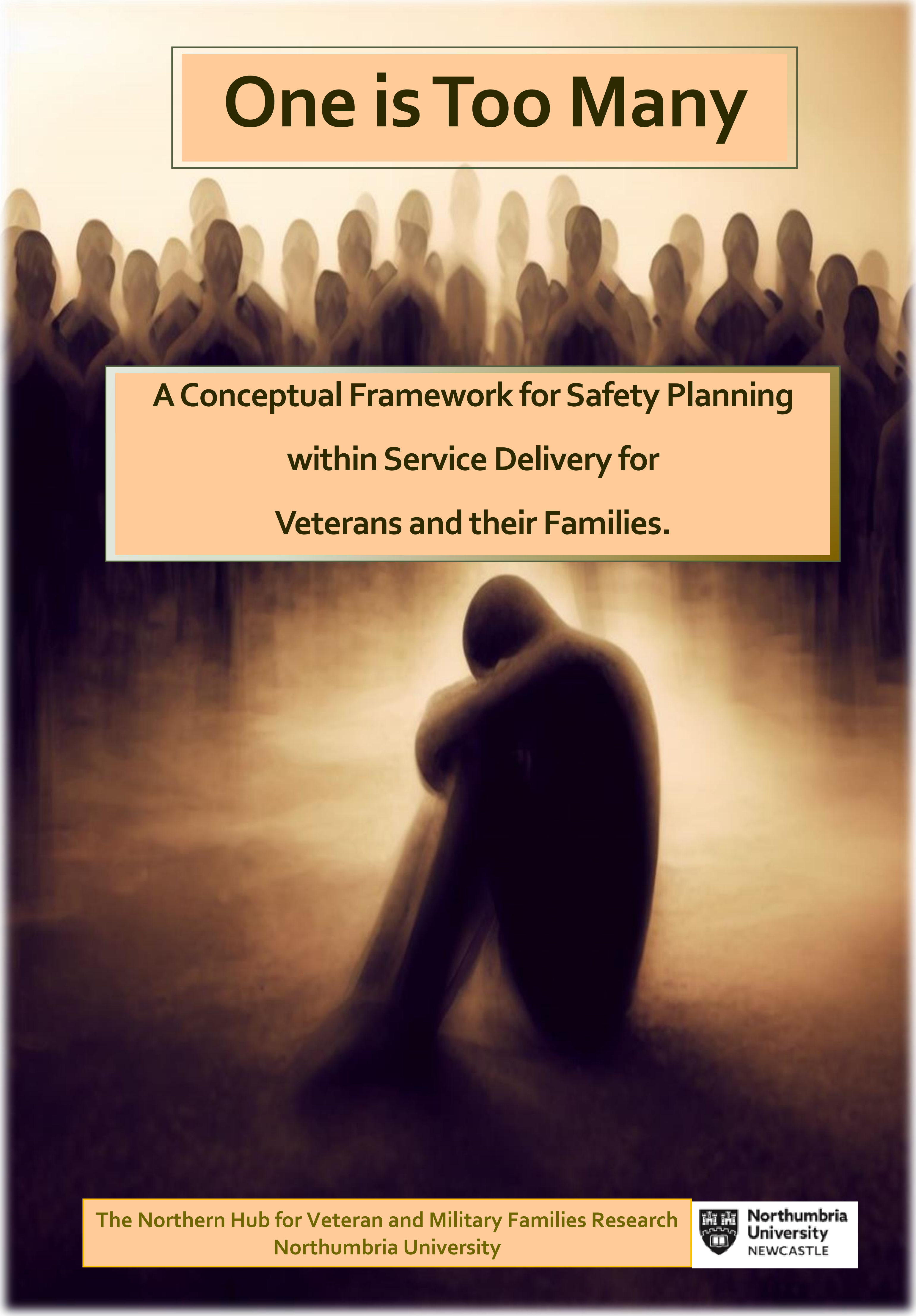
One is Too Many



A Conceptual Framework for Safety Planning within Service Delivery for Veterans and their Families.

The Northern Hub for Veteran and Military Families Research
Northumbria University

Northumbria University
NEWCASTLE

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Executive summary

Many members of the military and veteran community have made significant sacrifices in the service of their country. Through combat, multiple deployments, and various operations some face significant physical and psychological consequence from their military service. For some, the burden of this toll, can result in the ultimate sacrifice – death by suicide. Such a loss is always a tragedy, an indelible footprint which often wreaks havoc on families and loved ones. The loss of just one military or veteran comrade is always one too many.

Many veterans experience ongoing mental health struggles where suicide may be seen as the only endpoint of a prolonged and painful battle. When a suicide occurs, questions need to be raised about whether that individual had access to the right help and assistance, at the right time, with the right intervention, and the right level of care and support. The critical question – "Were opportunities missed?"

This research study was established to undertake an in-depth exploration of both military (those still serving) and veteran death by suicide. It consisted of three distinct phases:

- **Phase 1:** Carrying out in-depth interviews with families bereaved by suicide within serving military and military veteran populations.

- **Phase 2:** Using Co-production research methodology, including families, care providers, subject experts, critical stakeholders to ascertain greater depth in understanding, and to establish an intervention piece to better identify, understand, and prevent further loss of life.

- **Phase 3:** Developing a framework and toolkit centred around two critical factors: (i) Enhancing knowledge and psychoeducation tools to increase awareness, promote greater understanding, and improve service provision; (ii) Challenging both internal and external stigma.

A critical aspect for the One is Too Many (OiTM) study, was in sufficiently capturing the narratives of those left behind through death by suicide – families and loved ones. These interviews repeated time and again critical patterns in the family's stories – not being heard, understood, valued, cared for, nor sufficiently empowered to be any part of care provision in terms of either reducing risk or preventing loss of life. Many of them witnessed first-hand the slow decline and disintegration of their loved one – and felt helpless, and powerless in doing so. Family's experiences were that of passive care, often disjointed, uncoordinated, with frequent deficits in compassion and understanding. As we move forward it is imperative that vital lessons are learnt here.

The utilisation of Co-production research methodology in phase 2 provided a robust framework in capturing a broad range of narratives generating a richer, more in-depth perspective of the broader landscape. The need for personalised care is imperative, care that is proactive and accessible; is authentically collaborative, client-centred, co-ordinated and, essentially, involves the family.

Such an approach, ideally, should include psychoeducation around death by suicide, how to prevent it, what protective strategies can be put in place to prevent occurrences, and what strategies are required to protect military veterans, their families, and wider communities, and the part that broader society can play in reducing death by suicide within the military/ veteran population.

The goal ultimately must be suicide prevention. Phase 3 provides a framework for creating a safe environment focussed on training and education, strengthening resources and protective factors, and challenging stigma. The critical mantra:

- **IDENTIFY** the risk.
- **UNDERSTAND** the reasons why.
- **PREVENT** – by building better safety, individually, within the family, service provision, and environmentally.

