regardless of whether that is in Basic Training, Initial Trade Training or Officer training at RMAS.
16 **JSP 770** Annex A to Chapter 1 refers
[17] Coleman, S.J., Stevelink, S.A.M., Hatch, S.L., Denny, J.A. and Greenberg, N., 2017. Stigma-related barriers and facilitators to help seeking for mental health issues in the armed forces: a systematic review and thematic synthesis of qualitative literature. *Psychological Medicine*, *47*(11), pp.1880-1892.
[18] Stecker T, Fortney JC, Hamilton F, Ajzen I (2007). An assessment of beliefs about mental health care among veterans who served in Iraq. Psychiatric Services 58, 1358–1361.

110.011. Assurance. Unit compliance with AGAI 110 is conducted via the G1 Audit (G1A) process in accordance with ACSO 9001[19] and 2018DIN03-017[20].

110.012. Point of Contact. The Senior Health Advisor (Army) is the authority for the Army's VRM policy. SO2 Mental Health and Wellbeing policy is the desk lead for this policy in the Army Health branch in Army Headquarters, email: [redacted]

110.013 – 110.030. Reserved

[19] ACSO 9001 -The Army Policy for Audit and Inspection
[20] 2018DIN03-017- The Army Policy for Audit and Inspection

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Part 2 – The VRM Process

110.031. Commanding Officer Responsibility. Responsibility for the application of the VRM process at unit level rests with the Commanding Officer to ensure that the Unit and CoC fulfil their moral and legal duty of care responsibility to all personnel. Commanding Officers must ensure that a culture of trust, confidential disclosure and non-stigmatisation of VRM issues is engendered in their unit.

110.032. Unit VRM Register. It is mandatory to hold a VRM risk conference and place an individual onto the Unit VRM register if they have suggested, threatened, or carried out any suicidal or self-harm behaviour. For all other reasons, the decision to put someone on the register rests with the Commanding Officer (or nominated empowered replacement in their absence) and is based on the assessment of the risk and whether the underlying factors affecting the individual are sufficient to require the full application of the policy to ensure their support.

110.033. The Unit VRM Register is held electronically on the Vulnerability Risk Management Information System (VRMIS). Introduced in 2015, VRMIS provides a mandated secure platform for the recording and management of individuals identified at risk and replaced the previous paper-based system that was fragile and vulnerable to human error. Details of VRMIS can be found at **Annex A**.

110.034. Identify the Unit VRM Lead. Each unit must identify a Unit VRM lead. This will normally be the Adjutant or equivalent individual (but can in some instances be the Unit Welfare Officer (UWO)/Regimental Operational Support Officer (ROSO)) who receives training on the VRM lead role at their respective pre-employment training[21]. The Unit VRM Lead must be widely known throughout the unit and the chain of command and has overall responsibility for the maintenance and management of the unit VRM process directly on behalf of the Commanding Officer.

110.035. VRM Stages. The four stages of the VRM process are summarised in the flow chart at **Annex B** and detailed below.

110.036. STAGE 1 - Risk Identification. Suicide and self-harm behaviours are complex and often occur when life stressors converge to overwhelm an individual. Suicide behaviour is not always associated with mental illness but some of the factors that lead to suicide may be causative in mental illness and vice versa. Suicide research reveals that the majority of those who die by suicide will have displayed warning signs prior to the event. Therefore, understanding the risk factors and the behaviour associated with suicide and, most importantly, knowledge of the individual will be key to ensuring early detection and identification. Formal identification of individuals at risk involves the recognition of risk factors or behavioural changes; either or both could indicate an increased propensity to self-harm or suicide. The success of the VRM process requires good communication and early referral of individuals potentially at risk by those who know them best: their chain of command, immediate colleagues, family and friends.

110.037. The identification of an individual potentially at risk could originate from many sources: a formal referral by a medical practitioner or Army Welfare Services to the chain of command; an informal expression of concern from the unit padre or unit welfare staff; an informal expression of concern or casual remark from a colleague; communication from a worried spouse, partner, family or friend; an anonymous call, or many others. Whatever the source of the concern, whatever the provenance and to whomever it is addressed, it must always be referred to the Unit VRM Lead who must initiate a meeting or “risk conference” to consider how to support the individual.

110.038. COs must also be mindful of the possibility that an individual may not seek help because of a perceived risk to career and/or vetting status, conversely, they may attempt to utilise the VRM

[21] All Arms Adjutants Course for Adjutants and Unit Welfare Officers Course for Unit Welfare Officers/Unit Welfare Staff.

process to prematurely end their military career. COs must also take account of culture when investigating soldiers potentially at risk, for example it may be against an individual's religion, belief or culture[22] to discuss debt, sexuality or relationship issues and this vital information may not be shared.

110.039. Risk Factors. Risk factors are individual, relational, community and societal factors that contribute to the risk of suicide[23] and can be generic, environmental or circumstantial, such as recent exposure to significant stressors. These are issues in an individual's life that increase the probability of the development of serious behavioural, physical or mental health problems which could culminate in a desire to take their own life or to self-harm. The presence of these factors does not automatically mean someone will become suicidal; indeed, most people will experience many of these stressors at various times in their lives without adverse effects, but these factors can raise the risk of suicidal behaviour in some individuals. Many of these risk factors can be modified, reduced, or eliminated by their own actions supported by compassionate, careful and caring management by their CoC.

110.040. Behaviour Associated with the Presence of Risk Factors. Some individuals may respond to distress by developing unhealthy behaviours including withdrawal from social support and ineffective problem solving. This may intensify the risk of suicide but can also be the manifestation i.e. the symptom, of a desire to die by suicide. Those who see an individual every day (chain of command, colleagues, family and friends) are best placed to recognise behavioural changes stemming from distress, provide support and alert those who can take the necessary action. **Doing nothing is never an option** and any substantial or observable change in behaviour warrants further discussion with the individual. This discussion will not increase the risk of suicide by raising the topic and is very likely to reduce the risk. Often the reason for the distress is not identified or identifiable, but a behavioural change as a result of that risk factor may be seen. Comprehensive guidance outlining both the risk factors and the behaviour that can be associated with them is at **Annex C.**

110.041. Self-Harm. Self-Harm has a broad definition[24,25] including poisoning, medication overdose, cutting or asphyxiation. Whilst some individuals who self-harm do not have intent to kill themselves, and are using it as a maladaptive coping mechanism to relieve emotional pain or discomfort (or occasionally as an attention seeking act)[26], evidence clearly shows us that an individual with a history of self-harm is more likely to attempt suicide in the future. It is seldom possible to fully understand the motivation behind the act of self-harm and whether the intent was to kill themselves, therefore all cases must be taken seriously. All instances of self-harm, however minor the injury sustained, must therefore be considered as seriously as a failed suicide attempt and the individual must be given appropriate care and support, including referral to the Medical Chain for assessment. Commanding Officers may also wish to consider the options available to them where individuals undertake recurrent and/or persistent acts of self-harm by referring to Army manning policy, the Queen's Regulations for the Army 1975 (QR(Army))[27], Promotions and Appointments Warrant (PAW)[28], JSP 950 Lft 6-7-7 Section 5 Annex L and taking advice as appropriate.

110.042. Any individual who Self-Harms[29], regardless of the apparent intent or severity of actual injury, is to be automatically placed on the Unit VRM Register **for a minimum period of 12**

[22] **Guide on Religion and Belief in the MOD and Armed Forces.pdf**
[23] Military Suicide Prevention: Report Prepared for NATO Leadership, STO Technical Report TR-HFM-218 June 2018
[24] World Health Organization; 'an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences'.
[25] Self-Harm refers to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. NICE QS34 dated June 2013
[26] **NHS**-Self-harm
[27] **The Queen's Regulations for the Army 1975**, Chapter 9, Section 5, pars 9.434 -9.434 refer.
[28] **Promotions and Appointments Warrant**. Para 196 refers
[29] Self-Harm refers to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation.

months. This step is considered necessary because self-harm may be a pre-cursor to suicidal behaviour, and it is not always possible to ascertain intent. **The removal from the Unit VRM Register for anyone who has self-harmed, prior to the completion of the 12-month period can only occur if the individual is discharged from service / end of service and in accordance with the protocols described later in this Chapter**.

110.043. Suicide threats and active ideation. Where an individual expresses active thoughts of, or threatens suicide the individual must automatically be placed on the register for a minimum period of **one month** to allow a full assessment of the risk factors to be conducted and for the case to be formally reviewed as part of the Commander's Monthly Case Review process[30]. The CoC must take seriously any suicide threat or active suicide ideation that is made by any SP and the individual must be referred to the medical chain for assessment at the earliest opportunity. Units must raise an INCREP for all suicide threats or active ideation in accordance with AGAI 62[31] and a copy sent to [redacted]

110.044. Basic Training and U18's. COs must ensure appropriate duty of care of those in Basic Training[32] and/or under 18's placed on the Unit VRM register, with referral to welfare and medical as necessary. Medical Professionals will assess against JSP 950 Lft 6-7-7 and decide if the individual meets the standards for retention in-service but the decision to retain or discharge the individual belongs to the CoC. Any individual under the age of 18[33] has the same right of confidentiality however the Army has an enhanced duty of care to junior soldiers who may lack capacity, and in some circumstances next of kin may be informed without consent of the individual. Where an individual who is under 18, or in Basic Training, completes an act of self-harm, CO's are required to consider their actions in accordance with current Army manning policy (including the relevant sections of QR(Army), Promotions and Appointments Warrant (PAW)[34] and JSP 950 Lft 67-7) and taking advice as appropriate.

110.045. NOTICAS, INCREP and Learning Accounts. All incidents of self-harm are to be reported by the CoC as *Non-Operational Injury Violent or Unnatural Causes* (NOI VUC) via both the NOTICAS process in accordance with JSP 751 – Joint Casualty and Compassionate Policy and Procedures and an INCREP in accordance with AGAI 62; both must be completed strictly in accordance with Data Protection Act 2018 (DPA 18), General Data Protection Regulation (GDPR) and Caldicott and confidentiality guidelines[35,36]. A learning account must be raised, in accordance with the direction laid down in ACSO 3207[37], for all instances of self-harm that come to the attention of the CoC.

110.046. Reporting to the Service Police. All incidents of self-harm that come to the attention of the CoC must be reported by the Unit (normally the Adjutant) to the RMP (a phone call is sufficient in the first instance) in order that the RMP can investigate the circumstances of the incident. This is **not** to investigate the service person but is essential to determine if any criminality has occurred, such as bullying or harassment[38]. The Investigations and Policing Branch Policy Note 02/17[39,40,41]provides the guidance to the RMP on action to be taken on all incidents of self-harm and attempted suicide and is applicable to all persons subject to service law including Reserves.

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[30] **AGAI 57,** Chapter 3, refers.
[31] **AGAI 62** Discipline Policy - to be amended to reflect this requirement.
[32] In accordance with **JSP 822** Part 1, Chapter 2.3 – Supervisory Care for Phase 1 Recruits and Phase 2 Trainees, and, the Supervisory Care Direction issued by ARITC in the **Army Recruiting and Initial Training Command Handbook**
[33] **JSP 822** Part 1, Chapter 2.4 – Care of Service Personnel Under the Age of 18, refers.
[34] Promotions and Appointments Warrant - Para 196 refers
[35] **https://www.igt.hscic.gov.uk/Caldicott2publications**
[36] Annex E: The Commanders ' Guide to Medical Confidentiality.
[37] **ACSO 3207** Conduct and Management of Service Inquiries and Non-Statutory Inquiries, Para 30 c refers
[38] This was a recommendation from the DHALI/BLAKE reports into Deepcut.
[39] Investigations & Policing Branch Policy Note 02/17:Incidents of Deliberate Self Harm and Attempted Suicide.
[40] PMA/Tech_06-04 dated 18 Mar 20: Investigations & Policing Branch Policy Note – 04/20 Reporting Responsibilities in Cases of Suspected Deliberate Self Harm (DSH) involving RMP
[41] PMA/Tech_06_04 dated 18 Jun 19:Investigations & Policing Branch Policy Note – 04/19 Suicide Prevention and Risk Management relating to Perpetrators of Child Sexual Exploitation (CSE) and Indecent Images of Children (IIOC)

110.047. PM(A) policy and Military Police Investigations Doctrine reminds all RMP staff that whilst engaging with victims they are to be cognisant that their presence may cause anxiety in the individual they are interviewing. They are briefed to ensure that the individual is supported and made aware of the reasons for the interview and that they are not in any kind of trouble. This must be made absolutely clear to the CoC when arranging the interview and again when meeting with the individual. The CoC must support the individual as a duty of care, including explanation of the process and support at interview. If medical advice has stated that an individual should not be questioned at a particular point in time, this is the same as any other investigation where someone is classed as not fit for interview and managed by the RMP. The outcome of the interview may either establish personal reasons for the self-harm or reasons linked to a crime; if linked to criminality the RMP will initiate a full police investigation. If the motive is due entirely to personal circumstances, then no further investigation action is required, and all relevant information will be reported to the CoC and the incident report will be filed by the RMP.

110.048. Reservist duty status. When a unit becomes aware that a Reservist has completed an act of self-harm whilst not on duty (and therefore not covered by Service Law), the CO must establish whether the cause of their self-harm or attempted suicide was related to service or their treatment by unit personnel. This is best achieved by sensitive direct contact with the individual. If the cause is linked to the behaviour of an individual/s in the unit, then it is appropriate to either carry out a unit inquiry, consider administrative action against those involved or to report the matter as a disciplinary offence (breach of the Armed Forces Act 2006 (AFA 06)) depending on the circumstances of the allegation. The CO must take this CoA to prevent abuse from continuing in the unit and reoccurrence involving the same or additional victims, potentially ending with fatal consequences. This investigation enables the person concerned to confirm if the cause of their self-harm is 'personal reasons' not linked to HM Forces and no further RMP investigation is required but the Unit may wish to provide support for the individual.

110.049. STAGE 2 – Initial Risk Conference. The purpose of the initial risk conference is to determine and analyse all of the known circumstances pertinent to the individual to assist the CO in deciding whether an individual should be placed onto the Unit VRM Register and subsequent actions completed.

110.050. The requirement to include an individual on a Unit VRM Register may not be immediately apparent. However, the discussion at the Initial Risk Conference allows all the available information to be considered. Small indicators seen by different people can be joined together to create a full picture of the risk. Evidence shows that the most common risk factor is difficulties with personal relationships and in most cases at least two factors from **Annex C** have been present. The decision to place an individual on the VRM Register will inevitably be a subjective judgement based on the knowledge available at that time, the immediate circumstances, military judgement, balance of risk, duty of care and using the guidance at **Annex C**.

110.051. COs are advised to err on the side of caution and place individuals on the VRM register in circumstances where there is any doubt. Rank or seniority of the individual **must not** be considered a factor that prevents inclusion onto the Unit VRM Register.

110.052. Engagement by the Chain of Command and Supporting Agencies. The CO is responsible for deciding whether an individual should be considered at risk of suicide or self-harm behaviours, formulating the management response and selecting the appropriate measures to reduce risk. They must ensure close collaboration with the immediate chain of command, welfare, pastoral and medical personnel and, most importantly, the individual at risk.

110.053. Attendance at the Initial Risk Conference. Once an individual has been identified as being at risk an initial 'risk conference' must be held as soon as reasonably practicable, initiated by the Unit VRM Lead. The VRM lead should not delay a risk conference to maximise attendance.