This OiTM Framework aims to offer guidance and support to all agencies (statutory, voluntary and third sector) working with veterans and their families to aid the reduction of suicide. It is constructed to reflect the journey to suicide, and to enhance support to those working with vulnerable populations including veterans and their families. The intention is for this document to operate on two different levels: firstly, the veteran and their family, and secondly, existing service provision. However, the aim of this document is not to provide a specific plan to implement, as one plan will never fit all. The Framework and Tool Kit is specifically designed to help and assist organisations focus on specific areas associated with suicide in the veteran population (based on the empirical findings of this OiTM study), whilst also highlighting the importance of protective factors. This OiTM document is designed to aid organisations in developing a bespoke approach to suicide prevention and improving provision and support for service users and families.

Every effort needs to be made to prevent death by suicide. Enhancing better military veteran-focussed mental health awareness, challenging stigma, improving access to services and resources, providing better ‘fit for purpose’ support systems, which are client-centred and family inclusive, is essential moving forward. Death by suicide is always a tragedy, and frequently, an opportunity missed. Learning these vital lessons seems the very least we can do.

Research Team

Team Member	Project Role
Professor Matthew Kiernan	Principal Investigator
Dr Gill McGill	Co- Principle Investigator
Dr Paul Watson	Co-Investigator
Professor Derek Farrell MBE	Co-Investigator
Professor. Gavin Oxburgh	Co-Investigator
Ass Prof. Jane Arnfield	Co-Investigator
Dr Annessa Rebair	Co-Investigator
Lorrain Knibbs	Co-Investigator
Shannon Allen	Senior Research Assistant
Richard Gettings	Research Assistant
Lyndsey Nicholson	Transcriber
Helen Tailyour	Transcriber

Acknowledgements

The One is Too Many project, funded by the Armed Forces Covenant Fund Trust, was undertaken with key stakeholders to understand, identify and prevent suicide within the Armed Forces Community. This research is the first of its kind and captured the stories of families from across the UK.

We would like to thank all those who took the time to be part of this research. Importantly, this project could not have happened without the unconditional support and willingness of the families who are bereaved by suicide and who gave their time to tell their personal stories. The selfless courage demonstrated by the families enabled the research team to fully understand and map the moments in time of the heartbreaking journey to suicide. For their sacrifice we are forever grateful.

We would also like to extend our sincere gratitude to the Bastion Baton who administered and led this project. We would also like to thank For the Fallen who were not only instrumental to the design of the project, but also facilitated the recruitment of the participants and provided ongoing support to those who participated in the research.

We would also like to express a sincere thanks to Liza Jarvis at the NHS England Southwest Integrated Personalised Care Team and Partners from the Social Prescribing Demonstrator – Active Plus, Help and Care, Durham Dales Health Federation & Independence Trust, in partnership with key stakeholders for sharing there help and expertise in developing the self-assessment tool for this project (Phase 3)

We would also like to extend our thanks to Worcester University for their support with the investigation of the project and the development of the findings and Dr Julie Repper and ImROC for their help in facilitating the co-production events.

The Armed Forces Covenant Fund Trust

We thank the Armed Forces Covenant Fund Trust for their invaluable contribution in instigating this research into such an important issue – from inception through to dissemination of the research findings.

To those who are no longer with us

They shall grow not old, as we that are left grow old:
Age shall not weary them, nor the years condemn.
At the going down of the sun and in the morning
We will remember them.

Overview of the Strategic Planning Approach

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH 2023)[1], reported that between 2010 and 2020, there were 68,357 suicides across the general population of the UK aged ten years and above. This amounts to an average of 6,214 suicides per year, however, [2] the latest 2021 statistics[3] continues to report long-term trends. Three-quarters of suicides are attributed to males (those aged 50-54 being [4]highlight concerns (post-Covid 19)) and vulnerable groups such as those experiencing job loss, debt, reduced income, bereavement, social isolation, and loneliness. Additionally, NCISH (2023) advise awareness of common risk factors (e.g., comorbid drug and alcohol misuse, living alone, self-harm, loss of contact with services) as factors for vulnerability to suicide. The national data outlined above must be considered in relation to areas of shared concerns and knowledge of changing societal trends that could have a future impact on the needs of the military and veteran community.

Whereas there are crossovers concerning risk groups, there are specific needs associated with the veteran community that require unravelling. Research commissioned by the Ministry of Defence (MoD) and National Health Service England (NHSE) to review suicide on leaving the Armed Forces relayed findings that the risk of suicide in veterans was no more significant than the general population. However, the MoD cohort study (1996-2018) highlighted veterans under the age of 35 years, with shorter service, untrained on discharge, were more at risk of suicide. Marriage, serving for longer periods and operational tours were associated with reduced risk of suicide. There was lower contact with specialist NHS mental health services in the 16–24-year-old age group, further impressing the need to understand issues around engagement and help-seeking in the veteran community[5] . Viewing this with general population data raises questions about what is happening for young people and how prepared they are for military service and subsequent transitioning back to civilian life.

Much is accomplished to prevent suicide across the UK, with countries producing detailed suicide prevention strategies. In England, local government association public health and prevention teams

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[1] NCISH (2023) National Confidential Inquiry into Suicide Safety and Mental Health. Annual report 2023. Available at: https://documents.manchester.ac.uk/display.aspx?DocID=66829 [Accessed, 25th May 2023)

[2] ONS (2022) Suicides in England and Wales 2021 registrations Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations [Accesses 25th May 2023]

[3] ONS (2022) Suicides in England and Wales 2021 registrations Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations [Accesses 25th May 2023]

[4] NCISH (2021) Preventing Suicide in England: fifth progress report of the cross government outcomes strategy to save lives. HM Government. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973935/fifth-suicide-prevention-strategy-progress-report.pdf [Accessed 25th May 2023]

[5] Rodway, C., Ibrahim, S., Westheadd., J., Bojanic, L., Turnbull, P., Appleby, L., Bacon, A;, Dale, H., Harrison, K. and Kapur, N. (2022) Suicide after leaving the UK armed Forces 1996-2018: a cohort study. Available at: https://www.medrxiv.org/content/10.1101/2022.12.12.22283340v1 [Accessed 25th May 20023]

for sector-led improvement align with community wellbeing boards to effect local council suicide prevention strategies. Community, health sector, educational, charitable and third sector organisations all contribute to creating comprehensive local knowledge and producing actionable plans for suicide-safer communities. The UK Government pledged further funding of £57 million for suicide prevention (NHS, 2019)[6] to continue to support local plans, including education, training, service development and research to understand antecedents to suicide.