Attendees not present can be briefed by the VRM lead subsequently or can join by electronic means if appropriate. It may be appropriate for the individual to be present for part of the initial risk conference but there will need to be a portion of the meeting which is held without them. Attendance by other supporting agencies or specialists, such as the Army Welfare Service (AWS) or someone from the Department of Community Mental Health (DCMH), should always be considered. The circumstances of each individual case will dictate the attendance, but the following personnel should be included as a minimum:

a. CO (or nominated empowered replacement in their absence).

b. Adjutant (normally the Unit VRM Lead).

c. RSM.

d. UWO or empowered welfare representative.

e. Medical Officer or empowered medical representative[42].

f. Padre.

g. Individual's OC.

h. The individual (recommended for appropriate part of the conference).

110.054. Engagement with the Individual. Engagement with the individual is essential, both in acknowledgement that they have problems that require resolution or are going through life events that require them to receive enhanced support, and in the development of the care assessment plan to manage this risk. This acknowledgement can itself be cathartic. People who attempt suicide or go on to complete suicide generally face problems they feel cannot be resolved. Frequently there are solutions, but someone who is overwhelmed may not be thinking clearly and cannot see possible positive solutions or outcomes. It is vital to engage both the individual and other agencies that can assist (subject to agreement by the individual), in order to understand these stressors and find solutions as soon as possible.

110.055. Creating an Entry on VRMIS. Once the decision has been made to place the individual onto the VRM Register, the Unit VRM lead must create the entry on VRMIS and assign the appropriate person to become the Care Assessment Plan (CAP) lead. The CAP lead will normally be someone in the individual's CoC, unless the CoC are a contributing factor in the adverse situation. This should normally be the OC unless the CO appoints another Officer to be the principal point of contact, or a more appropriate CAP Lead (e.g. UWO, RAO, RCMO). The Unit VRM Lead and CAP lead must not be the same person for an open entry on the VRM Register apart from in exceptional circumstances and only where permission has been sought and granted by the AGAI 110 policy lead.

110.056. STAGE 3 – Ongoing Management, Engagement and Care of individual and Risk Review. Once the decision has been made to place the individual onto the unit VRM Register, it is essential to actively manage the risk and the underpinning causation. This is achieved by the formulation of the Care Assessment Plan (CAP), which must provide a programme of proactive management actions, care and support for the individual. The record must be initiated and then maintained on VRMIS by the CAP lead.

[42] For FTRS(HC/LC) and non-mobilised Reservist personnel it will not usually be possible for the individual's doctor to be present as medical care will be normally provided by a civilian GP. All reserves are entitled to Occupational Health assessments from DPHC, such as pre-course assessments and medical grading reviews. An overview of OH entitlement for the Reserve is provided by **JSP 950 Leaflet 1-3-6. 2019DIN01-080** provides a guide to the key components of Reserve Occupational Health provision. Those graded other than MFD should attend an annual medical review with a military doctor in order for the Appendix 9 to be produced, amended or updated, and the CoC made aware of any changes to medical employment limitations.

110.057. The CAP is a chronological version of events that demonstrate how the individual on the Unit VRM register is being actively managed and supported by the unit/CoC. The CAP lead is responsible for maintaining a summary of events, actions and measures aimed at both supporting and addressing the issues affecting the individual considered at risk. All relevant information relating to the individual's mood, behaviour and situation, including any changes must be recorded along with information on how they are coping with the actions and measures laid down in the CAP. The CAP is a live document held securely on VRMIS and is to be used and maintained for the duration that the individual is considered to be at risk; as long as an individual is at any risk, the entry must remain open on VRMIS.

110.058. The development of the CAP requires a focus on developing the 'protective measures' to reduce the possibility that an individual will self-harm or attempt suicide; these will include physical measures, such as removing access to means, as well as the opportunity to talk about what issues are affecting them. In order to successfully reduce the risk of harm, the activity must address both the underlying causes and contributory factors that have caused the elevated risk, as well as the potential consequences of the underlying causes. Guidance on the development of the CAP, including information on protective measures, is at **Annex D**. In all cases the individual's OC must interview the individual before and after the initial risk conference, this must include an explanation of the VRM process along with details of additional sources of help and support that are available to the individual. These discussions must be recorded on the CAP.

110.059. Individual Case Management and Commander's Monthly Case Review. VRM is a dynamic process to manage an individual at risk; progress must be regularly reviewed, and the CAP updated. As a minimum, all soldiers on the unit VRM Register must be regularly assessed as part of ongoing Individual case management review by the CAP lead and formally assessed at the Commander's Monthly Case Review in accordance with Chapter 3 of AGAI 57 - Army Health Committees. These regular assessments must be fully documented as an event on the CAP that is held on VRMIS.

110.060. Consent and Sharing. Once individuals have been assessed as being at risk, they must be afforded an explanation of the VRM process and asked to agree the resulting summary information about their management and care and with whom it can be shared. This must be entered onto the CAP and visibility access granted to those personnel with whom the individual has agreed for information to be shared[43]. The summary information can normally be shared with those who can implement the plan and provide support for them and the individual must be asked to sign the information sharing agreement in the relevant section of the CAP. Individuals must remain fully involved in subsequent reviews, which in itself may help them to understand their situation, assist them in resolving the underlying issues and provide a safety net. If the individual does not agree to information being shared, the relevant agencies (Padre, MO, UWO and others) must respect this decision which must be formally documented in the CAP by the CAP Lead. The individual must be clearly informed by their CoC that this may limit the assistance that the CoC can provide to resolve their problems and that it will be recorded in the CAP.

110.061. Confidentiality. Personal, medical and welfare[44] data must be protected in accordance with Data Protection Act 2018 (DPA 18), General Data Protection Regulation (GDPR), and Caldicott principles. Confidentiality underpins the relationship between the CoC, the individual and all stakeholders involved in the VRM process. **Annex E** provides a useful guide to Medical Confidentiality for the CoC and the Caldicott Guidelines.

110.062. Medical Opinion. Medical Officers (MOs) and other clinicians must alert the CoC where the health of an individual on the Unit VRM Register could affect their employability or

[43] This is for those personnel and agencies such as UWO, Padre, MO, AWS etc who can provide additional support to the individual, and is not applicable wrt CO, Unit VRM lead and CAP Lead.
[44] All welfare work within the Army is conducted within a Code of Confidentiality in accordance with **AGAI 81.** para 81.012-81.014 refer.

deployability, for example due to access to weapons and live ammunition or deployment on exercises or operations. If patients do not consent to disclosure, then information would be limited to management advice in AGAI 78 **Appendix 9** and JMES grading. In extreme cases where there is assessed to be a serious risk to health of the individual or others, the duty of confidentiality[45, 46, 47, 48] must be assessed against this risk and professional advice taken[49]. Where the risk of suicide exists and the GP/MO has concerns then the patient's unwillingness to consent must be reviewed from an organisational/GMC perspective and the risk to the individual and the unit must be assessed.

110.063. Employment Restrictions and Deployment. If an individual is on the Unit VRM Register this will not automatically preclude them from attending courses or adventurous training, going on exercise or deploying. The MO will advise on medical employment restrictions and the individual's medical grade will be altered if necessary. Deployment on operations, however, will be a Command decision based on medical advice and the CO must complete AGAI 78 **Appendix 26** (Medical Risk Assessment), before deploying an individual who is on the Unit VRM Register. Employment restrictions may impact on promotion opportunities but being on the VRM register itself must not be considered as a bar to promotion. These decisions must all be formally recorded in the CAP.

110.064. Temporary Detached Duty. The majority of individuals with an open CAP on the VRM Register will still be able to attend courses or other periods of detached duty. The procedure in paragraph **110.063 above** must be applied in these instances. When attending a course or period of detached duty, the parent unit can either transfer the CAP lead responsibility to the Unit VRM Lead at the detached duty unit, or put in place local arrangements to ensure that the individual is managed appropriately whilst absent from their parent unit. All such arrangements must be recorded on the CAP with explicit consent from the individual for this sharing and / or transfer of information to ensure that the individual is supported whilst on temporary detached duty. If the individual is unwilling to provide consent then consideration as to whether the individual can attend the period of detached duty should be made.

110.065. Actions on Assignment. The accurate and timely transfer of an individual's open VRMIS record is essential when personnel are posted so that the new CoC are able to provide appropriate support. In addition, if an individual who is being assigned has a closed record (up to 3 years from the date of closure) on VRMIS, then this must also be transferred to the receiving unit prior to arrival using the process laid down in para **110.066 below**. The transfer of a closed record may be a contentious point, because the SP may wish to have a "fresh start" in the new Unit, and must be handled sensitively in discussion with the SP; explaining the issues of confidentiality and the CoC duty of care.

110.066. As soon as notification is received that an individual with either an open or closed record on VRMIS is to be assigned to another unit the following actions must be taken:

a. Losing Unit. The losing Unit VRM Lead must, in advance of the assignment date, contact the receiving Unit VRM Lead at the new unit and arrange to transfer the record across, irrespective of whether the record is open or closed.

b. Gaining Unit. Where the individual has an open record on VRMIS, the gaining unit must ensure they are fully read into the individuals circumstances and they must ensure that any necessary measures are put in place prior to arrival. On arrival, the normal frequency of individual case discussions / case conferences must be held in accordance with this AGAI and AGAI 57.

[45] Confidentiality guidance - Disclosing patients' personal information: General Medical Council.
[46] Information Sharing and Suicide Prevention Consensus Statement, Department of Health, January 2014.
[47] **AGAI 57** Annex G - Commanders' Guide to Medical Confidentiality.
[48] The Code: Professional Standards of Practice and behaviour for Nurses and Midwives. Nursing and Midwifery Council 2018.
[49] Senior Medical Support / Defence Union / GMC / Caldicott Guardian.

c. **Handover Date.** Both units must agree a date when the responsibility for an individual is passed between units and by which time both units will have satisfactorily handed over details of the SP on the VRM Register.

110.067. On moving between Training Establishments or from a Training Establishment into a Regular unit. An open record on the Unit VRM register must not be closed purely because an individual is moving between training establishments[50] or from a training establishment into a regular unit. It is essential that the flow of information continues and that the receiving unit is able to continue to provide support to an individual on the VRM Register. The process applies in all cases as per **paras 110.065 – 110.066 above**. There are no exceptions to this direction and being on the Unit VRM Register should not automatically preclude an individual from passing out of soldier or officer training but an AF B203 waiver may be required for someone who is downgraded in ITT and is being passed across to the Field Army.

110.068. Army Recovery Capability Assignment Board (ARCAB) applications and Assignment to a PRU. In accordance with AGAI 99[51], where an ARCAB application is made for personnel who have an open entry on the Unit VRM Register the unit must ensure that the VRM box is ticked on the AFB 10027A Application Form. If the assignment to the Personal Recovery Unit (PRU) is successful, then the losing unit must follow the direction given at **paras 110.065 – 110.066 above** and in accordance with Annex L of AGAI 99.

110.069. Service Custody Premises (SCP)[52]. If an individual who has an open record on VRMIS is sent to the Military Corrective Training Centre (MCTC) or a Service Custody Facility then the losing unit must contact the Unit VRM lead at the SCP and provide them with a copy of the CAP. The losing unit retains responsibility for the individual until they are either returned back to their unit after their custodial sentence is complete or discharged from service. The SCP will conduct their own assessment of the individual's wellbeing as part of their mandated detainee risk management procedures detailed in JSP 837, Part 2, Chapter 3, as part of this process which will be used throughout the duration of the individual's detention.

110.070. STAGE 4 – Closing Risk Conference and Closure of the CAP. COs must comply with the rules applicable to minimum time on the register for personnel who have conducted an act of self-harm as per **para 110.042 and 110.043 above**. For all other reasons there is no minimum (or maximum) time period for an individual to stay on the register. The CO (or their nominated empowered replacement) is the only person authorised to direct the closure of a CAP.

110.071. The decision to close a CAP must be made at a Closing Risk Conference, the details of which must be recorded as an entry on the CAP held on VRMIS before closure of the record. Attendance at the Closing Risk Conference should mirror the attendance at the Initial Risk Conference (details at **para 110.053. above**). The decision on closure of the CAP will be made in close collaboration with the immediate chain of command and pastoral, welfare and medical personnel, who will, taking all factors into consideration, decide if an individual is considered to be no longer at risk; what is key when making the decision to close a CAP is whether the underlying causative factors have been addressed and resolved.

110.072. Discharge from Service / End of Service. If an individual completes or is discharged

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[50] This includes from Basic Training (Phase 1 training) to Initial Trade Training (Phase 2 Training) or from Initial Trade Training to Supplementary Trade Training (Phase 3 Training).

[51] **AGAI 99** - Command and Care of Wounded Injured and Sick Service Personnel

[52] Service Custody Premises is the collective term for the Military Corrective Training Centre (MCTC) and all Service Custody Facilities (SCF) - Service Custody and Service of Relevant Sentences Rules 2009 (SCSRSR)

from service whilst still on the unit VRM Register (VRMIS), an assessment of the individual's needs must be made, regardless of the reason for discharge. Units identifying Transitional Welfare Requirement needs must use the Defence Transition Referral Protocol (DTRP)[53]. The DTRP identifies the needs of the SP that may endure beyond discharge / end of service and that require ongoing support. The earlier a referral is made, the easier it is for Defence Transition Service (DTS) or Veterans' Welfare Service (VWS) to provide the required support. The referral criteria, method and the process for engagement, timing of referrals as well as the relevant application forms must be completed in accordance with JSP 100 - Defence Holistic Transition Policy. The process is also described at: https://www.gov.uk/government/publications/defence-transition-referral-protocol-dtrp. This process also applies to those personnel on the Unit VRM register who are under 18 and / or in Basic training.

110.073. Closure of the CAP. The following action is to be taken once an individual is deemed by the CO to no longer be at risk following a Closing Risk Conference:

a. The CAP is updated with the details from the Closing Risk Conference and then closed on VRMIS. Where the individual remains in service the CAP will be retained on VRMIS as a closed record for a further three years, and then archived.

b. For individuals being discharged from service / end of service at the point of closure the record is to be updated including inclusion of the submitted DTRP proforma in accordance with **para 110.072 above** and then closed. The record can then be archived after 3 months.

c. For those with an open record on the Unit VRM Register at the time of their death, the CAP must be downloaded, and a copy forwarded to [redacted] by the Unit VRM lead so that it can be provided to the Coroner. If the death is subject to a Service Inquiry a copy will also be provided to the President of the Service Inquiry Board (by APSG for Army cases and relevant RN, RAF equivalents). Once this action has been completed the CAP should then be closed.

110.074. Creation of a unit SOP. Whilst a Unit may feel that there is benefit in the creation of a SOP regarding the use of the VRM process within its lines, any SOP must ensure that this AGAI is referred to in its entirety and not broken into parts or rewritten in any way. This requirement is because the full text of the AGAI is essential when dealing with the complexity of managing an individual at risk and the Annex structure presents easily accessible information. Any Unit SOP must explain how AGAI 110 is applied within the unit local circumstances, i.e. who has responsibility for what, both during working hours and silent hours. Unit Duty Orders must include the reporting requirements stated at **para 110.045 and 110.046**.

110.075 – 110.100. Reserved.