In March 2020, The Chancellor of the Exchequer announced additional funding for UK military veterans' mental health as part of the Veterans Mental Health and Wellbeing Fund. This programme seeks to understand the difficulties experienced by vulnerable veterans in dealing with suicidal thoughts and feelings but who are not successfully accessing the support they need. As a result of this investment, the Armed Forces suicide prevention strategy, developed with reference to current national suicide prevention guidelines (MoD, 2023)[7] highlights eight focus areas to deliver the overall health outcomes of increasing and supporting health and well-being whilst reducing suicide. One of these areas explicates that "…*service leavers are given additional support in transition to civilian life if they are identified as vulnerable"* (MoD, 2023, p.5).

It is encouraging that the needs of veteran and military personnel appear in general population national suicide prevention plans as well as MoD-specific prevention plans, demonstrating the importance of partnership working. For example, there is a specific reference to veterans in the NHS Long Term Plan (2019) stating there will be "…*support to veterans and families transitioning regardless of when people left the service*." This report indicates reference to, '*local transition teams'* for service leavers to respond to veteran needs and a rollout accreditation scheme for General Practitioners (GPs) to support the veteran community appropriately (p.119). In addition, NCISH (2021) report on actions and key milestones for suicide prevention for veterans, including work led by NHSE, such as: (I) pilot studies for access to services, (ii) regional distribution of relevant materials to support veterans and families; (iii) expansion of mental health services and (iv) commissioning of veteran high-intensity services (live from 2021). There are also recorded actions specific to data collection, for example, the Office of Veterans Affairs stipulates to improve data collation and reporting amongst serving personnel and veterans who die by suicide. The MoD does report data on death by suicide of military personnel, however, the data concerning veterans is not being recorded in England and Wales at present. From 2023, data relating to death by suicide for veterans will be recorded in England and

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[6] NHS Long Term Plan (2019) Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [Accessed 25th May 2023]

[7] MoD (2023) Armed Forces Suicide Prevention Strategy and Action Plan. Available at: Armed_Forces_Suicide_Prevention_Strategy_And_Action_Plan.pdf (publishing.service.gov.uk) [Accessed 25th May 2023]

Wales[8]. Improvements are relayed regarding the integration of MoD IT systems with NHS administration systems to flag if a patient has a military GP; thus, improving communication during the transition process, and improving access to salient information within existing NHS care provision.

Suicide is a serious public health problem that can have long-lasting effects on individuals, families, and communities. Preventing suicide requires strategies across all levels of society. Such an approach, ideally, should include psychoeducation around death by suicide, how to prevent it, what protective strategies can be put in place to prevent occurrences, and what strategies are required to protect military veterans, their families, and wider communities, and the part that broader society can play in reducing death by suicide within the military/ veteran population.

Advances in health and social care provision increasingly supports the integration of empirically supported interventions. Evidence-based practice is defined as the careful, transparent, and judicious use of current best evidence in making decisions about the care of service users and their families in health and social care and includes:

1. Making decisions based on peer-reviewed research evidence
2. Patient/Practitioner experience and expertise
3. Using data and information systems systematically
4. Conducting robust evaluation of the use of any new intervention in practice
5. Feedback from practice, practitioners, patients, and systems
6. Dissemination of what is learned.

The One is Too Many (OiTM) Programme[9] and the 'Identify, Understand, and Prevent' research carried out by The Northern Hub for Veterans and Military Families Research at Northumbria University, was mindful of the above principles. This document will provide an overview of the research undertaken to understand suicide within the veteran population and provide organisations with a framework and toolkit to help them consider and reflect on how they might create a safer environment for those that the organisation cares for and reduce suicide.

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[8] Balogun, B, and Garrott, K (2022)Suicide prevention: policy and strategy House of Commons Library Available at: https://researchbriefings.files.parliament.uk/documents/CBP-8221/CBP-8221.pdf [Accessed 25th May 2023]

[9] Part of the Veterans' Mental Health and Wellbeing Fund, the One is Too Many programme awarded grants of up to £300,000 to two-year projects that aim to reduce suicide risks within vulnerable veterans in a co-ordinated and targeted way.

Identify, Understand, and Prevent

How to use this document

This OiTM report aims to offer guidance and support to all agencies (statutory, voluntary and third sector) working with veterans and their families to aid the reduction of suicide. It is constructed to reflect the journey to suicide, and to enhance support to those working with vulnerable populations including veterans and their families. The intention is for this document to operate on two different levels: firstly, the veteran and their family, and secondly, existing service provision. However, the aim of this document is not to provide a specific plan to implement, as one plan will never fit all. The Framework and Tool Kit is specifically designed to help and assist organisations focus on specific areas associated with suicide in the veteran population (based on the empirical findings of this OiTM study), whilst also highlighting the importance of protective factors. This OiTM document is designed to aid organisations in developing a bespoke approach to suicide prevention and improving provision and support for service users and families.

Terminology

The primary data collected for this OiTM study principally came from surviving families of completed suicide by both serving and veteran populations. The research identified multiple layers of complexities from the many narratives captured – all of which are important and needing a voice. However, this document will only highlight critical components from the data obtained from the research. Several further research articles will follow to disseminate, in more detail, the broader aspects of the research data. To be more precise, this document will solely focus on a specific narrative - a veteran population who, at the time of their death by suicide, were under the care of either statutory or third sector services. For further clarity, this OiTM report acknowledges that the term 'family' has different meanings to different stakeholders, and therefore when we discuss the family, we are referring to family members (spouse/child etc), significant others, close friends, or those the veteran identifies as significant others.

The approach to this OiTM research project utilised a philosophy essential to maximise in-depth understanding of the lived experience of bereaved families in capturing the journey to suicide and the indelible footprint left with families and loved ones. Co-production research methodology has distinct benefits in capturing multiple narratives to improve the process of shared learning. Often, by involving individuals with a stake in an area of focus, enhances the quality and richness of the narratives obtained, and in working towards positive change. All the narratives obtained came directly from surviving families. These narratives then helped shape this report, its critical findings, and subsequent recommendations in maximising understanding, improving service provision, and nurturing best-practice moving forward.

Research Aims and Objectives

The overall aim of the **Identify**, **Understand**, and **Prevent** project was to:

1. Develop a richer understanding of the journey to suicide in the veteran and military population[10];

2. Co-produce an integrated Framework and Model of safety which uses a multi-agency approach to identify, manage, and reduce the risk of suicide for those under care of the NHS, HSC, third sector Mental Health provider and the veteran connected voluntary sector.

The two-year research project consisted of three distinct phases, highlighted in Table 1:

Table 1 Project Phases

Phase 1:	In-depth interviews with military families and military Veteran's Families bereaved by suicide to explore the complex life events and circumstances which led to suicide, the suicide itself, and the subsequent impact on the family
Phase 2:	A series of co-production workshop method[11] delivered across the UK including families, selected experts and representatives from the health and social care sector as well as key veteran-connected stakeholders including health and social care providers (statutory, third sector and charities) and local authorities
Phase 3:	Develop a framework and toolkit for suicide prevention using an integrated model of safety developed during phase 2

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[10] We will be addressing suicide in the military serving population in a later publication.