[53] Defence Transition Referral Protocol (DTRP) enables individuals with severe physical or psychological disablement or those considered as having an enduring welfare need with which they will require support post-service AND/OR Service leavers (and their families) who fail to meet this criteria, but who have transitional issues which are likely to impede their chances of a successful transition out of the military, to be referred or to self-refer to Veterans UK.

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ANNEX A TO CHAPTER 110

A GUIDE TO A UNIT VRM REGISTER AND USE OF THE VULNERABILITY RISK MANAGEMENT INFORMATION SYSTEM

General

1. The Vulnerability Risk Management Information System (VRMIS) is the system that is to be used by **ALL** units, (including Formation and Brigade HQ's), both Regular and Reserve as the Unit VRM Register. VRMIS is a command tool for the management of SP who are considered to be vulnerable to, and at risk of suicide or self-harm behaviours. Each record held on VRMIS forms the case history of the actions taken by the CoC to manage, support and care for the individual whilst they are considered to be at risk and will be referred to should there be a subsequent Service Complaint, Subject Access Request, Service Inquiry, Legal Proceedings or by the Coroner in the event of death.

2. The use of VRMIS is mandated for all Army personnel (Officers and Soldiers, both Regular and Reserve and regardless of whether they are sat in a Tri-Service, Naval or RAF unit/establishment[54]), including all Soldiers under Training (SuT) and on "Holdover", University Officers' Training Corps Cadets and RMAS Officer Cadets[55], and for all Naval Service or RAF Service personnel in Tri-Service units where the Army is the Service Lead who have been assessed at risk of suicide or self-harm behaviours. The system is to be used overseas (beyond operations) for all who come under Service law[56] where practicable.

3. VRMIS is a closed system and is strictly restricted to designated users (via their PUID), with only the Commanding Officer and the Unit VRM Lead having read-only access to all individuals records within the unit. All personal and medical data should be protected in accordance with the Data Protection Act 2018 (DPA 18), General Data Protection Regulation (GDPR) and Caldicott principles. Formal SyOps for VRMIS are available via the Army Information Front Door.

4. Commanding Officers must ensure that a culture of trust, confidential disclosure and non-stigmatisation of VRM issues is engendered in their unit. They are responsible for ensuring that the VRM process and the VRMIS system are used correctly within their unit and that all individuals considered to be vulnerable to, or at risk of suicide or self-harm behaviours are placed on the system and managed in accordance with this AGAI and that the Care Assessment Plan (CAP) on VRMIS is maintained and is up to date at all times.

5. Formations are responsible for ensuring that all of their Units have access to and are aware of their responsibility to use VRMIS for managing individuals assessed at risk in accordance with this AGAI.

6. VRMIS does not currently have the capability to provide Formations and Brigades with an overview of statistics for their units. Therefore if Formations & Brigades wish to have summary information from their subordinate units regarding numbers of personnel on the VRM register they must ensure that the information request does not allow for those individuals to be identified and that all data requests are fully compliant with Data Protection Act 2018 (DPA 18), General Data Protection Regulation (GDPR) and Caldicott principles.

[54] Navy Policy BRd 3(1) Chapter 24 and RAF Policy AP9012, Chapter 6
[55] Regardless of whether that is in Basic Training, Initial Trade Training or Officer training at RMAS.
[56] **JSP 770**, Annex A to Chapter 1 refers

Access, Roles and Responsibilities

7. **Access.** VRMIS, accessed via Defence Intranet or on Google Chrome using the following link: https://vrm.ahe.r.mil.uk/, is limited to only those personnel directly involved in the management of personnel on a Unit VRM Register.

8. VRMIS access is linked solely to an individual's PUID and not to their post or role within a Unit and is granted by the Unit VRM Lead. It is therefore paramount that when an Individual with access to VRMIS moves away from the Unit that their VRMIS access is withdrawn immediately. This is the responsibility of the Unit VRM Lead, who will reassign the CO or CAP Lead as necessary and then raise a call via the Army Information Front Door to have formal VRMIS access removed. If the departed VRMIS user requires VRMIS access at their new unit, it can be restored by their receiving Unit VRM Lead once they arrive in post.

9. Responsibility for giving Visibility (read-only) access on a CAP rests solely with the respective CAP Lead. The CAP Lead is responsible for the granting, ending or amending visibility on a CAP. The Commanding Officer and Unit VRM Lead have automatic read-only access because of the positions they hold within the Unit so separate visibility does not need to be granted.

10. **Roles.** There are four defined User roles within VRMIS:

a. The Commanding Officer. Self-explanatory and as per paragraph 4 above.

b. The Unit VRM Lead is the Unit VRMIS Point of Contact and will normally be the Adjutant although it can be the UWO[57]. This individual is responsible for managing and maintaining the Unit VRM Register held on VRMIS on a day to day basis directly on behalf of the Commanding Officer and must be appropriately trained for the Unit VRM Lead role at their respective pre-employment training[58].

c. The CAP Lead. The CAP Lead is normally someone in the individuals CoC and is responsible for creating, updating and maintaining the Care Assessment Plan on VRMIS. They should be at an appropriate level within the CoC as per para 110.055 in the main body of this AGAI.

d. Visibility. Any individual granted visibility will have read-only access to the record on VRMIS that the visibility is linked to. Normally this would be someone who is involved in the management, care and support of the individual on the Unit VRM Register, such as the UWO, Padre, MO, DCMH clinician, AWS. Visibility can only be granted with the express permission of the individual on the VRM Register in accordance with Para 110.060 of this AGAI.

11. **Management of Accounts.** The Unit VRM Lead is responsible for creating, transferring and deleting user accounts and granting access to VRMIS (apart from Visibility access to the CAP which is the responsibility of the respective CAP Lead).

12. The Unit VRM Lead is to transfer their responsibilities to a nominated replacement during any periods of absence (Leave, Long Courses, Deployments etc). This is completed by the Unit VRM Lead who initiates a "Bulk Transfer" of cases linked to their PUID (i.e. JonesB123) across to the nominated replacement, who will transfer all cases back to the formal Unit VRM Lead on their return.

[57] Or equivalent in a Reserve Unit
[58] All Arms Adjutants Course for Adjutants and the Unit Welfare Officers Course for Unit Welfare Officer

13. The Unit VRM Lead is also responsible for conducting a full handover of their role regarding the application of the VRM process within the unit and the Unit Register held on VRMIS to their successor and does this (transfer of Unit VRM Lead permissions and creation of the successors account) by using the Bulk transfer functionality in the VRMIS application.

14. The Unit VRM Lead is also responsible for updating the Commanding Officer and CAP leads as personalities change or CAP Lead responsibilities change for all unit entries on VRMIS. Where there are multiple records this can be completed quickly and efficiently using the bulk transfer functionality in the VRMIS application.

15. Responsibilities. The following summarises the responsibilities of each of the roles laid down in Para 10 above:

a. **Commanding Officer**. As the owner of the risk, the CO has automatic read only access of all CAPS in their unit.

b. **Unit VRM Lead**. The Unit VRM lead is responsible for managing the VRM process and maintaining the Unit VRM register on VRMIS on behalf of the CO. This task includes:

(1) convening the Initial Risk Conference and any subsequent risk conferences.

(2) creating register entries and assigning CAP Leads permission to manage Individuals.

(3) raising all internal (updating personnel in roles such as the CO and CAP Leads) and external transfers (on assignment of Individual).

(4) maintaining and updating the VRMIS users list within the unit.

(5) ensuring that all CAPs are up to date.

(6) ensuring that the formal assessment at the Commander's Monthly Case Review takes place in accordance with Chapter 3 of AGAI 57, Health Committees and that this is entered onto VRMIS by the respective CAP Lead.

(7) handing over to an appropriate individual when absent on leave or duty (using the Bulk Transfer function to update the VRM lead on all records).

(8) raising Unit Transfers where an individual with an open record on VRMIS, or with a closed record no older than three years old, is posted to another unit.

(9) handing over the Unit VRM & VRMIS responsibilities to their successor in a timely manner as per para 13 above.

c. **CAP Lead.** The CAP Lead is responsible for the day to day management and engagement with the individual and those supporting the individual on the VRM Register. In addition, the CAP Lead is responsible for:

(1) initiating the Care Assessment Plan (CAP) and maintaining a chronological summary of events, actions and measures on the CAP.

(2) adding and removing visibility on the CAP.

(3) uploading all documents pertaining to the case into the documents section of the CAP.

(4) ensuring that the CAP is up to date and that regular case management reviews with the individual are conducted and recorded and also the Commanders Monthly Case Review in accordance with AGAI 57.

(5) printing off the last page of the CAP, signing it along with the individual and recording this on VRMIS on the signature section of the CAP along with uploading the signed page into the documents section. Signatures from the individual are required when the CAP is first opened, when adding visibility and when the CAP is ready to be closed.

(6) ensuring that where a Defence Transition Referral Protocol form is completed that an event is recorded on the CAP and a copy of the completed form is uploaded onto the Documents section of the CAP.

(7) closing the CAP following a closing risk conference.

(8) following a death of an individual who has an entry on VRMIS, downloading the CAP and emailing it to the Unit VRM lead to allow them to follow the actions laid down in para 110.073.c of the AGAI main body.

16. User Guides. User Guides for the VRMIS application are available on the VRM page of the Army Information Front Door catalogue of applications: https://sr.ahe.r.mil.uk/ux/myitapp/#/catalog/home.

17. Application Issues. Individuals with any VRMIS application issues should raise a call in the first instance via the VRM Page on the Army Information Front Door catalogue of applications: https://sr.ahe.r.mil.uk/ux/myitapp/#/catalog/home by selecting the ***"****Report an Incident*" button and completing the "Report an issue with VRM" form.

18. Summary. VRMIS is an essential G1 Management tool in managing those individuals who are considered to be vulnerable to suicide or self-harm behaviours, but it **must** be used correctly. It is imperative that all commanders and managers embrace and utilise VRMIS to help manage those personnel assessed as vulnerable to suicide or self-harm behaviours.

19. Reserves. Reserve units are required to comply with the use of VRMIS in the same way as Regular units, noting that Reserve units do not have the same access to pastoral, welfare and medical support, the complexity of command relationships and timelines which may be affected by irregular attendance and access to resources.

ANNEX B

FLOW CHART OF THE VRM PROCESS

Has the individual already attempted suicide or self-harmed?

Yes → **Unit to report to Service Police** (para 110.046 refers) and **raise NOTICAS, INCREP and Learning Account** (para 110.045. refers)

Appointment with MO/GP

N.B. Basic training/U18's and recurrent and /or persistent acts of self-harm:

- If an individual has completed an act of self-harm and is in Basic Training or under 18 years of age, or has less than 3 years of service the CO may consider discharge in accordance with Army Manning Policies, QR(Army) Chapter 9, Para 9.434 - Soldiers Temperamentally Unsuitable, Promotions and Appointments Warrant (PAW) Para 196, JSP 950 Leaflet 6-7-7 (Section 5, Annex L) and taking advice as appropriate.
- CO's may also wish to consider the options available to them where Individuals undertake recurrent and/or persistent self-harm by referring to Army Manning Policies (including QR(Army) Chapter 9 section 5, PAW para 193 and JSP 950 (Leaflet 6-7-7 Section 5, Annex L) and taking advice as appropriate.

Stage 1 - Unit identifies an individual as 'at risk' of potential suicide or self-harm behaviours

The identification of an individual as potentially at risk of suicide or self-harm behaviours could originate from numerous sources: Medical practitioner, Unit Padre, Welfare staff, Colleagues, Line Manager, Spouse, Partner, Friend, Family (para 110.036-110.037 refer).

Refer also to **Annex C**.

Stage 2 - Initial Risk Conference convened.

Anyone who undertakes an act of self-harm or threatens suicide **must** be placed on the Unit VRM Register.

For all other reasons the decision made to place someone on the Register will be based on the facts presented by all parties around the table, **Annex C** and military judgement.

Stage 3 - Ongoing Management, Engagement and Care of individual comprising of:

- Care Assessment Plan creation and maintenance
- Ongoing engagement with individual (Individual Case Management)
- Formal Commanders Monthly Case Review (**AGAI 57** Chapter 3 refers)

N.B. Minimum time on the VRM Register:

- Instances of Self Harm (regardless of Intent) automatically placed on Unit VRM Register for **a minimum period of 12 months** (para 110.042 refers) .
- Suicide Threats or active ideation warrant **a minimum of one month** on the Unit VRM Register (para 110.043 refers)
- **No minimum mandated time period** on the Register for any other reason. (para 110.070 refers).

Stage 4 - Closing Risk Conference and CAP Closure

Review the case, have causative factors been resolved?

What is key when making the decision to close a CAP is whether the underlying causative factors have been addressed and

Discharge / End of Service?

If the individual on the VRM Register is being discharged or has reached the end of their Service ensure you complete the

Yes

Defence Transition Referral Protocol (DTRP) in accordance with **JSP 100**, regardless of reason for Discharge (para 110.072 refers).

Record on VRMIS to be archived after 3 months from date of discharge/ end of service.

Individual removed from Unit VRM Register after Review

Individual risk assessed as no longer vulnerable to suicide or self-harm behaviours with all underlying issues resolved.

Record to be closed on VRMIS and archived after 3 years.

Deceased?

Download CAP from VRMIS and forward to

[redacted]

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ANNEX C

A GUIDE TO PROTECTIVE AND RISK FACTORS AND RECOGNISING DISTRESS IN INDIVIDUALS

1. Suicide and self-harm behaviours are complex and often occur when life stressors converge to overwhelm the individual. Suicide behaviour in the military is not always associated with mental illness but some of the factors that lead to suicide may also be causative in mental ill health and vice versa. This policy is specifically about the risk of suicide and self-harm behaviours but the holistic risks that should be considered are below.

2. Everyone has a different level of tolerance to stress and this varies throughout their lives, influenced by internal and external factors. While there is no 'typical' profile for someone who may contemplate suicide or self-harm behaviours, there are some common risk factors that should be understood in an effort to save lives. *Knowing your people* means that you are likely to recognise behavioural changes as they appear, and these changes should warrant discussion with the individual, Officers and Soldiers alike.

3. Extensive research into suicides has shown that where certain factors are present in an individual's life, they will inherently be less likely to contemplate suicide. These protective factors[59] are known as 'Life Anchors' and include:

a. Unit cohesion, camaraderie, a sense of belonging and loyalty.

b. Peer friendship and support.

c. Good social skills.

d. Social and family support[60] and a sense of inter-dependence.

e. Marriage / long term stable relationship (strengthened if there are dependent children)[61].

f. Physical and mental activity where there is a sense of purpose.

g. Participation in and membership of a community or club(s).

h. A measure of personal control over life and its circumstances.

i. Religious[62], spiritual and moral context and awareness.

j. A willingness to engage and easy access to supporting resources.

Some of these Life Anchors are personal and cannot be externally generated, however supportive measures can strengthen the personal support to those at risk.

[59] STO-TR-HFM-218 Military Suicide Prevention: Report prepared for NATO Leadership June 2018, Chapter 3.. Protective and Risk Factors for Military Suicide. Protective factors are defined as individual, relational, community and societal factors that "buffer" individuals from suicidal thoughts and behaviour.

[60] Resnick, M.D., Bearman, P.S., Blum, R.M. *et al*. Protecting adolescents from harm: findings from the national longitudinal study on adolescent health. *J Am Med Assoc*. 1997;278(10):823-832.

[61] Smith, J.C., Mercy, J.A. and Conn, J.M. Marital Status and the risk of suicide. *Am J Public Health*. 1988;78(1):78-80

[62] Dervic,K., Oquendo, M.A., Grunebaum, M.F., Ellis, S., Burke, A.K. and Mann, J.J. Religious affiliation and suicide attempt. *Am J Psychiatry*. 2004;161:2303-2308

4. Risk factors are those factors that potentially increase the possibility of suicidal behaviour and can be individual, relational, community and societal factors. The following risk factors, in no significant order, have been associated with suicidal or self-harm behaviour in the UK military:

a. **History of Previous Suicide Attempts.** A previous suicide attempt is recognised as the single most significant predictor of suicidal intent[63].

b. History of Self-Harm. Self-Harm refers to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation[64]. Self-Harm is a maladaptive coping mechanism and some incidents of self-harm may be just a way of coping or expressing overwhelming emotional distress. However, evidence[65] in the general population shows that a previous history of self-harm is the strongest risk factor for future suicide. Whilst a previous episode of self-harm does not necessarily mean that an individual has any intent to complete suicide, the risk increases if action is not taken to resolve the difficulties, perceived or real, and the underlying reason for self-harming. There is also significant evidence of four risk factors that are associated with a higher risk of dying by suicide following a self-harm event: previous episodes of self-harm, suicidal intent, poor physical health and male gender[66].

c. Family History of Suicide. Suicidal behaviour within families is well recognised and a family history of completed suicide and/or psychiatric illness significantly and independently increase suicide risk. Family history of suicide should be recorded in the assessment of suicide risk[67].

d. Suicide Ideation. Suicide ideation is the term used to describe thinking about the act of suicide. Suicide ideation can be active or passive. Active suicide ideation includes making plans and having the intent to follow through on those plans. Passive suicide ideation includes thoughts of wishing to die, such as the wish to die during sleep, to be killed in an accident, or to develop terminal cancer. Suicidal ideation, active or passive reflects an **ongoing change in the individual's state of mind and all disclosures of suicide ideation must** be taken seriously and investigated. *Where an individual expresses active thoughts of, or threatens, suicide the individual should automatically be placed on the Unit VRM register for a minimum period of **one month** to allow a full assessment of the risk factors to be conducted and for the case to be formally reviewed as part of the Commander's Monthly Case Review process[68].*

e. Mental Health Referral or Diagnosis[69,70]. Emerging or established symptoms of a mental disorder, or recent psychiatric diagnosis are key risk factors for suicide behaviours. Specific mental disorders such as depressive illness are associated with, or predictors of suicide; Post Traumatic Stress Disorder (PTSD)[71] is a risk factor for suicide behaviour and evidence shows that it is most significantly related to suicide when it occurs alongside depressive illness or moral injury. Sleep problems are a substantial feature of many mental

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[63] Indu, P.S., et al. (2017) Prevalence of depression and past suicide attempts in primary care. Asian Journal of Psychiatry, 27, 48-52.
[64] NICE QS34 dated June 2013
[65] Hawton, K., Zahl, D., Weatherall, R. (2003). Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. The British Journal of Psychiatry, 182 (6), 537-542.
[66] Chan, M.K., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R.C., Kapur, N. and Kendall, T., 2016. Predicting suicide following self-harm: systematic review of risk factors and risk scales. *The British Journal of Psychiatry*, *209*(4), pp.277-283.
[67] Runeson, B., & Asberg, M. (2003) Family History of Suicide Among Suicide Victims. The American journal of Psychiatry, 160(8), 1525-1526
[68] AGAI 57,Chapter 3, refers.
[69] Goldstein, T.R., Ha, W., Axelson, D.A. et al. Predictors of prospectively examined suicide attempts among youth with bipolar disorder. Arch Gen Psychiatry. 2012;69(11):1113-1122.
[70] Ilgen, M.A., Bohnert, A.S.B., Ignacio, R.V. et al. Psychiatric diagnoses and risk of suicide in veterans. Arch Gen Psychiatry. 2010;67(11):1152-1158.
[71] Griffith, J. Suicide and war: The mediating effects of negative mood, posttraumatic stress disorder symptoms, and social support among Army National Guard soldiers. Suicide Life Threat Behav. 2012;42(4):453-469.

disorders; research shows that poor sleep in the presence of mental disorder symptoms is associated with increased suicide risk[72].

f. Discharge from a Mental Health In-Patient Facility. Patients who have been hospitalised with a mental illness and discharged will be followed up by the DCMH within 7 days but should be considered as high risk and assessed and monitored by the CoC accordingly.

g. An unexpected/sudden or 'miraculous' apparent improvement in mental state. Some individuals who have made up their mind that they are going to complete suicide may suddenly appear to have improved and no longer present a risk. This can be because they have a firm plan and are "at peace with themselves". They may genuinely feel better once they have made the decision to end their lives and identified the means; they will then have the energy to wrap up loose ends, see others, say goodbye and generally exhibit signs of apparent improvement or resignation.

h. Relationship Problems. Relationship problems, particularly the breakdown of a relationship or marriage, are a significant risk factor associated with suicide behaviours[73] [74]. Relationship issues may be both the underlying cause of distress and the provocation factors that lead to suicide and self-harm behaviours at that time. Sexual infidelity or enforced separation from children, particularly where the relationship has become toxic, will significantly exacerbate the risk and additional support should be provided.

i. A Sense of Powerlessness, Helplessness or Hopelessness. A sense of hopelessness, induced by despair, is a significant underlying symptom of many suicidal behaviours. Combined with a feeling of powerlessness or helplessness to make things better, and an absence of any hope or apparent escape options from an intolerable situation, some individuals will simply give up. However, it does not necessarily follow that an individual will translate that despair into a desire for death or into suicidal intent.

j. Loneliness. The way that we live, work and communicate to each other has shifted as society has become more digital and may lead to loneliness. Loneliness is about the connection with other people rather than just being in contact, so it is possible to be lonely when in the company of others. New recruits on joining the Army may be away from their previous friends and family for the first time and in some cases will be experiencing a change in culture and conditions, as well as discipline and demands. In the older military population, the "over 37s package" or unaccompanied service can lead to loneliness, particularly after a relationship breakdown, with no family to go home to, and may be exacerbated during periods of block leave.

k. Poor social skills including difficulty interacting with others (social and emotional isolation). Social isolation is an absence of social relationships and can be a precipitating factor for suicidal behaviour. This may be more prevalent in those who have poor social skills and as a result have difficulty creating friendships, maintaining contact or interacting with people both within and outside of the workplace. Emotional isolation occurs when someone is unable or unwilling to share their emotions with others. Someone may be reluctant to discuss anything other than the most superficial matters. Without

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[72] Weber FC, Norra C, Wetter TC. Sleep Disturbances and Suicidality in Posttraumatic Stress Disorder: An Overview of the Literature. *Front Psychiatry*. 2020;11:167. Published 2020 Mar 10.
[73] Ide, N., Wyder, M., Kõlves, K., & De Leo, D. (2010). Separation as an important risk factor for suicide: A systematic review. Journal of Family Issues, 31, 1689-1716.
[74] Why Might Men Be More at Risk of Suicide After a Relationship Breakdown? Sociological Insights Jonathan Scourfield, PhD and Rhiannon Evans, PhD

emotional support, they may feel “shut down” or numb. Emotional isolation can occur due to social isolation, yet a person may feel emotionally isolated despite having a social network. Relationships are necessary for our well-being, but they can be a source of conflict which triggers negative feelings and thoughts.

l. Social Media. There is increasing evidence that the Internet and Social Media can influence suicide behaviour[75]. The risks include; cyberbullying and cyber harassment, trolling and posting unwanted images of the person on social media. Social media can make people feel lonely and isolated or inferior when they see the apparent perfect lives of others and what they post may be an indicator of distress. Being socially rejected on social media can increase suicide risk especially for those with poor coping skills. Individuals considering suicide may post their intent on social media prior to completing the act and this can provide an opportunity for intervention. Personnel should be actively encouraged to immediately report any concerns about colleagues that are broadcast over social media.

m. Sexual Abuse and Bullying. Sexual abuse and bullying (verbal, social, physical, cyber) are associated with substantially increased suicide risk irrespective of the context in which they occur; pre-service, during deployment or during service life more generally. Sexual assault and bullying may have a wide array of consequences including an increased risk of mental health issues and suicidal behaviours in both the perpetrator and victim.

n. Significant Loss (Death of Someone Close). Death of a loved one can cause intense emotions, particularly when the death is unexpected, even more so if that death is by suicide. The suicide related death of a spouse or child can be especially stressful. Specific long-term stressors associated with the death of a loved one include; change of routine, loss of emotional support, increased responsibility for family and financial hardship. Social withdrawal and the desire to be left alone is a common reaction to bereavement and important dates and anniversaries of a death are times when the person is significantly more vulnerable.

o. Current or Pending Disciplinary or Legal Action. Investigations, particularly those conducted by the SIB or civil police, are usually drawn-out, time-consuming and stressful for the individual being investigated. This is compounded by the fact that legal outcomes may be difficult to anticipate and thus will generate anxiety. Individuals facing serious legal problems may feel shame worry about being disgraced and the detrimental impact on their family and career. Whilst under investigation or facing disciplinary action, special vigilance should be maintained particularly for individuals with a history of anxiety, depression or alcohol abuse.

p. Investigations in Relation to Sex Offences. Extreme care must be taken of an individual who is under investigation for sexual offences or child pornography. This situation is stressful not just for the individual being investigated but also for the victim of the crime and indeed witnesses. Units must ensure that victims are supported in accordance with JSP 839[76]. Confidentiality relating to the alleged offence must be carefully guarded and all care and support must be entirely non-judgemental. Commanding Officers must bear in mind that some of their colleagues may find it difficult to provide appropriate help in such a situation and the support of family and friends, normally so vital in mitigating risk, is by no means guaranteed. In principle, any investigation for a sex related offence should warrant an individual being placed on the Unit VRM Register.

q. Alcohol Misuse. Alcohol misuse may be associated with distress and is often linked to a wide array of other problems that degrade effectiveness at work and personal quality of life.

[75] Luxton DD, June JD, Fairall JM. Social media and suicide: a public health perspective. *Am J Public Health*. 2012;102 Suppl 2(Suppl 2):S195-S200. doi:10.2105/AJPH.2011.300608

[76] Code of Practice on Services to be provided by Armed Forces to Victims of Crime

People undergoing stressful life events may turn to alcohol to help alleviate their distress through 'blocking out' the real world. Significant amounts of alcohol can act as the stimulant to induce an impulsive, spontaneous and irrational desire to complete suicide. Heavy drinking, often culminating in an inter-personal difficulty such as an argument with a close friend or the apparent break-up of a relationship, may lead to an alcohol-induced corrosive and impetuous desire to complete suicide.

r. CDT Failure. Personnel who fail a CDT test may respond to the knowledge that their career in the Army is over with a variety of reactions that can include suicidal behaviour. *In principle a CDT failure should warrant an individual being placed on the Unit VRM Register* and for the individual to be managed as part of any transition in accordance with this AGAI and the Defence Transition Referral Protocol (DTRP) as laid down in JSP 100 and at https://www.gov.uk/government/publications/defence-transition-referral-protocol-dtrp. Note that in some cases CDT failure may be used as a mechanism for rapid discharge from Service and there is no risk of suicide or self-harm.

s. Gambling Problems/Addiction. Gambling problems and addiction can have many adverse consequences such as financial distress and debt, relationship breakdowns, social isolation, and impairments to both mental health and wellbeing. Research[77] shows that problem gamblers are six times more likely to have suicidal thoughts or try to take their own life.

t. Financial Problems. Financial challenges can arise from mismanagement, unanticipated emergencies, or behaviours such as gambling or alcohol abuse. Financial hardship can affect all ranks, single parents, newly divorced / separated individuals and newlyweds and those becoming parents for the first time; all groups of personnel who have a changed circumstance financially and / or emotionally. Warning signs of financial problems include repeated use of advance pay, creditors calling for payments, repeated borrowing from friends, and being unable to buy essentials (such as food). Financial strain can cause personality and behavioural changes in an individual and has been linked to considerable stress and depression which can impact on work performance and interpersonal relationships.

u. Serious Medical Problem. Diagnosis of chronic and/or terminal illness is an acute source of stress and need for adjustment and carries a high risk of suicide. During an illness, many life activities can be disrupted which may result in a state of crisis for the individual. They may experience intense feelings of anxiety, fear, depression and hopelessness. The medical problem may have potentially significant financial and career impact, especially if it is long term. The development of an illness can also create problems in social interaction. New responsibilities may fall to the person's spouse and children, creating additional challenges for a family. Those on long term sickness absence should be managed in accordance with AGAI 78, AGAI 99 and JSP 100 as appropriate.

v. Domestic Abuse. Physical violence, verbal and emotional abuse are all linked with an increased risk of suicide related to the duration, frequency and severity of abuse. The perpetrator of domestic abuse may be at increased risk of suicide once the abuse has been exposed and they are subject to disciplinary and/or legal action.

[77] Wardle et al, Problem gambling, suicidal thoughts, suicide attempts and non-suicidal self-harm - May 2019 and John et al, Exploring problem gambling, loneliness and lifetime suicidal behaviours – June 2019

w. LGBTQ+. The LBGTQ+ group has a two-fold increase of suicide attempts under the age of 25; this is related to a perceived rejection by peers or parents when disclosing sexuality or sexual preferences[78] and a confused sense of identity.

x. Adult at Risk. Adults at Risk (previously known as Vulnerable Adults) are defined[79] as any person aged 18 years and over who is or may be in need of community care services by reason of mental health issues, learning or physical disability, sensory impairment, age or illness and who is or may be unable to take care of themselves or unable to protect themselves against significant harm or serious exploitation. Guidance on Safeguarding vulnerable groups such as these is provided in JSP 834[80] and JSP 893[81] and AGAI 119[82]. The Adults at Risk category will be particularly relevant wrt individuals on WISMIS or those on the Vulnerable Persons Register held by DPHCS[83].

y. Performance at Work. A history of service-related discipline events or a change in job performance and / or personal behaviour at work may signal problems in the workplace. Indicators include tardiness, attitude problems, poor concentration, an inability to complete jobs on time, broken promises of specific achievement, and lack of participation in organised activities. These changes may specifically indicate mental illness or may be the result of other problems such as being overwhelmed by the work, under trained for the job, relationship difficulties with superiors or subordinates, or a lack of responsibility, satisfaction or recognition for their work. Physical problems affecting work performance that entail frequent doctor's appointments, and complaints such as fatigue and sleep problems may also be indications of stress.

z. Service Inquiries and Service Complaints. The investigations into Service Inquiries (SI) and Service Complaints (SC) are frequently drawn-out, time-consuming and stressful for the individuals being investigated, those with unit responsibility as well as the person who has initiated the complaint. This is compounded by the fact that outcomes may be difficult to anticipate and thus can generate considerable anxiety. During a SI or whilst under investigation for a SC special vigilance should be maintained particularly on those individuals with a known history of anxiety, depression, self-harm or alcohol abuse. Other formal investigations may also provoke distress and individuals must be carefully assessed and supported.

aa. **Deployments.** There is little evidence to suggest that deployment alone is associated with heightened suicide risk, although suicides that have occurred during deployment have involved the use of an issued weapon. On operational deployments, there may be no or limited ‘down-time’ for relaxation with little or no privacy; equally, boredom can be a problem. Those who have welfare or relationship concerns at home will be especially vulnerable to suicide behaviours, particularly if they are unable to communicate with home regularly or feel unable to do anything about the situation. A sense of powerlessness or hopelessness in such a situation can be corrosive and can lead to impulsive suicide behaviour.

bb. **Re-adjustment from Operations.** Some individuals may have a protracted readjustment on their return from Operations (regardless of the nature of the Operation) which may result in suicidal thoughts. An initial period of normalisation should be expected on return from any Operation, regardless of the nature of the Operation. Guidance is provided in ACSO 3209[84] and the booklet Coming Home – A Guide for Army Personnel

[78] **Understanding Suicidal Distress and Promoting Survival in LGBT Communities**
[79] The Care Act 2014
[80] **JSP 834 - Safeguarding Service Children and Young People**
[81] **JSP 893 -Policy on Safeguarding Vulnerable Groups**
[82] **AGAI 119–** Army Policy for Employment Checks on Personnel for the Purpose of Safeguarding Vulnerable Groups
[83] DPHC General Practice SOPs- GN 07/18 Vulnerable Persons Register
[84] **ACSO 3209-** Land Post Operational Stress Management

Returning from Operational Duty[85], that should be issued to all personnel on return from Operations. The CoC should be aware of important dates and anniversaries of a death/deaths that occurred on operations which can make individuals vulnerable at that specific point in time. Coroners' Courts or any other court hearings or inquiries that takes place in relation to events that occurred on Operations may cause distress which can provoke suicidal behaviour.

cc. **Transition (Early Service Leavers, Retirement, Administrative or Medical Discharge).** Transitioning from the military into the civilian environment will have a significant impact on an individual. It is not only a job transition but may also produce a change in lifestyle and social status. Although most personnel look forward to this next phase of life as a new challenge, the multitude of changes that occur may be stressful. The individual may feel threatened by civilian culture which is alien to them, experience a loss of prestige, and be concerned about the overall transition. In cases of sudden discharge, commanders must make reasonable efforts to assist individuals in adapting to the civilian environment. When undergoing an administrative or medical discharge, an individual will usually experience significant stress. Stressors may include impending unemployment, financial problems, housing concerns, family disappointment, and feelings of failure and reactions to such stressors can include suicidal behaviour.