[11] Co-production is a collaborative model of research that includes stakeholders such as patients, the public, donors, clinicians, service providers, and policy makers. It is a sharing of power, with stakeholders and researchers working together to develop the agenda, design and implement the research, and interpret, disseminate, and implement the findings.
Redman S, Greenhalgh T, Adedokun L, Staniszewska S, Denegri S, et al. Co-production of knowledge: the future *BMJ* 2021; 372 :n434 doi:10.1136/bmj.n434

Phase 1: In-depth Interviews

Ethics

Full ethical approval for this OiTM research project was granted by Northumbria University. For each interview, a Participant Information Sheet (PIS) was provided, including a Consent Form to participate within the study. Throughout the in-depth interview process multiple consent points were used.

Method

Families were recruited from 'For the Fallen' – a Social Enterprise/ Community Interest Company[12] and NGO, whose goal is to raise awareness and 'give voice' to families left behind by military and veteran suicide.

Phase 1 used a Narrative Inquiry methodology, which is appropriate when seeking to enquire into the meanings people make of their lived experiences, where the intention is to study a person in the context of their social environment, and where the study relates to a new and relatively unexplored area within the existing academic literature[13]. Additionally, a modified 'life-grid' approach[14]was used for the interviews, which provided a structure from which to elicit a narrative and diagrammatic chronography of significant events in a person's life. A series of structured prompts served to scaffold the storytelling and map the temporal journey to suicide.

Participant Group

The minimum age for participation for inclusion within the OiTM study was 11-years old. The rationale for this being twofold: (i) 11 years is the age that most children in the UK commence secondary school, and (ii) the increasing literature on children being active researchers and the realisation that children, as social actors with rights, agency, and world view[15].

A peer-informed approach was adopted to recruit participants through the agency of 'For the Fallen' (CIC). Potential participants were sent a study information sheet to assist them in deciding if they wished to participate. Informed consent was obtained prior to data collection, with participants informed they could withdraw from the study at any time (up to the end of the formal project), without consequence.

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[12] For the Fallen Community Interest Company works with military families who have been bereaved through suicide

[13] Patton, Michael Quinn. 2002. 'Qualitative research and evaluation methods. Sage', Thousand Oaks, CA.

[14] Richardson, J., Ong, B. N., Sim, J., & Corbett, M. (2009). Begin at the beginning … using a life grid for exploring illness experience. Social Research Update, 57, 1–4.

[15] Kellet, M., Forrest, R., Dent, N., Ward, S., Carlini, A., Barry, E., ... & Graham, D. (2005). Children as active researchers. A new paradigm for the 21st Century.

Study Demographics

The study included 37 participants from 23 families from across the UK who were bereaved by suicide. Table 2 outlines the study population, which consisted of 37 participants (family members of those that died by suicide), with 75.7% (n=28) female and 24.3% (n=9) male. The mean age of the participants was 52.65 (SD 13.6) years and the ages ranged from 21 to 80 years. The mean age of the family member who died by suicide was 37.2 years (SD 13.3) and the age at death ranged from 20 to 74 years. The mean time since the death occurred and when the study was undertaken was 7.35 years (SD 8.3), and the years since death ranged from 1 to 38 years. The service in which the deceased served was predominantly Army (82.6%; n=19) and the gender of those that died was all male.

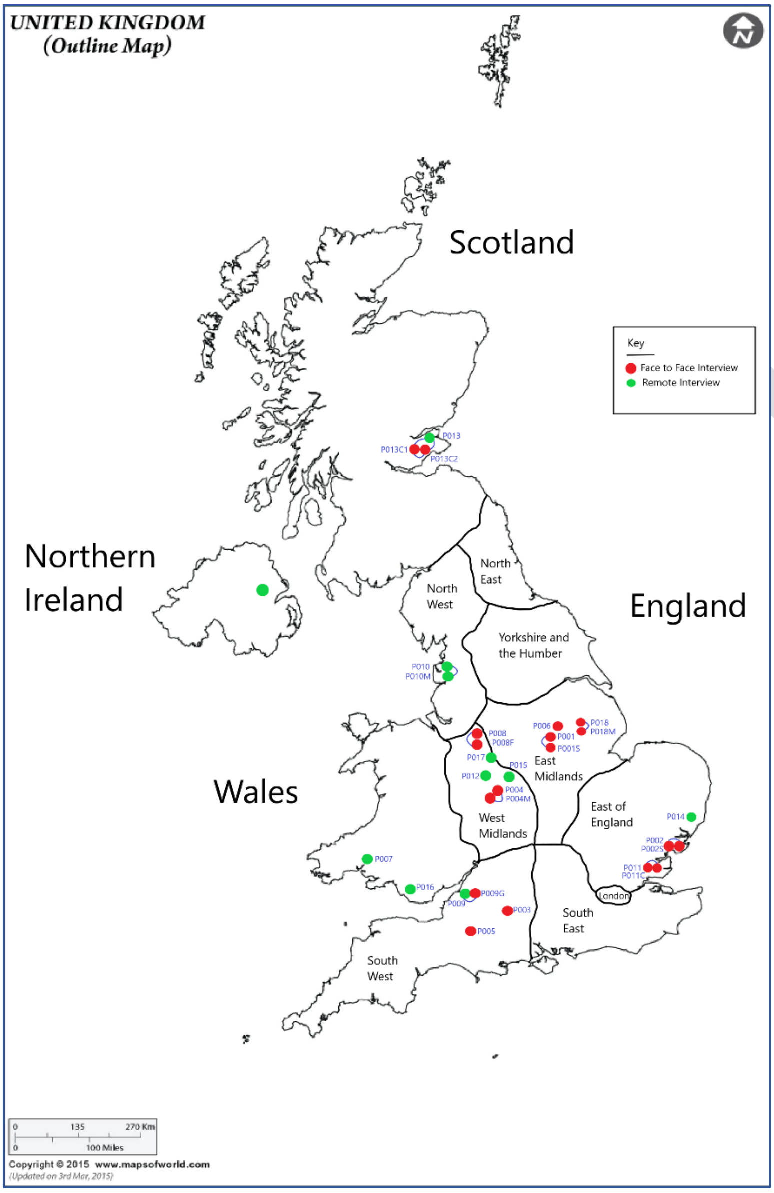
Table 2 Demographic Characteristics of participants

No of Participants		**N = 37**
Mean age of participants in years (SD)		52.65 (13.6)
Age range of Participants in years		21 – 80
Gender (%)	Female	28 (75.7)
	Male	9 (24.3)
Relationship to the deceased (%)	Mother	9 (24.3)
	Father	4 (10.8)
	Spouse/Partner	10 (27)
	Son/Daughter	3 (8.1)
	Grandparent	1 (2.7)
	Sibling	5 (13.5)
	Step-Son/Daughter	3 (8.1)
	Step-Parent	1 (2.7)
	Friend	1 (2.7)
Mean age of family member who died by suicide in years (SD)		37.2 (13.3)
Age range of family member who died by suicide in years.		20-74
Missing		1
Mean time since death in years (SD)		7.35 (8.3)
Time since death range in years		1-38
Service (%)	Royal Navy/Marines	1 (4.3)
	Army	19 (82.6)
	Royal Air Force	2 (8.7)
	Missing	1 (4.3)

Geospatial Demographics

Figure 1 highlights the geospatial demographics of the participants within this study. The team used a hybrid approach to data collection which consisted of in-person recorded interviews together with online audio-recorded interviews.