RECOGNISING STRESS VULNERABILITY IN INDIVIDUALS WITH IDENTIFIED RISK FACTORS

5. Significant, prolonged and/or perceived unmanageable stress can lead to the development of unhealthy behaviours, including potentially suicidal behaviours. The people who see an individual every day are in the best position to recognise changes and to provide support.

6. Any observable change in behaviour should warrant further discussion with the individual and, where appropriate, further investigation by the chain of command, unit padre, unit welfare staff and / or a medical referral or AWS referral. The people supporting the individual exhibiting these behaviours must be comfortable approaching the CoC and appropriate SMEs for advice and they must understand how to access this resource.

7. Significant, prolonged and/or unmanageable stress may cause one or more of the following behavioural changes:

a. Excessive, abnormal or irrational mood swings.

b. An apparent inability to concentrate or focus on issues at hand.

c. Sleep problems (initiating, maintaining sleep or early wakening).

d. A lack of energy or apparent listlessness.

e. A significant change of appetite; usually a loss of appetite or abnormal eating habits /eating at inappropriate times.

f. Significant changes in alcohol use, particularly anti-social drinking or heavy drinking outside social occasions.

[85] **Coming Home – A Guide for Army Personnel Returning from Operational Duty** - AC64539

g. Impulsive or reckless behaviour, such as binge drinking, fighting or inflicting self-harm, drink driving, gambling, inappropriate disclosure or excessive bragging about high risk behaviours.

h. Poor anger control, such as throwing objects or swearing / yelling at a superior or subordinate or domestic violence.

i. An apparent lack of capacity for enjoyment.

j. An inability to participate in or enjoy recreational or physical activity.

k. A sense of helplessness or hopelessness.

l. Deteriorating relations with friends and peers.

m. Deteriorating work performance for no apparent reason.

n. Disenchantment with the Army or wish to PVR.

8. The risk of suicide or self-harm behaviour is increased if any of the changes described above can be linked to a situation where a person appears to have:

a. No friends or anyone who trusts or likes them.

b. Few inhibitors or reasons not to kill themselves.

c. A view of themselves as worthless.

d. Excessive guilt or shame – perceived or real.

e. An inability to stop negative thinking.

f. A strong sense of pessimism about life's problems.

g. An obsession about death and dying.

h. A desire to give away possessions.

i. Excessive sorrow or regret about life or past events.

j. An inability to see a future without pain.

k. A perceived loss of control over their life or life circumstances.

l. A tendency to challenge people in an aggressive manner.

9. Where risk factors are present and a person discusses or talks about any of the following, even apparently joking, then the risk of suicide may be very real indeed:

a. A desire to die.

b. A suicide plan.

c. Access to the method of suicide described.

d. Stating they intend to complete the plan.

e. Settling affairs or saying goodbye to people in unnatural circumstances.

f. Planning or writing a suicide note.

IF YOU FEEL THAT SOMEONE maybe at risk of suicide or self-harm either by verbal or physical intent/indications the following actions **must** be taken:

A – ASK	Do not be afraid to ask someone if they are thinking about suicide.
I – INTERVENE	Taking no action is not an option if a person's life is at stake.
D – DISCLOSE	Everyone can help. Respecting someone's privacy is pointless if they are dead.

We all have a role to play in Suicide Prevention.

Remember:

- Take time to talk to each other.
- Listen without judging and be interested in what they are telling you.
- Reinforce that seeking help in times of distress displays courage, strength, responsibility, and good judgment.

IT IS IMPORTANT TO EMPHASISE THAT ASKING SOMEONE IF THEY ARE THINKING ABOUT SUICIDE WILL NOT PLANT THE SEED IN THEIR MIND.

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ANNEX D

A GUIDE TO THE MANAGEMENT AND CARE OF THOSE ON THE UNIT VRM REGISTER

1. When an individual has been identified as at risk of suicide or self-harm behaviours, a pragmatic management and Care Assessment Plan (CAP) must be created and followed through, to mitigate the risk of suicide. The response may be complex and time consuming and require a number of actions to address multiple factors, with continuous review of the evolving situation. This is not a “tick box” exercise to say that the factors have been considered; the CAP is a dynamic process and requires active management to address the issues facing the individual.

2. A suicide prevention response is successful if it prevents suicide, which can be impossible to prove, whereas failure of the process is all too obvious. Despite good leadership and careful management, some individuals will complete suicide; some will not have been identified as being at risk, sometimes the response will have been inadequate, insufficient or inappropriate. In many cases, measures will be put in place where the risk might actually be assessed as low but **‘doing nothing is never an option’**.

3. The creation and delivery of the CAP is an essential part of AGAI 110 policy. The CAP will invariably involve many agencies and, most importantly, the engagement and consent of the individual in most aspects of the plan. It is likely to involve a combination of physical measures (such as limiting access to weapons), professional help and maximising other protective factors.

a. The CAP is a summary of events, actions and measures aimed at addressing the issues affecting the individual.

b. The CAP lead must record details of the conversations that take place between the individual’s OC and the individual both before and after the initial risk conference as mandated in para 110.058 of the main body of this AGAI.

c. The CAP must record relevant information relating to the mood, behaviour and situation of the individual, including any changes.

d. The CAP should record how the individual is coping with the actions and measures set down in the plan.

e. The CAP should record details of visits, phone calls, informal and formal discussions and conversations with the person on the register, to support them or evaluate their progress and care:

(1) All entries should be specific and meaningful.

(2) Recording “no change” or “NFTR” is not acceptable.

f. The CAP must record if the individual is not engaging.

g. If the individual on the VRM Register self-harms then an entry must be made providing information about the circumstances of the incident, method used etc.

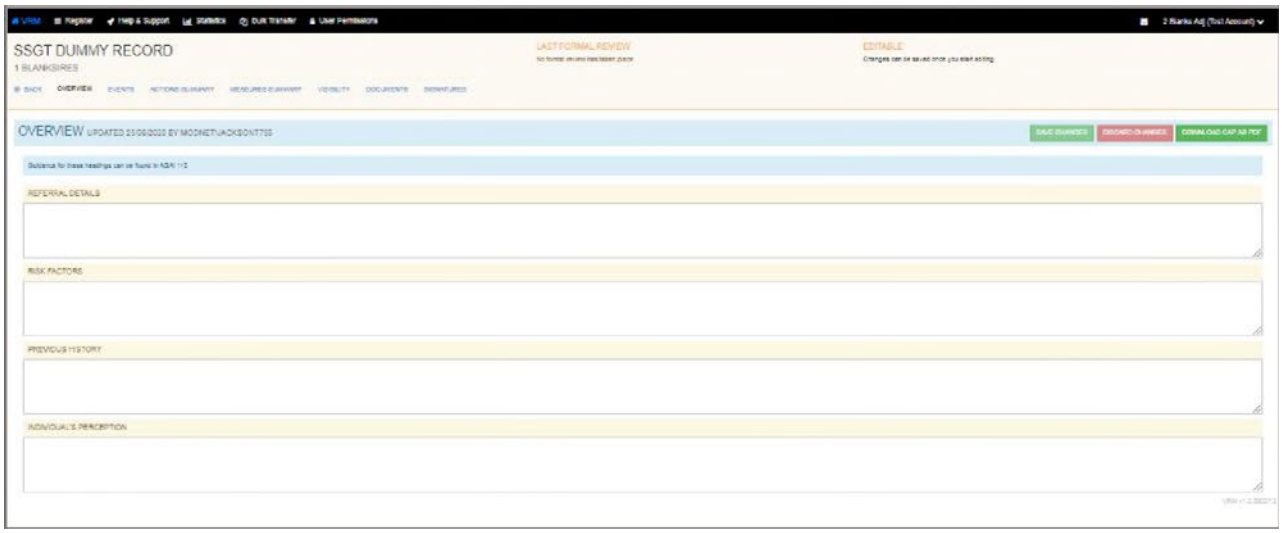
h. The CAP must record a summary of any Case Discussions and the formal Commanders Monthly Case Review part of the UHC, and any respective actions or measures.

i. The CAP should record details of other support (provided by the UWO or Padre for example) or referrals to professional agencies such as AWS.

4. The process for initiating and completing the CAP is detailed in the User Guides that are available via the VRM page on the Army Information Front Door, however a short extract is provided below: https://sr.ahe.r.mil.uk/ux/myitapp/#/catalog/home

5. Once the CAP is initiated the CAP lead (who is the only person with edit rights on the CAP) must complete the "Overview" page of the CAP. The "Overview" page consists of four boxes that must be populated:

a. Referral Details,
b. Risk Factors,
c. Previous History,
. Individual's Perception.



- **Referral Details:** This should detail how you have become aware of the issue. For example, medical referral, padre, welfare staff, colleagues, chain of command, spouse, partner, family, friends and the nature of the referral.

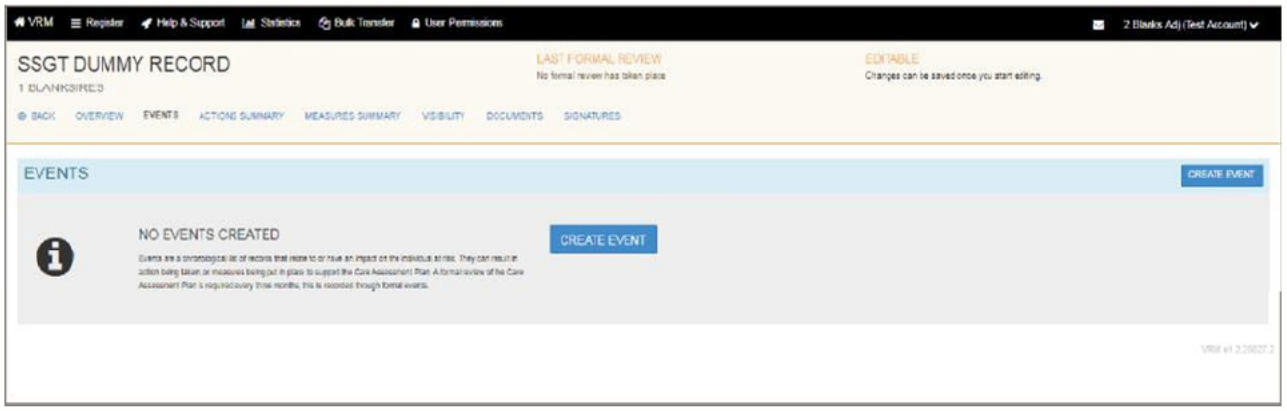
- **Risk Factors**: Risk factors are characteristics that make it more likely that the individual will consider or attempt suicide or self-harm. Refer to Annex C of this AGAI for details of Risk Factors.

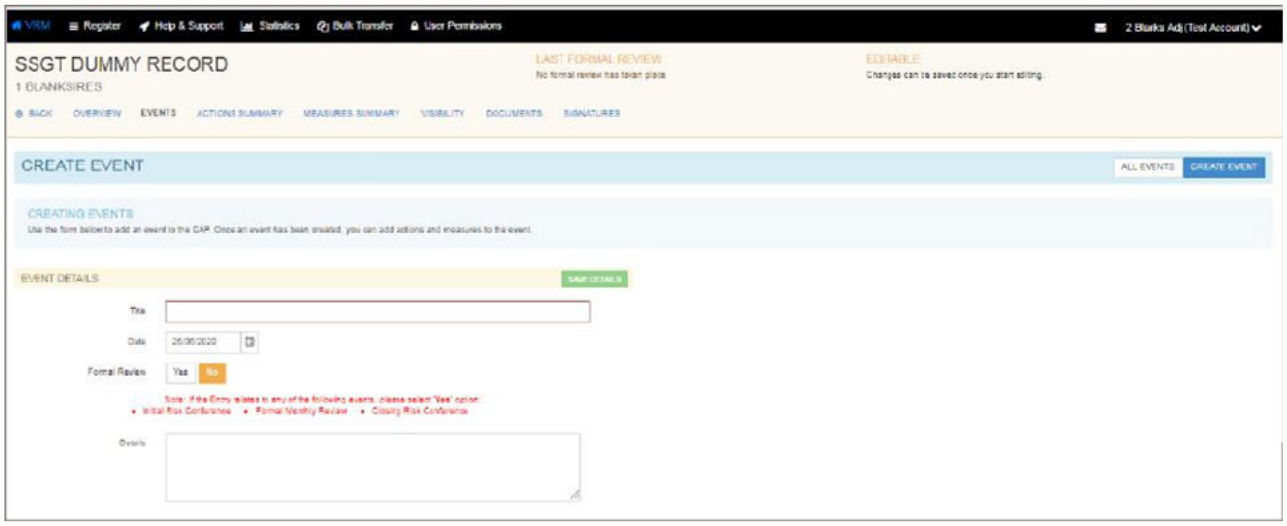
- **Previous History**: Is there any recorded history of risk factors or previous incidents or events - has the individual disclosed anything?

- **Individual's Perception**: Engagement with the Individual is key. Does the individual feel that there is no solution to their current issues? Is the individual willing to engage?

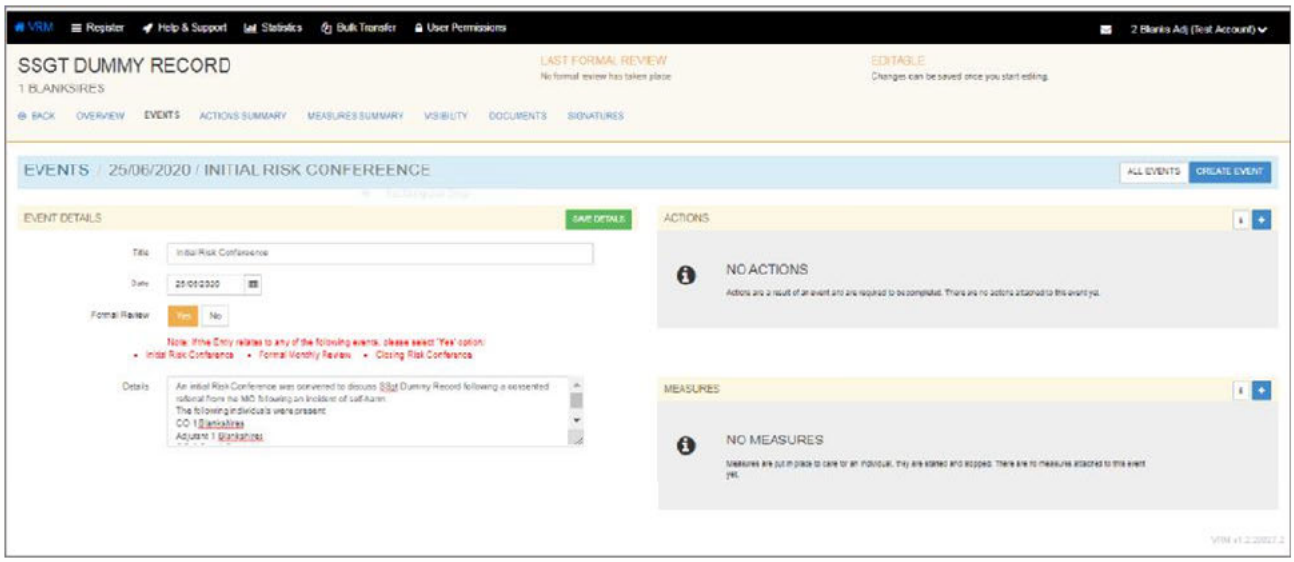
6. Once the CAP lead has completed the "Overview" page, the CAP Lead can then start the process of recording the events, actions and measures that take place throughout the time that the CAP is open which are aimed at both managing and supporting the individual and addressing the

causative factors. The chronological version of events is created by the CAP lead using the "**E**vents" page of the CAP:





Once the event has been created (and saved) the following additional options to add Actions and Measures linked to each Event appear. Not all events will have an Action (to do list) or Measure (protective measures such as removal from guard duty, remove access to firearms or live ammunition, providing supervision etc):



7. The CAP should also be used to formulate a coping strategy and plan with the individual who has been assessed at risk to assist them in coping and dealing with their current crisis or issues impacting on them. The actions decided on by the CoC and those supporting the individual should work towards this plan.

8. The individual and the CAP Lead are both required to sign the CAP when the CAP is first initiated and (after the last entry) prior to closure and this must be recorded in the “Signatures” page on VRMIS and a copy of the signature page uploaded into the “Documents” page of the CAP. Full details on this process are detailed in the user guides for the VRMIS application located at https://sr.ahe.r.mil.uk/ux/myitapp/#/catalog/home. These signatures provide confirmation that the individual has been made aware that they have been placed on / removed from the CAP in accordance with para 110.054 and 110.058 of this AGAI. If the individual refuses to sign the CAP this should be recorded as an entry on the CAP along with the reason why. The same signature process is applicable when the individual provides consent for information sharing permissions to be given, in accordance with para 110.060.

9. The regular Individual Case Management (ICM) review must take place in accordance with para 110.059. and AGAI 57 and these must be fully recorded as an entry on the CAP and tagged accordingly (as a formal review). The ICM review comprises a series of discussions between the individual, CoC and those involved in their management and care. The following format is suggested:

a. Context.

b. Actions taken since last review.

c. Actions to be taken.

d. Review of control measures.

e. Review safeguarding.

f. Discuss the proposed end state.

g. Agree steps to take.

h. Agree decision points

10. The above format is also suggested for the monthly Commanders Case Review. This will provide both assurance to the Commanding Officer that the individual is being managed appropriately, whilst fulfilling their moral and legal duty of care responsibilities in accordance with para 110.031.

11. It is important to remember that each record held on VRMIS forms the case history of the actions taken by the CoC to manage, support and care for the individual whilst they are considered to be at risk. The CAP will be referred to and a copy provided should there be a subsequent Service Complaint, Subject Access Request, Service Inquiry, Legal Proceedings or by the Coroner in the event of death.

12. A number of generic responses that could be incorporated in the CAP and used to support an individual who is on the VRM Register are listed below. This list is not exhaustive and these are just some possible options which can be selected to suit individual circumstances and must be reviewed as circumstances change. Common sense, military judgement and a supportive CoC are

key. **The key to suicide prevention is to increase the protective factors and to decrease the risk factors whilst seeking to address the underlying issues.**

SER (a)	RESPONSE (b)	EXPLANATION (c)
1	Identify the underlying causes of suicide or self-harm behaviours	Identification of underlying risk factors requires careful and possibly prolonged discussions and interviews, often by the CoC, UWO, Padre or professional agencies, as well as consultation and advice from family, friends and colleagues. Once the underlying problems have been identified, it should be discussed with the individual what steps are being taken to support them. The CoC and any welfare, pastoral or medical services must work closely with the individual to help them resolve these issues. Honesty is essential and "broken promises" could have a significant negative impact on the individual.
2	Medical referral	Although the suicide or self-harm behaviour may be unrelated to mental ill-health, consultation for medical advice and referral is mandatory for any individual deemed to be at risk of suicide or self-harm behaviour. The MO / Medical Centre must be informed immediately if an individual has been placed on the unit VRM Register (although they should have been fully involved in the risk conference leading to that decision in accordance with para 110.052 in the main body of this AGAI). This is necessary where the reason for being placed on the Unit VRM Register is non-medical (debt, fraud, discipline, family issues etc) because the stress may subsequently lead to a deterioration in mental health and the medical team should therefore be made aware, ideally by encouraging the individual to make an appointment with the MO. All individuals under medical care require active management and support, including time to attend appointments. If any individual on the Unit VRM Register fails to attend a medical appointment, then it is mandatory for the MO / Medical Centre or DCMH[86] to inform the unit chain of command so that robust arrangements can be made for a new appointment. Equally, the chain of command must never interfere with, arbitrarily change or cancel a medical appointment for an at-risk individual; such appointments should take priority over almost all other activities. The CoC must never overrule or interfere with clear medical advice on clinical treatment pathways or a rehabilitation regime from qualified medical professionals (MOs, Community Psychiatric Nurses (CPN), Psychologists or Psychiatrists) about a treatment or rehabilitation regime, sick leave or fitness for duty concerning at risk individuals who are currently on a Unit VRM Register[87]. Dialogue must always take place between the CoC and the Medical Chain, and the clinician's medical opinion regarding the medical treatment pathway is considered to have primacy as long as the clinician is in possession of all the facts. The chain of command should ensure that they have read the Commander's Guide to Confidentiality[88] and have appropriately liaised with the individual and supporting staff (welfare, pastoral, medical) as

[86] DPHC SOP MH-17 Failure to Attend
[87] This advice (only for those on a Unit VRM Register) specifically supersedes the rules in PULHHEEMS Administrative Pamphlet 200, paras 0714-0717 and JSP 760, para 15.003.
[88] AGAI Vol 2 Ch 57 Annex G Page 57 G1-G5 and Annex E to this AGAI.

SER (a)	RESPONSE (b)	EXPLANATION (c)
		required for Case Discussions. This management advice for the chain of command will be required on an ongoing basis as part of the Individual Case Management and the formal Commanders Monthly Case Reviews in accordance with the direction laid down in AGAI 57.
		There can be a difference between what the unit have assessed as a high-risk individual and someone that the DCMH or medical centre have assessed to be at low risk of suicide[89]. When this occurs, the CoC must speak directly to the clinical team in order to confirm the management options and safety netting available to them. In many cases this communication will reassure the CoC and support the care action plan. This communication, on the difference in risk assessed between the CoC and the medical services, should be documented in the CAP. The difference in the assessment of risk may arise because of different information disclosed to one or the other, and this should discussed so that both parties understood why there is this difference of opinion.
		Reserve Personnel. Primary Health Care for non-mobilised Reserves is provided by their civilian GP but all Reserves have access to military Occupational Health assessments. When the VRM process is being considered, the SP should be encouraged to book an OH assessment[90] so that the MO can provide advice and signpost to appropriate support, particularly if their mental state relates to veteran or deployed Reserve service[91]. With patient consent, the MO will be able to provide management information for the Unit Health Committee Case Discussions and the Joint Medical Employment Policy (JMES)[92] can be amended if appropriate. Non-mobilised reservists are an NHS issue for England (normally at Clinical Commissioning Group level) and for each Devolved Administration (normally at Health Board level) will have their needs and commissioning considered, along with other groups, and within the context of their identified needs and the wider armed forces community. All non-mobilised reservists have the same access to all NHS services where they live, along with additional commitments to 'no disadvantage' and certain 'priority services' (as per the AF Covenant). This means that: • NHS England they can access the Mental Health Transition,
		Intervention and Liaison Service (TILS) and Mental Health Complex Treatment Service (CTS) provided by NHS England. Individuals can self-refer or ask a GP or military charity to refer them. As part of the Service Offer, families are supported to access care and treatment where appropriate. Further information is available here and here.
		• NHS Scotland has Veterans First Point, a unique collaboration
		of NHS mental health teams and veteran peer mentors. Demobilised reservists can access V1PAs. Focus is on Veterans First Point (V1P), a one stop shop for veterans

[89] Deliberate Self Harm Decision Support Tool on DMICP
[90] Reserves OH Aide Memoire
[91] DPHC SOP MH-09 Reserves and Veterans and MOD Civilian Mental Health Services
[92] In accordance with AGAI 78

SER (a)	RESPONSE (b)	EXPLANATION (c)
		and their families. It is staffed by clinicians and veterans and is provided as part of the NHS. • NHS Wales has Veterans Wales as the first point of contact for veterans and non-mobilised reservists residing in Wales who have a potentially service-related Mental Health problem. This consists of outreach teams with a base in Cardiff University. It is a specialised priority service providing timely outpatient assessment and psychological therapy for veterans who are experiencing Mental Health difficulties related to their military service. Following assessment by an experienced Veteran Therapist, the veteran may be offered treatment by a Veteran Therapist or referred to the NHS for further treatment. Both the Scottish and Welsh services interface with general NHS Mental Health services or local service charities to share in or hand over care and treatment. Combat Stress has a strong presence in Scotland at Hollybush House in Ayrshire. • In Northern Ireland veterans and non-mobilised Reservists have access to Mental Health services within the Health and Social Care system on a similar basis to other members of the Northern Ireland population, in line with section 75 of the Northern Ireland Act 1998. Combat Stress operates an outpatient service from their Belfast office. Some demobilised reservists will consult their GP with a view to referral to the general NHS Mental Health services. However, many ex-military and current reservists living in NI are cautious about going through their NHS GP due to security concerns for themselves and their families, in being identified to the community as British military. The Veterans & Reservers Mental Health Programme (VRMHP)[93]run by DPHC, operates out of DCMH Colchester[94]. The eligibility for the use of VRMHP is as follows: • Ex-Regular personnel with operational deployment experience since 1982 (including veterans of the Falklands conflict) • Demobilised Reserves who deployed on operations since 2003, who are normally resident in the United Kingdom of Great Britain or Northern Ireland, who feel they may have mental health problems resulting from their deployed experiences, and who are presenting for the first time to healthcare service about such problems. Referrals to the VRMHP should be made via an individual's GP.
3	Use of the DPHC In Service Provider (ISP)	In exceptional circumstances the CoC may request the referral of an individual for admission to a secure psychiatric unit. This should be through the medical chain, in and out-of-hours, duty doctor, on-call Community Psychiatric Nurse (CPN), and A&E by exception. Admission to an In-Service Provider (ISP) is dependent on clinical need and risk state. The ISP will provide: • A place of safety for assessment,

[93] DPHC SOP MH-09 Reserves and Veterans and MOD Civilian Mental Health Services
[94] 2019DIN01-080 Occupational Health and Rehabilitation for Reservists

SER (a)	RESPONSE (b)	EXPLANATION (c)
		• A full psychiatric assessment conducted by a Consultant Psychiatrist, • An admission bed in a suitable facility chosen to match clinical need or to a preferred location where possible. This should be within easy reach of their service unit or place of residence (2 hours travelling time of the referring DCMH within the UK). It is accepted that some flexibility is required for this request. The ISP provides an inpatient service for SP whose needs cannot be met safely and efficiently within the community. The thresholds and tolerances for admission and management are quite different to those of the NHS population. This is largely due to the unique nature of the job and the role that the Armed Forces undertake. The majority of Service persons admitted will not be suffering from Severe Mental Illness (SMI); they will be admitted for a place of safety, assessment and stabilisation. The key component that makes the threshold for admission low is safety; many of those patients referred for admission work in safety-critical environments that present management issues such as access to weapons and working on/with complex maritime, 'land' and aviation equipment and lack of normal family support where they live (e.g. in barracks or a ship). Given the sometimes isolated nature of some service accommodation, particularly for single personnel, it is usually *not* appropriate that patients with mental illness or those assessed as being vulnerable remain in barrack blocks, and a place of sanctuary may be required. When a Service person is experiencing crisis in their life the MOD requires a suitable environment which offers a place of safety, is appropriate for their needs and focused on retention in employment and early return to service.
4	Consider working with the Individual to create a personal safety plan	The following website: https://www.stayingsafe.net/ST/ has online templates and guidance video tutorials purposefully designed to help people through the process of writing their own safety plan to identify actions and strategies to resist suicidal thoughts whilst developing positive ways to cope with stress and emotional distress. Anyone struggling to cope or experiencing deep distress may begin to think about harming themselves and consider suicide as a means to escape their emotional pain. It can be incredibly difficult to think clearly during these times. Individuals should be encouraged to PREPARE for possible difficult times ahead BEFORE they happen, by completing a safety plan. In summary during times of deep distress, safety plans become a vital and valuable reminder of: • What individuals can do for themselves to get through difficult times • Practical ways they can make their situation safer • Who to contact for support • Where to go or who to contact in an emergency This safety plan should, once created, be attached to the CAP on VRMIS as a record of action that that individual has taken.