Figure 1 Geospatial Distribution of Participants



Data Collection

Narrative Inquiry requires the systematic gathering, analyses (and re-telling) of peoples' stories and involves the following two stages:

1. **In-depth interview/s:** This was the primary means of data collection (please see background information for interviews below) and, usually, cannot be conducted solely within one research interview. If required, the interview team allowed gaps between interviews to allow participants time to reflect on their stories. If a second interview was not needed, the participant was able to contact the team if they felt they required to follow up with any additional information.

2. **Observation:** This involved the project team shadowing the participants over the course of the project to better understand their particular stories, enhance the trusting relationship, with the purpose of creating safe spaces to maximise disclosure of thoughts, feelings, insights, and behaviours.

Participant-led Interview Topic Areas

The aim of using a life grid approach to interviewing enabled the interviewer to elicit a full narration by the interviewee to capture the journey to suicide. Moreover, using a narrative whole-life approach method to data collection, the start, middle and ends of the narrated stories were dictated by the participants. Utilising this approach to data collection enabled the fluid nature of the participants storytelling to be actively constructed and, therefore, achieving a comprehensive narrative of the participants' experience of three central issues:

1. ***The Journey towards:*** The participant's observations of the cumulative events that led to the suicide – paying attention to the temporal context of events – past, present, and future, and in turn, how these are characterised and understood. It was important to remember that the narrated events, in some cases provided a whole life narrative, going back to early childhood.
2. ***Experiences of Services:*** The participant's experiences of the death by suicide and the concept of external service providers service delivery or contributing factors that potentially led to the decision for the family member to take their life.
3. ***Legacy Impact:*** Capturing the participant's unique, lived experience following the death by suicide.

The structured prompts utilised (see Table 3) served as a support to the storytelling to ensure all life events were covered. Some of the participants started with the suicide and were supported by other prompts to explore the whole life of the individual.

Table 3 Structured Prompts

Question	Please tell us about or describe, where possible and if you can:
1	Exactly what happened – in your own words, tell the story
2	A time when you can remember when they had no worries and they enjoyed life. What were their home-life/family-life/relationships like at this time?
3	About earlier life and up-bringing
4	Any salient events or experiences during earlier years that you may consider important – negative or positive.
5	Your experiences of the person before their time in service
6	Any profoundly positive aspects of the person
7	Your experiences of NHS/Social Services/ Charities
8	Ways in which their care was 'trauma-informed'
9	An example of a 'success story' in their care
10	Feedback you would provide to those NHS/Social Services/ Charities that were involved? How sensitive or compassionate were these services/ interventions? How well do you think the support was handled?
11	Your experience of 'crisis situations' and how quickly they were responded to

Further open-ended and probing questions explored how respondents thought/felt about certain events, or to seek clarification. Open-ended questions typically start with: 'Tell', Explain', 'Describe' and generally yield longer, more detailed and more accurate responses than other forms of questions. Probing questions, also known as 5WH questions, are generally asked to follow up on a topic that was highlighted following the open question. They include questions that start with: 'what', when', 'where', 'why', 'who' and, 'how'.

Service history experience	Joining up/recruitment. Training Operational events
Veteran experience	Rehabilitation Physical and Emotional support Home life and Family life Housing and Post-service employment

Data Analysis

Phase 1 interviews were analysed using the life-grid approach[16] and chronological coding to identity the beginning, the middle, and the end of the participant story. This approach to organising stories provided a structure from which to elicit a narrative and provided a diagrammatic chronography of significant events in the deceased person's life. The series of structured prompts served to scaffold the storytelling and enabled a parallel set of personal biographical narratives to be formed into a systematic temporal structure. This provided a 'whole' life story, identifying aspects and moments in time, which included early life, pre-enlisting home life, current home-life, relationships, marriage, children, occupational matters, and housing.

Participants' transcripts were initially analysed as an individual story (as described above) to identify themes within their temporally ordered narrative (i.e., the beginning, the middle, and the end of their story). Each individual story was summarised by the developed themes. The next phase of data analysis consisted of collating all the individually themed description, and thematically analysing them across all families. On completion of this data analysis phase, the data was further analysed to identify the themes which mapped the collective temporal journey which identified specific moments in time across all the themed data (see Figure 2).

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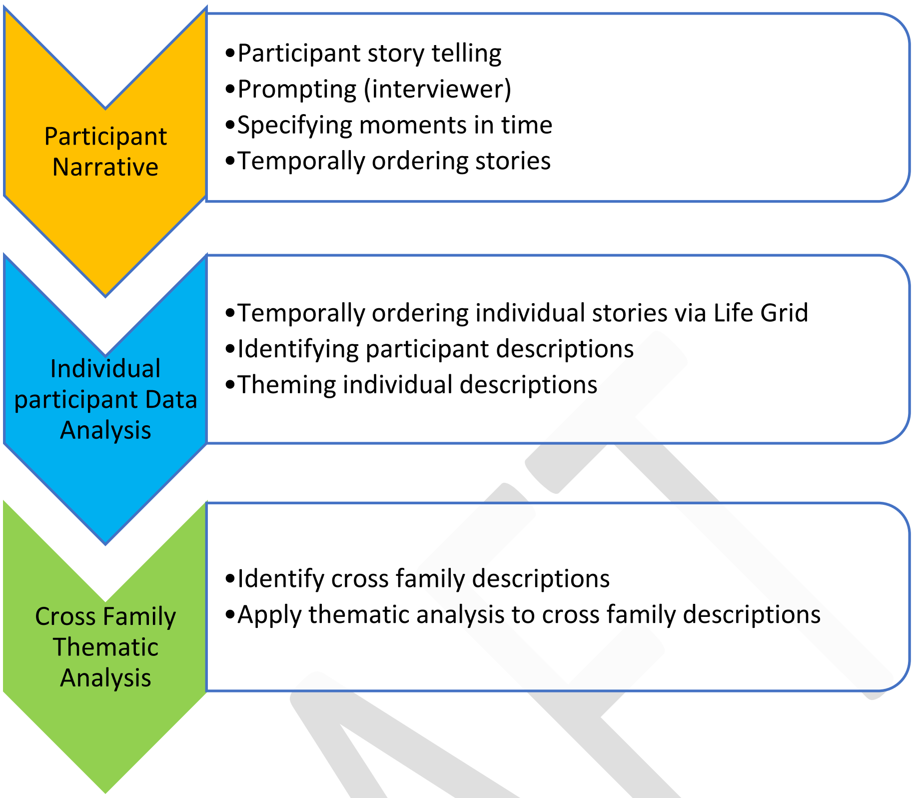
[16] Richardson, J. C., et al. (2009). "Begin at the beginning, Using a Life grid for Exploring illness experience." Social Research Update 57 http://sru.soc.surrey.ac.uk/SRU33.html.