SER (a)	RESPONSE (b)	EXPLANATION (c)
5	Multiple incidents of Self-Harm	CO's may wish to consider the options available to them where individuals undertake recurrent or persistent self-harm by referring to Army Manning Policies, QR(Army)[95], Promotions and Appointments Warrant (PAW)[96] and JSP 950 Lft 6-7-7[97] and taking advice accordingly.
6	Engage other professional agencies and support	The Unit Welfare team, the Unit Padre or the Army Welfare Service (or Social Welfare Service (overseas)) should usually be informed when an individual has been placed on the Unit VRM register, noting that consent ***is*** required. Engagement with support services should be strongly encouraged, explaining that this is to assist the individual and where they remain unwilling to seek professional support from one agency, this should be compensated where possible by another. For example, if they are unwilling to attend the medical centre, but will speak to the padre, then this should be encouraged and facilitated. The Case Discussions / Risk Conference provide the opportunity for supporting agencies to understand the holistic care and support package, managed by the CAP lead. The individual should be made aware (para 110.058 of the main body of this AGAI), that confidential support and advice is always available to them from unit welfare staff, Army Welfare Services, unit padre or civilian ministers or external sources such as agencies such as the Samaritans, the 24-hour Military Mental Health Line (run by Combat Stress), Togetherall (formally the Big White Wall) which is a confidential 24hr staffed digital MH support service, and Shout 85258. The leaflet at: https://www.army.mod.uk/umbraco/Surface/Download/Get/15081 provides a useful source of information. Individuals should also be made aware of by the CoC who they can contact out of hours. **Reserve Personnel.** Both primary and specialist welfare support is available to all Reserve Personnel in accordance with JSP 770 - Tri Service Operational and Non-Operational Welfare Policy[98] and AGAI 81 - Army Welfare Policy.
7	Specialist Welfare Recommendation referral	The CoC may have access to incomplete information on which to make informed decisions when managing a soldier and may require a welfare specialist to assess the situation and make a recommendation. To facilitate this, the CoC may request a 'Specialist Welfare Recommendation' in accordance with Para 81.212 of AGAI 81. Annex C of AGAI 81 provide full details on the circumstances in which a Unit may legitimately request a 'Specialist Welfare Recommendation'. Only a commanding officer, unit welfare officer or personnel recovery officer is authorised to make this request.
8	Sick Leave	Sick Leave may be a contentious topic because of the perception that it may "reward" suicidal or self-harm behaviour. Excessive / long-term sick leave may have a negative impact on motivation and must be actively reviewed as part of the VRM and UHC process.

[95] Chapter 9 section 5 refers
[96] Promotions and Appointments Warrant - Para 196 refers
[97] Section 5, Annex L refers
[98] (Paras 1.1.06 – 1.1.08 and Annex A to Chapter 1 of JSP 770 refer)

SER (a)	RESPONSE (b)	EXPLANATION (c)
		Return to Work (RtW) planning should be considered and discussed with the Service Person at the earliest stage in order to ascertain when, how and if prompt RtW is possible. Consider employment options as per Ser 13. There is a significant difference between sick leave in the accommodation block and individuals being sent home to their SFA, or family other than spouse/partner. Wherever sick leave is to be taken, it must be actively managed with careful consideration of aims (resolution of contributing factors, period of rest), the support network, access to means and opportunity for further suicidal behaviour. If the MO has recommended a period of sick leave (SL) for the SP the Commanding Officer should ensure in consultation with clinical advice that a risk case conference is held. This would include what appropriate visit timeline is required and the level of supervision needed, how and who should conduct this i.e. family, UWO, specialist staff, padre and timeline i.e. hourly, daily, weekly or as part of the normal AGAI 99, 14-day visits. This information must be recorded on the CAP. This is a Command decision based on clinical advice. Where a WIS SP is assigned to PRU and is recommended a period of SL by the MO, the CO has the ability to amend the normal recovery visit timeline from 14 days i.e. to daily or extend to 28 days if transitioning imminently with no or very little ongoing support required. The later would not happen where a transitioning WIS SP was on a CAP and appropriate engagement with Social Services/NHS should have already been factored in as part of the clinical transition plan.
9	Remove or control access to means	Removing or controlling the access to means is a critical element in any suicide prevention response. An informed 'risk assessment' must be conducted to consider the possible means of suicide or self-harm available to the individual. This should ideally be done in consultation with the individual, stressing the duty of care and responsibility to keep them safe. This does not mean an immediate, blanket restriction on access to weapons or ammunition as this may actually cause more harm; for example preventing someone from performing their role which could lower their self-esteem and stigmatising them, leading to a deterioration in their mental state. Inter alia, the CO should consider: • Checking and removing or simply loosening all obvious ligature points, such as hooks on the back of doors (hanging is the most prevalent method of suicide in the military). • Checking and tightening procedures for the issue of weapons and live ammunition, particularly in relation to the individual at risk. • Ensuring that the individual cannot be 'accidentally' issued with a weapon. Access to private weapons must also be checked. • Searching the individual's room, usually as part of a formal search of an entire block, for any hidden ammunition. Metal detectors could be used if available. • Removing or limiting, with medical agreement, prescription drugs.

SER (a)	RESPONSE (b)	EXPLANATION (c)
		• Removing or limiting non-prescription drugs. • Restricting or removing the ability to drive vehicles, particularly armoured vehicles or troop carriers. The individual could be advised not to drive civilian vehicles.
10	Engage peer support	Peers provide an essential source of support for individuals experiencing difficulties. It may be difficult to balance confidentiality and disclosure of concerns to peers but, in general, a degree of honesty with friends and colleagues is usually helpful. Ideally consent should be sought from the individual to include others in both informal support and the care pathway. Information sharing with carefully selected, responsible peers must be strictly limited and tightly controlled – and caveated with guidance about the moral and social responsibilities that such knowledge carries. This must be on a voluntary basis and peers should not be coerced in any way to take responsibility for the individual or substitute for formal CoC or medical support. Peer support includes a wide range of activities from simply being there and listening to a colleague, to more active planning and intervention aimed at helping the person in need to address their problems. Peer support is essential for minimising social isolation and alleviating distress. The peer may also require additional support from unit staff / line management during this time and they must know who to contact in case of emergency. They should be conversant with AGAI 110 policy, in particular the useful information within the Annexes.
11	Engage family support	Family support may be a critical component of suicide prevention, however it is essential to clearly establish the individual's domestic situation and relationship with their family. Whenever possible, the individual should be encouraged to tell their family about their problems and difficulties. They may choose to do this themselves or may welcome the CoC or medical team initiating that conversation, with their permission. In exceptional circumstances, the chain of command may approach a family without the individual's permission, but no personal information may be disclosed other than to say that there is concern about the individual's welfare and it would be helpful if the family made contact. Where an individual is under 18, it is mandatory for the CO to make contact with the family, with or without the individual's permission in accordance with JSP 822, Part 2, Chapter 2.4. When contacting Next
		Of Kin (NOK) or Emergency Contact (EC), discretion should always be used in passing confidential information or in unduly worrying the NOK or EC; over-reaction by the NOK or EC could worsen the situation. If appropriate, arrangements should be facilitated for the family to visit the individual or for the individual to return to their family on leave. In such instances, travel at public expense can be exceptionally authorised at the discretion of the CO. All contact with the NOK or EC must be formally documented on the CAP.

SER (a)	RESPONSE (b)	EXPLANATION (c)
12	Active and regular Engagement with Individual on VRMIS	The CoC, unit welfare staff, unit padre or trusted peers can be tasked to ensure regular contact with the individual so that they are seen and spoken to at least daily by someone in authority, including weekends, holidays and down-time. If a leave period is approaching, it is essential to ensure that the individual has a structured and monitored plan for leave periods which must be carefully coordinated and the details recorded in the CAP.
13	Assess employment options	Employment can be a contributory factor in suicide behaviour risk but, if well handled, it can also aid recovery. Each case must be carefully considered to maximise the benefit and opportunity for the individual and the employer, considering factors such as whether the work environment was a contributing factor (workplace bullying, long hours) or may mitigate the risk (gainful employment, peer support). In some cases a change in assignment or temporary detached duty may be helpful. The CO should consider: • Changing their immediate employment within the unit. • Giving them more / less challenge and responsibility. • Ensuring that they are given more recognition and appreciation. • Giving them specific targets or goals to focus their mind beyond their immediate situation. • Restricting or removing: guards; other duties; minor punishments; week-end work; night work; exercises; and nights away from home. • Supervising, restricting or removing any potentially hazardous work activity, particularly if it involves driving or heavy machinery. • Requesting an assignment for the individual to another unit or location. • Assigning them elsewhere on temporary duty or detachment.
14	Implement special leave arrangements on compassionate grounds	Suicidal behaviour may be related to compassionate and welfare difficulties at home, particularly for young people. An inability to take leave to get home and deal with the problem and / or an inability to pay for travel may exacerbate the distress. Where an individual has been placed on the unit Risk / Welfare Register, COs may authorise leave on compassionate grounds in accordance with JSP 760 (Tri-Service Regulations for Leave and Other Absence) if they judge that it would be beneficial for the individual. This must be carefully controlled and those at the leave destination should be informed of the arrangements including safeguarding actions if the situation deteriorates.
15	Restrict access to firearms and live ammunition	Any individual who is deemed to be at risk of suicide or self-harm behaviour should not routinely be allowed access to weapons or live ammunition. If access is permitted, then it must be carefully controlled and the individual must never be left alone with the weapon, or given any opportunity take live ammunition from the range. This may be determined by the chain of command or by the medical chain (where it would be communicated on Appendix 9 of AGAI 78). If restriction is

SER (a)	RESPONSE (b)	EXPLANATION (c)
		considered necessary, it should be extended to include private firearms and the chain of command must assess what access an individual has to private firearms as part of the initial risk conference. A careful balance needs to be struck between publicising the fact that an individual is not permitted to handle weapons and ensuring that they do not inadvertently, or covertly gain access to a weapon.
16	Limit Access to alcohol	People undergoing stressful life events may turn to alcohol to help alleviate their distress through 'blocking out' the real world. Significant amounts of alcohol can act as the stimulant to induce an impulsive, spontaneous and irrational desire to complete suicide, therefore individuals at risk of suicide and self-harm behaviours should be carefully counselled about the impact of alcohol which lowers inhibitions and increases impulse behaviour.
17	Minimise boredom and isolation	Ensure that an individual is kept occupied with gainful, structured and monitored activity, both physical and mental. This must not be mindless activity for the sake of it, nor must it appear to be overtly contrived. Consider allocating specific projects or tasks with achievable goals. Physical activity, particularly organised sport and recreation where there is a social element, may improve mood. The key is to ensure that an individual is kept usefully occupied within their capabilities but not significantly imposed upon. Family, friends and colleagues will play a vital role in ensuring that the individual feels involved in normal activities and is not allowed to become introspective and 'fester' in isolation.
18	Reduce or remove guard duties	In principle, an individual deemed to be at risk of suicide and self-harm behaviours should not be placed on guard duty. They should not be left alone in possession of a weapon and live ammunition. However, removal from guard duty may have negative impact if advertises the fact that the individual has a problem or implies that they are unable to perform a role. In addition to stigma and impact on self-esteem, it may increase the burden on their colleagues and cause resentment, so should be carefully handled, maybe by giving them an equivalent but non-safety critical task.
19	Instigate a 'buddy-buddy' system	The 'buddy-buddy' system is actively promoted throughout service and forms part of normal support behaviour. This may be part of informal peer support or a more formal arrangement whereby one or more individuals are specifically detailed to act as 'buddies' for an individual at risk. The balance of confidentiality and necessary disclosure of private information must be carefully considered and is best achieved through open dialogue with the consent of the individual at risk. Under no circumstances should a 'buddy' be ordered or coerced into this role and it must be entirely voluntary with clear direction as to the limit of this responsibility. Tasks and role should be agreed but formal TOR are not recommended as this implies a level of responsibility which is not fair on the 'buddy'. If formal supervision is required, this must be arranged (see Para 21 below).

SER (a)	RESPONSE (b)	EXPLANATION (c)
		The 'buddy' may also require additional support from unit staff / line management during this time and they must know who to contact in case of emergency. They should be conversant with AGAI 110 policy, in particular the useful information within the Annexes.
20	Introduce communal living arrangements	Although there is no formal evidence to link single room accommodation with suicide risk, there are concerns that segregated accommodation arrangements may lead to increased loneliness and isolation. Single room accommodation makes it more difficult to monitor an individual at risk and may make it easier for an individual to find the opportunity to complete suicide. Where individuals at risk are in single room accommodation, COs should consider the benefits of moving them into shared accommodation with friends they know and trust. The Chain of Command must consider the risks associated with those living outside of SLA; in SFA, private accommodation, SSSA etc.
21	Implement constant formal supervision	24-hour supervision will rarely be necessary unless an individual is deemed to be at immediate and significant risk; perhaps following an unsuccessful suicide attempt with an indication that another attempt might be made. An individual in this state will need urgent medical attention. It will usually be unhelpful to place such an individual in the guardroom but very close supervision, involving a roster, should be maintained in their normal living environment until such time as DCMH staff can take over or admission to hospital can be arranged. Proper control and coordination, much like guard duty, will be important. Supervision should be as unobtrusive as possible, commensurate with the need to be able to physically stop the individual should suicide be attempted. Close supervision is always best carried out by peers and immediate superiors (not Provost staff) but appropriate people in authority need to be on call and aware of the situation at all times. Constant supervision should rarely be necessary for more than a day or so, although it could continue for longer on a more informal and less constrained basis. Physical restraint should never be contemplated other than as a last resort in the face of an actual suicide attempt. The 'supervisors' may also require additional support from unit staff / line management during this time.
22	Periods of Unit stand downs / Block Leave	COs should ensure that the monthly review of SP on the unit VRM Register is up-to-date prior to block leave and that it is recorded within the SP's CAP on VRMIS along with details of the structured and monitored support plan that is to be provided to the SP over the leave period.
23	During Transition - Release from recovery duty and commitment to attend visit as on designated leave in accordance with JSP 760 for	When a SP is under a CAP it is a CoC responsibility to manage the SP's leave in accordance with the level of risk identified and ensure that sufficient measures are in place to mitigate this risk where possible. If the SP is Wounded Injured and Sick (WIS), under a CAP and discharging from Service, they may elect to use their accumulative ILA, GRT, Invaliding and Terminal leave entitlements in accordance with JSP 760 (Leave) and JSP 534 (Resettlement) to make themselves officially unavailable for recovery activity and recovery visits. Under such circumstances a commanding officer is to offer the

SER (a)	RESPONSE (b)	EXPLANATION (c)
	personnel under a CAP on VRMIS	WIS SP ongoing recovery visit support up to discharge. If declined and where there is also a CAP in place the unit are to update the CAP with all relevant documentation as evidence of the SP's decision declining support and visits. The SP's WISMIS record must also be updated with the SP's decision where it prevents the unit from conducting the mandated 14-day recovery visits during the final stages of transition in accordance with AGAI 99. The UHC must still review WIS SP's case and note any changes accordingly until point of discharge.
24	Detaining an Individual in distress for safety reasons.	The Policing and Crime Act 2017 amendments to the Mental Health Act 1983, refer to the powers of a constable. The Service Police are not defined as constables and these powers are not therefore extended to the RMP. The Service Police therefore cannot apply for the warrants of detention detailed in the Act and must rely on making a lawful order. In the UK they must call the civil police to exercise these powers.
25	Civilian Police Safety Checks	There may be occasions when an individual who is on the Unit VRM Register is at home and have either called to say they are in distress or have failed to answer any phone calls made by the unit (as agreed with the individual as part of the CAP, for example when they are on sick leave or on individual leave). The unit can call the Civilian Police local to where the individual lives and ask for a safety check/visit to be conducted. Alternatively the unit can agree with an individual (and record it on the CAP) if a friend or family member can be contacted, in the event of an emergency or if the individual fails to answer a call from the unit, to go round to their home to check on them. In some circumstances, the civilian police may be contacted in advance and informed that an individual who is on the VRM Register is in their locality.
26	Self-Help resources	There is a plethora of self-help available for the individual and the peers, friends and CoC supporting them. The OPSMART[99] team have created a large number of digital products which are available on the Army Knowledge Exchange[100], Defence Connect[101] and the British Army Website[102]. The Suicide Prevention information includes the AID leaflet[103] **(A-ASK, I-INTERVENE, D-DISCLOSE)** and sources of support including the Samaritans, Combat Stress Military Mental Health Helpline and Togetherall[104]. The new *Commander's Guide to Suicide Prevention* complements the extant A Commander's Guide to Mental Health and Wellbeing.

[99] Optimising Performance through Stress Management And Resilience Training (OPSMART) is the Army's through-life, coherent and progressive programme that is aimed at improving the mental fitness and resilience of both Regular and Reserve personnel.
[100] AKX: https://akx.sps.ahe.r.mil.uk/sites/akx/doctrine/sustainment/army-health-and-deployability
[101] Defence Connect: https://jive.defencegateway.mod.uk/groups/ahp/content?filterID=contentstatus%5Bpublished%5D~category%5Bopsmart%5D
[102] Army Website: https://www.army.mod.uk/people/join-well/mental-resilience/
[103] https://www.army.mod.uk/people/join-well/managing-stress/ask-for-help/
[104] Formally known as the Big White Wall. The MoD have partnered with "Togetherall" to allow Armed Forces personnel access to its 24hr staffed digital MH support service

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ANNEX E

COMMANDERS' GUIDE TO MEDICAL CONFIDENTIALITY

1. **Introduction.** The chain of command (CoC) is responsible for the health and wellbeing of its people[105]. It must ensure that its people are fit for military work, including the safety critical tasks of handling live weapons and driving, and do not pose a threat to themselves or others in the workplace[106]. To meet its duty of care the CoC requires timely and relevant medical advice. This guide explains the role and responsibilities of Service Persons (SP), healthcare providers, and the CoC, in providing and managing medical advice, acknowledging the limitations of medical confidentiality and the requirement for consent.

2. **Medical Confidentiality.** Medical confidentiality underpins the relationship between healthcare provider and patient[107], with protections afforded by both common law and statute[108,109]. Additionally, healthcare providers are subject to strict professional regulations[110,111]. SP can therefore expect that their medical information will remain confidential and will not be disclosed to the CoC. Without assurances about medical confidentiality SP may be reluctant to seek medical attention and access necessary medical care, with implications for operational effectiveness. This is particularly relevant where there may be perceived stigma, such as mental health conditions.

3. **Disclosure of Patient Information.** Medical confidentiality is not absolute. Patient information can be disclosed by a healthcare provider if either:

a. The patient gives explicit consent to disclose information.

b. The patient does not consent, but the disclosure is required by law, or under a statutory process that sets aside common law duties. For example, if the patient or others may be exposed to a risk of death or serious harm. Non-consensual disclosure is relevant when a SP is not fit to drive, handle weapons or poses a serious risk to themselves or others.

c. The disclosure can be justified in the public interest in very exceptional circumstances to prevent a serious crime or serious communicable disease. Preventing a patient from self-harm is seldom admissible in the public interest and this information cannot be disclosed without consent.

4. **Military Healthcare Model** Multiple stakeholders must communicate effectively to confirm fitness to work. Communication is enabled by explicit patient consent and cannot occur without it,

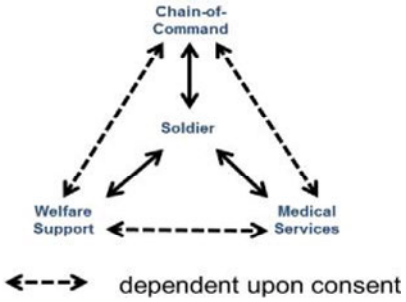

Figure1 – The consent triangle

105 **AGAI 57–** Army Health Committees
106 **Health and Safety at Work Act 1974**.
107 SP seeking healthcare from Defence Medical Services (DMS) facilities are patients.
108 **Human Rights Act 1998.**
109 **Data Protection Act 2018 (DPA 18).**
110 **Disclosing patients' personal information: General Medical Council.**
111 **The Code. Professional standards of practice and behaviour for nurses and midwives. Nursing and Midwifery Council 2018.**

unless there are safety implications that justify non-consensual disclosure. The diagram at Figure 1 above illustrates the military healthcare model for ensuring health and wellbeing.

5. **Roles and Responsibilities.** Everyone within the military healthcare model must prioritise time to establish effective communication and good working relationships. As a minimum this requires active engagement in the Health Committee Individual Case Management process with formal Commander's Monthly Case Reviews[112]. This will ensure trust between all parties and enable access to medical treatment and timely, relevant medical advice. Specific responsibilities are detailed below:

a. **Service Person (SP)**. SP have a responsibility to maintain their own health and wellbeing and enable workplace safety:

i. SP must access healthcare appropriately. Medical confidentiality facilitates this.

ii. SP have a legal duty to co-operate with their CoC to ensure the safety of the workplace[113] and the individuals (including themselves), working within it.

b. **Medical Services**. Military healthcare providers have dual obligations, to both the SP (as a patient) and the CoC:

i. A healthcare provider is subject to strict professional regulations[114,115] and must respect medical confidentiality. Any breach, unless justified by the risk to safety of others (and in limited circumstances, risk to the individual SP), will be investigated and could result in disciplinary action and a healthcare provider being permanently barred from clinical practice[116].

ii. Healthcare providers have an obligation to the individual and the CoC to assess the impact of a health condition on fitness to work at every clinical contact, consider confidentiality ring safety implications for both the SP and others in the workplace. The SP's living accommodation and the safety of others within it must also be considered. This obligation to the CoC must be discussed with the SP and informed explicit consent obtained to communicate with the CoC, explaining that refusal to consent may have employment implications, and hinders the CoC in providing appropriate management support. If a SP withholds consent the healthcare provider is not relieved of their obligation to the CoC; accordingly, the healthcare provider must be aware that in the absence of communication the CoC will assume there are no issues. Therefore, the healthcare provider must be satisfied that there is no risk to safety in the workplace when respecting medical confidentiality but endorsing continued military employment; if not the case the healthcare provider must advise removal from the workplace without disclosing any detail, unless there is a requirement for non-consensual disclosure (see Para 9 below).

iii. Healthcare providers are expected to keep disclosures to the minimum necessary. They must only disclose sufficient medical information about the relevant medical condition to enable the CoC to ensure workplace safety and manage the SP. For example, an individual with a knee injury may be unable to walk over uneven ground or participate in impact activities, including running and dynamic range packages. These restrictions must be detailed, without explanation of the underlying

[112] In accordance with **AGAI 57–** Army Health Committees
[113] **Health and Safety at Work Act 1974**.
[114] **Confidentiality: disclosing information for employment, insurance and similar purposes. General Medical Council.**
[115] **The Code. Professional standards of practice and behaviour for nurses and midwives. Nursing and Midwifery Council 2018.**
[116] The healthcare profession is advised to seek guidance from senior colleagues and their indemnity provider. They must keep clear, contemporaneous records detailing the assessed risk of serious harm to others to justify non-consensual disclosure.

condition. The healthcare provider must also discuss with the SP what and how the CoC has been advised, and confirm ongoing informed consent whenever possible, noting that the SP retains the right to withdraw consent to disclosure at any time. The healthcare provider must take measures to ensure that any privileged information released out with the medical chain is respected as confidential by those who receive it.

c. **CoC**. The CoC must ensure that its SP are fit for work and do not pose a threat to themselves or others in the workplace:

i. The CoC must access relevant medical advice to ensure safety in the workplace and the SP within it. The CoC does not require information about the underlying medical condition[117], only the impact on fitness to work and workplace safety. Whilst an informed CoC, with its welfare support services, may be able to positively influence health outcomes, this is not justification to breach medical confidentiality.

ii. The CoC has a responsibility to respect confidentiality and safeguard all privileged information released to them with or without explicit consent[118]. In particular, they are bound by the provisions of DPA 18 to protect personal information. Extreme care must be taken to ensure electronic distribution of personal information, including INCREP/NOTICAS[119] processes do not inadvertently breach medical confidentiality.

iii. The CoC must ensure that it is accessing appropriate medical advice from the DMS. If the CoC is concerned about the communication of medical advice this must be addressed immediately through both the operational and DMS hierarchy.

d. **Welfare Support.** A SP may choose to disclose personal medical information to access welfare support. Welfare services, both Unit welfare and Army Welfare Services, have a responsibility to respect confidentiality and safeguard all privileged information released to them. Care must be taken to ensure electronic distribution of personal information does not inadvertently breach confidentiality.

6. Medical Advice. Medical advice may be provided verbally[120] on an ad hoc basis, or formally at Unit Health Committees[121] when explicit consent has been given. Written medical advice is provided through 'Light Duties' chits (F Med 8721) and Appendices to AGAI 78 – Army Medical Employment Policy (PULHHEEMS Administrative Pamphlet)[122]. These detail Joint Medical Employment Standard (JMES) grades and employment restrictions, including fitness to: drive, handle weapons, work at height, work alone. Medical advice must not simply list things a SP cannot do but must also emphasise what they can do. Where consent is given, appropriate communication can also enable the CoC, with its welfare support, to positively influence health outcomes. This includes the requirement to attend medical appointments, to facilitate rehabilitation. Medical advice must not provide details about the underlying medical condition, only the functional implications and required employment restrictions.

7. Mental Ill Health. A SP with a mental health issue being treated in Primary Healthcare (PHC) may pose a risk to their own or others' safety and must be counselled of the benefits of informing the CoC, including access to additional welfare support[123] and the VRM process[124]. If they refuse

[117] QR 5.333
[118] Data Protection Act 2018 (DPA 18).
[119] In accordance with **JSP 751 – Joint Casualty and Compassionate Policy Procedures**
[120] The content of any verbal discussion should routinely be documented within the Defence Medical Information Capability Programme (DMICP) records.
[121] **AGAI 57-** Army Health Committees
[122] **AGAI 78 – Army Medical Employment Policy (PULHHEEMS Administrative Pamphlet)**
[123] Unit Welfare team or Army Welfare Services
[124] AGAI 110 – Army Vulnerability Risk Management Policy

to consent, specialist assessment of their competence to consent, risk to others and fitness to work must be sought urgently by the healthcare provider from the Department of Community Mental Health (DCMH). The DCMH must explicitly confirm that non-disclosure to the CoC[125] is appropriate if medical confidentiality is upheld and the SP remains in the workplace.

8. **Substance Abuse.** A SP suspected of being under the influence of, or misusing psychoactive substances including alcohol, is likely to be unfit to perform safety critical tasks. It is the duty of the CoC to engage with the SP and to remove the individual from safety-critical tasks if they have concerns. If the healthcare provider is aware of this condition, they must gain consent from the patient and ensure that the CoC is appropriately advised of any employment restrictions, but not the nature of the medical condition. If the patient withholds consent, the healthcare provider may be required to disclose the restrictions to the CoC if disclosure guidelines are met[126]. The healthcare provider is not expected to assist with any forensic investigations, including blood, urine or breath sampling[127].

9. **Withheld Consent.** The safety of the workplace cannot be assured if a SP withholds consent to release relevant advice about their fitness for work.

a. Non-Consensual Disclosure Appropriate. The healthcare provider is expected to enable workplace safety by promptly informing and receiving acknowledgement from only those who 'need to know' within the CoC. This is likely to initially occur through verbal communication, with the most senior commander available, followed up by written confirmation detailing the limited disclosure of employment restrictions. The disclosed information, and its onward distribution, must be restricted to the absolute minimum necessary to ensure safety. No explanation for the functional restriction should be provided. For example, the CoC would be informed that a SP with uncontrolled epilepsy must not be allowed access to live weapons or to drive vehicles, not that they have epilepsy.

b. Non-Consensual Disclosure Not Appropriate. The SP must be assigned the JMES of A6L6M6E1 within the Defence Medical Information Capability Programme (DMICP) records in accordance with AGAI 78[128]. The healthcare provider must promptly alert the CoC of this JMES change, without releasing any medical information, and ensure that the SP understands the requirement to do so. This JMES grade cannot occur in any other situation, so informs the CoC that the SP has withheld consent for release of their medical employment information. The CoC must interview the SP, explaining that the SP's consent will enable an informed assessment of the health risks of their employment; it must be made clear to the SP with whom the information will be shared and why this is required. Explaining the control measures and limit of disclosure may help to reassure the SP and in turn inform a positive decision about consent. In the absence of medical employment information, it may be considered necessary to terminate the SP's Service on administrative (rather than medical) grounds, namely QR(Army) para 9.414 Services No Longer Required for soldiers, and resignation of commission under PAW 09 Article 190 for officers. The SP must be fully informed that refusal to consent to disclose relevant medical information may have these implications for their employment without coercing them to consent.

10. **Caldicott Principles.** The Caldicott Report was a review commissioned in 1997 by the Chief Medical Officer of England. The focus of the report was to review how patient information is used in the NHS. The motivation behind the report was increasing concern about advancements in technology and the capability to distribute information about patients quickly and extensively.

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125 This should be clearly documented within the DMICP record.
126 The decision process should be clearly documented within the patient's DMICP record. Senior expert advice, including the medical indemnity provider, should be sought by the healthcare provider prior to disclosure.
127 This will be arranged by the Royal Military Police (RMP) as required.
128 Para 78.1032 of **AGAI 78 – Army Medical Employment Policy (PULHHEEMS Administrative Pamphlet).**

The basis of the review, therefore, was to ensure that confidentiality was not being undermined. The principles below have been drawn from the report.

11. **The 7 Caldicott principles are:**

a. Principle 1: Justify the purpose for using confidential information. Every proposed use or transfer of personally identifiable information, either within or from an organisation, should be clearly defined and scrutinised. Continued use of this information should be regularly reviewed by an appropriate guardian.

b. Principle 2: Don't use personal confidential data unless absolutely Necessary. Identifiable information should not be used unless it's essential for the specified purposes. The need for this information should be considered at each stage of the process.

c. Principle 3: Use the minimum necessary personal confidential data. Where the use of personally identifiable information is essential, each individual item should be considered and justified. This is so the minimum amount of data is shared and the likelihood of identification is reduced.

d. Principle 4: Access to personal confidential data should be on a strict need-to-know basis. Only those who need access to personal confidential data should have access to it. They should also only have access to the specific data items that they need.

e. Principle 5: Everyone with access to personal confidential data should be aware of their responsibilities. Action should be taken to ensure that those handling personally identifiable information are aware of their responsibilities and their obligation to respect patient and client confidentiality.

f. Principle 6: Understand and comply with the law. Every use of personally identifiable data must be lawful. Organisations that handle confidential data must have someone responsible for ensuring that the organisation complies with legal requirements.

g. Principle 7: The duty to share information can be as important as the duty to protect patient confidentiality. Health and social care professionals should have the confidence to share information in the best interests of their patients and within the framework set out by these principles. They should also be supported by the policies of their employers, regulators, and professional bodies.

12. **Summary.** Communication between the CoC, healthcare providers and SP about fitness to work is essential, to ensure safety in the workplace, but requires explicit consent unless risk to others (and in limited circumstances where the risk is to the individual) justifies non-consensual disclosure. The communication must only detail functional restrictions and must focus on functional ability but could provide further detail to enable positive health outcomes. If an individual insists on absolute medical confidentiality (and non-consensual disclosure is not appropriate), their fitness to work cannot be assumed; this is probably incompatible with military employment.

13. **Point of Contact.** AH Health and Wellbeing Policy and Army Caldicott Guardian. Email: [redacted]