Figure 2 Method of Analysis



Once the whole data set had been temporally themed, we identified that 41.67% (n=10) of the families within the study lost their family member to suicide whilst under the care of the NHS or a mental health service provided by the charity sector. At this stage of the data analysis, it was considered that caring for those that have been identified as vulnerable and under care should become a priority. This left the final stage of analysis focussing on the whole dataset which identified the cross-cutting themes from the middle of the stories associated with the breakdown of care from external health and social care providers.

Findings

As described in Table 2, the study cohort consisted of 37 participants (see Table 3), 75.7% (n=28) were female and 24.3% (n=9) were male. The study included 23 families from across the United Kingdom who were bereaved by suicide. The mean age of the participants was 52.65 (SD 13.6, range 21-80) years. The mean age of the family member who died by suicide was 37.2 (SD 13.3, range 20-74) years. The mean time since the death occurred and when the study was undertaken was 7.35 (SD 8.3, range 1-38) years. The service in which the deceased served was predominantly Army (82.6% - n=19) and the gender of those that died was all male.

Tragically, the failure to identify, connect, and positively engage with these individuals culminated in instances of suicide. Notably, a significant portion of the suicides occurred among military personnel, with **Error! Reference source not found.** demonstrating that a high percentage of veterans had been under mental health care at the time of their deaths or having had prior contact with services.

Table 4: Vulnerability and contact with services.

Suicides During Military Service	Veteran Suicides
○ 28.6% not identified as vulnerable	○ 23.5% not identified as vulnerable
○ 57.1% identified as vulnerable but not connected to services	○ 23.5% identified as vulnerable but not connected to services
○ 14.3% identified as vulnerable and connected to services	○ 52.9% identified as vulnerable and connected to services
○ Timespan between 1-38 years ago	○ Timespan between 1-12 years of leaving the military

Table 5 demonstrates data reduction and the transparent process of 'cross family's' narrative data analysis undertaken. The left of the table demonstrates the emerging themes from the participants stories, these stories were subsequently reduced into seven superordinate themes, which reflected the cross-family experiences and their collective journey to military suicide.

Table 5: Primary and secondary data reduction

Emerging themes from participant narratives	Cross-Family superordinate themes
1. Signs and symptoms: History of mental health disorders, evidence or previous suicide risk indicators, comorbid presentations & complex mental health presentations (e.g., substance misuse and aggression as coping strategies and indicators of vulnerability)	**1. Lack of knowledge, training, and education to identify, engage, and manage vulnerability.**
2. Stigma: Inequalities in physical vs mental health care & internal stigma (weakness, negative career repercussions, selfish, cry for help or attention-seeking, military suicide deaths unequal to combat deaths)	
3. Military service: Military-specific needs and priorities including culture, language, poor engagement & maladaptive coping (substance use, concealment, and avoidance)	
4. Treatment approach: Available services and referral process including compassionate engagement and care	
5. Lack of Trauma-informed care and communication	
6. Poor assessment, monitoring, and early identification of vulnerability 7. No pre-emptive transitional support (military to civilian life or between civilian services) 8. Wait and see approach when care relationship broke down (reactive not proactive)	**2. Passive Care**
9. Unpopular patient (substance use or perceived aggression) 10. Dismissive or disrespectful attitude 11. Early/repeated discharge or disengagement	**3. Compassion Fatigue**
12. Limited scope and eligibility (fail to address complex needs and comorbidities) 13. Unsuitable facilities and treatment (not military-specific or trauma-informed, default medication or Cognitive Behavioural Therapy approach) 14. Delays and lack of prioritisation in care	**4. Poor service accessibility and availability**
15. Lack of holistic and integrated support specific to individual needs 16. Repeated referrals and re-traumatisation 17. Lack of transparency and care continuity 18. Poor follow-up and relapse prevention	**5. Poor collaboration and communication between services**
19. Dismiss insight and input - Symptoms and functioning - Treatment plan development or feedback on efficacy - Safeguarding concerns and expectation of self-referral for support (family/significant other not refer on behalf of despite potential incapacity during crisis) 20. Limited communication and confidentiality used as a barrier 21. Lack of carer/family support and safeguarding	**6. Family exclusion**
22. Overt pathway: identification of vulnerability but unable to access effective support 23. Covert pathway: no identification of vulnerability until after suicide	**7. Specific contact failures for diverging suicide pathways:**

Lack of knowledge regarding military culture, training, and education to identify, engage, and manage vulnerability.

The findings suggest that service providers lacked the adequate knowledge to identify vulnerability in veterans and their families. This included both the clinical symptoms and subtle signs of common mental health disorders such as PTSD and depression, suicidality and specific complex and comorbid presentations found within this population, such as comorbid substance misuse.

> *“Because I weren’t all that knowledgeable about PTSD, I am still not, I suppose, of what, you know, what it can do and affect somebody, especially military PTSD. You know, and at the inquest, they were basically saying that [anonymised] had developed a drink problem and my argument was, well, is that not a symptom of PTSD? To alcohol abuse, yes, but they never once said that it was down to PTSD, it came back as a narrative verdict.”* ***[Participant 1]***

> *“…he wanted to get away from the alcohol, he wanted to get away from the kind of routine that he was in and he wanted a massive detox off the alcohol, when for him, he didn’t know how else to do it because he was begging to be like you know a residential thing for PTSD, he was told four times he would have this residential. It never happened.”* ***[Participant 4]***

For those who had left the Armed Forces, civilian service providers did not appear to understand military culture. In particular, understanding of the types of occupational stressors military personnel experienced, their specific needs and priorities, and how to effectively engage with and support these individuals. For example, their appeared to be a lack of awareness in relation to the importance of trauma-informed and compassionate care, understanding non-verbal communication and wider knowledge of internal stigma and the barriers to care that it poses for veterans who need help.

> *“The main things for me are, recognising these red flags specific to the military, acting on them and getting them to engage. They need to get it out of their heads. It is not man up, you know, it’s still a culture in the military, where they’ve got this man up attitude. So [anonymised] attitude is, if I can’t deal with this myself, I’m not a man….”* ***[Participant 10]***

> *“Stigmatised perceptions of mental health were observed, such as mental health being seen as unequal to physical health, suicidality as a sign of cowardice or attention seeking or suicide being something that, if discussed, may increase the risk of individuals dying by suicide.*

> *When [anonymised] first went into hospital, it was, he just didn’t want his family to know because of the stigma around mental health and what they would say and how they would react to that………his mum would sort of occasionally phone up and I’d have to lie and say well, [anonymised] not here right now, I will get him to phone*

> *you back……… it must have been a good four or five years before he finally told her that he was struggling with his mental health.”* ***[Participant 23]***

> *“…. how many children are growing up without their parents because their parents thought there was nothing else to live for, they’ve took their own lives. How many children are out there that are growing up with that stigma in their life, because it still is a massive stigma. I’ve… I’ve had a lot of negative comments about [anonymised] suicide ……”* ***[Participant 4]***

These negative stereotypes appeared to hinder the effective identification and management of vulnerability within service users when accompanied by harmful misperceptions of veterans such as aggression and substance misuse. Care providers seemed ill-equipped to identify and manage aggressive behaviour or substance misuse or view them as potential aspects of a complex and vulnerable presentation.

Passive Care

Participants reported a passive approach by service providers in identifying and managing vulnerable veterans and their families. In particular, it was identified that there was a poor baseline assessment, which failed to identify keys risk factors. The findings showed that assessment also failed to identify individual strengths that may have maintained the safety of the deceased. Following assessment, it was also observed there was poor active monitoring of indicators of risk, or active early intervention to prevent the cumulative erosion of coping resources over time.

> *“….the psychiatrist had planned to sign him off, discharge him and he hadn’t even finished the assessment. He’d already written in the notes, discharge at the next meeting, but he hadn’t finished the assessment.”* ***[Participant 10]***

> *“…….so, I’ve literally been paying, paying for this because of other people’s lack of risk assessment, poor judgement, poor perception, stigma, just laziness. Not wanting to engage in anything to do with people’s suicide”.* ***[Participant 5]***

There was also found to be lack of pre-emptive support during the transitional stages of the veteran’s military career, such as enlistment, pre-or-post military deployment, during the pre-retirement period and reintegration back into civilian life. Most notable was the poor support when veterans were transferred between different civilian services, especially during the period of crisis before death. The findings implied that overall, service providers applied a ‘wait and see’ approach which allowed cumulative vulnerability to develop without intervention until individuals had already reached a crisis point in their capacity to cope.

> *"He was saying, stating then he was going to kill himself, he'd had enough……….and [anonymised] dropped the children to me and said, obviously I am going to go back in to sit with him and wait and see………..a nurse had approached him, and he was very big on eye contact and if you respected him, then he would respect you, but she'd said to him, well what do you want me to do? What…? You know and he was like, well you're the medical professional. I'm saying I want to end it; I've had enough. I can't take anymore; you're supposed to be helping me. She went, well I don't… What do you want me to do for you? And he walked out, and they just let him walk out."* ***[Participant 1]***

Compassion Fatigue

The findings suggested that an additional aspect of the service user and families experience was a less than compassionate response to veteran and family vulnerability. Most significant was the reporting of a generally dismissive or disrespectful attitude towards the veteran and their families during attempted help-seeking. An approach that lacked compassion appeared to be underpinned by the service providers lack of knowledge or understanding about mental health, PTSD, Complex PTSD, suicide, and military culture. The lack of compassion often prevented veterans and their families from accessing appropriate support, caused disengagement with the care process, and early discharge from services. This further contributed to the veteran's growing vulnerability, eroding coping resources which culminated in resignation and suicide.

> *"….there's got to be someone who these complex PTSD veterans can be pointed in the direction of and say, you know, he's difficult, he does go on drink benders and obviously drugs. So, he's going to need a little bit more compassion. You're going to have to be a little calmer with him, because that's what he's like."* ***[Participant 4]***
>
> *"I was quite vocal that I wasn't happy with the level of care that he was receiving. So I, you know, I made it a point of going in ……. putting in a formal complaint to them that I wasn't happy that they were telling him, when he was telling them he was concerned about how much alcohol he was consuming, they were telling him it's fine, it's part of your [anonymised] culture. They were excusing his behaviour and his feelings down to his [anonymised] culture and not really helping him."* ***[Participant 16]***

Poor service accessibility and availability

The findings suggested that there was a lack of trauma-informed or military-specific services available, particularly for veterans and their families. Many services were not equipped to deal with the complex needs and comorbidities that veterans frequently presented with and therefore excluded these veterans and their families from care (for example, not allowing access to PTSD treatment until comorbid substance misuse has been treated or discharging them from treatment programmes if they had a substance misuse relapse).

> *“If we don’t get training in place for all of these Crisis Teams on how to deal with someone with complex needs, like CPTSD or PTSD, which was missing in our case, nobody had the education or the knowledge, because they didn’t feel they needed it, because they didn’t have very many veterans coming forward in this area. But we need to make sure that that’s kind of rolled out.”* ***[Participant 10]***

> *“I think we always knew it was going to be the way… he would end up killing himself, ……………..It wasn’t that he actually wanted to die. He wanted someone to take… to realise how seriously ill he was, and he was begging for help…………. If things didn’t go right, then he would go on a bit of a drinking binge.… you wouldn’t say he was a drinker, but when he’d start drinking then it would be a binge drinking for him…… he crashed his car and he hurt his back, but he was really drunk and tried to flee the scene……. but the police obviously caught up with him because it was his car…..he felt like he had been discriminated against because of his mental health.”* ***[Participant 4]***

The findings suggested stakeholders would often apply default care strategies without tailoring support for the social or physical challenges that the veteran was experiencing. Moreover, failing to address the wider practical and social difficulties in the veterans’ lives caused further disengagement and frustration. Frequent care delays (for example long waiting lists and referrals) and the lack of availability of preferred support (for example, residentials and military-specific treatment programmes) further contributed to overall feelings of being dismissed, not prioritised within the health and social care system.

> *“He was on a list. He kept on getting put to the bottom of the list, because they would ask him to be sober for a certain length of time…. he would achieve that, but then he wouldn’t have made it to the top of the list. By the time he’d achieved that. So, it was… they would never, it was never aligned…. there must be a way that they can do it in tandem... because the thing is, for me and this is you know, this is from you know, like a loved one perspective, the alcohol for him was his crutch…. If you’re taking that crutch away then you need to be, you need to put something else in its place.”* ***[Participant 16]***

Poor collaboration and communication between services

Findings from this theme demonstrated the disconnected nature of care available for veterans and their families. This was where different service providers did not work in collaboration, or communicate effectively, to deliver holistic and integrated support to simultaneously address all complex needs and priorities. This lack of care coordination caused an overall lack of transparency and care continuity where veterans were repeatedly referred to different services without their relevant medical or service history. This repeated ‘wrong door’ approach, appeared to have caused re-traumatisation in many cases; and as a result, the retellings of their experiences multiple times, resulted in the veteran and their family’s increasing frustration with the care process. Moreover, there was also a lack of follow-up care (for example, no welfare checks if missed appointments) and only short-term, time-limited care provision instead of long-term ongoing care to support relapse prevention.

> *“I think sometimes where… and I know [anonymised] case is probably unusual in the amount of cracks there were that he fell through. I think he was kind of the, you know, big case, but I think everyone falls through a crack and I think the more and more agencies that become involved, the more cracks there are because there isn’t communication between those agencies.”* **[Participant 10]**

> *“There’s a massive lack of co-ordination there. There’s a lack of communication, proper communication between services and I’ve seen it between an awful lot of services and there’s a total lack of, I don’t know if it’s a want to understand. I think there’s a fear of veterans. I noticed that with a lot, this… they didn’t know what to do. And they just assumed the worst.”* **[Participant 16]**

Family exclusion

The findings from the theme of family exclusion demonstrated how stakeholders excluded the veteran’s family from the care process. This exclusion was reported in terms of dismissive attitudes towards their unique insight into symptoms, daily functioning, and safeguarding concerns. Of importance it was concerning to the families they could not refer to services on behalf of their loved one during periods of crisis. The families were also not consulted during treatment plan development and any feedback offered to maximise its efficacy was not acknowledged.

> *“I was involved in the support that he was being provided and I spoke with them directly and I told them, I don’t think, I don’t think this is the right place for him and they pushed back because they were like, well if he doesn’t come to the sessions then he’s not going to get the help that he wants which is the EMDR therapy.”* **[Participant 16]**

> *“I rang them constantly and said how long have you got to wait; he needs the help now. They wouldn’t talk to me, even when he gave permission for them to talk to me, they still wouldn’t, and they wouldn’t give us a time on how long he would need to wait. So, I was constantly ringing them to say look, he’s in crisis, we need help now.”* **[Participant 24]**

There was limited communication between service providers and the veteran's family about the military or medical information of their loved ones, including the referral and treatment process that could have helped them be more aware of, or responsive to, potential signs of vulnerability. This would have enabled the veteran's family to work with stakeholders to improve treatment outcomes. There was also a lack of support by service providers for the veteran's family to safeguard their wellbeing during the care process, especially children or those acting as the primary carer for their loved one, and in terms of provision of military-specific trauma-informed support after the suicide occurred.

> *"I get hold of …. [anonymised].., something's not working here. I didn't know about this. Somewhere along the line communication isn't working [banging for emphasis]. I'm here highlighting it, helping, putting it back again, helping again. They said, no, no, no. We have these fairs, we go to all the welfare officers, and I said, you know what, here I am with my family, I could do with some help and things aren't coming to me, because nobody wants, nobody wants, nobody wants to know. Nobody wants to know."* **[Participant 5]**

> *"When it came to informing us [about him absconding], the police informed the hospital, but the hospital didn't inform us, again it was the police that informed us. Like there just seemed to be absolutely zero communication from the hospital itself."* **[Participant 23C1]**

Specific contact failures for diverging suicide pathways:

The findings from this theme suggested there was a divergent pathway to death in the cases that were studied. Whereas one group of families reported that they could see the suicide coming as part of an uncontrollable escalation of crisis, other families were completely 'blind-sided' by the death having detected no signs of concern. We have referred to these as concealed and unconcealed suicide.

When the suicide was unconcealed, families reported that the veteran would become increasingly problematic as a patient, present with increased substance use, erratic behaviour, aggression, and resist care interventions. In contrast, those veteran suicides that were concealed were reported to just quietly and passively slip away from services, usually demonstrated by passive compliance, but gradually disengaged from care, missed appointments, and informing family and carers that everything was all right. There appeared to have been a lack of knowledge to identify subtle and overt signs of vulnerability and in all cases, a failure by multiple stakeholders to adequately respond to vulnerability and help-seeking behaviour. This appeared to cause a sense of resignation in the veteran and disengagement from services. The outcome in all cases was death by suicide.

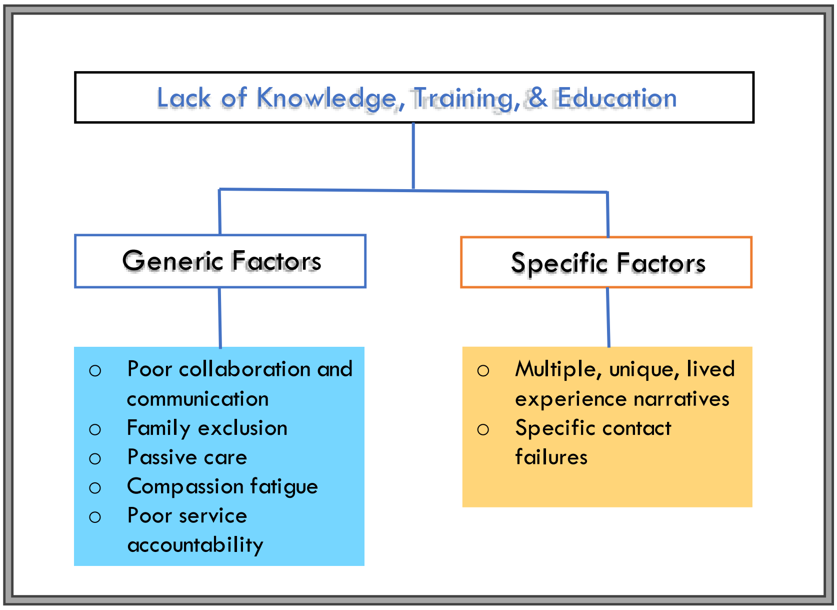
> *"I think what happened was, is he was prescribed medication before he went in [to prison], and then when he went in, he couldn't get hold of his medication, so then*

> *he took medication from people in prison and that was his, you know, fall to the end, because he then became addicted to that medication and that never stopped, he could never stop that medication."* **[Participant 2S1]**

> *"He was picked up by the police one day, I think for being drunk and disorderly. He had a bottle of whiskey and a packet of his medication because he was on medication for his mental health. I think it was olanzapine at that time and he… they released him, gave him all his medication and his whiskey back and he sat on the doorstep of the police station and drank all the whiskey and took all the medication. When I came to collect him, I found him there pretty much dead. He ended up in a coma."* **[Participant 16]**

Table 5 outlines the transparent process of 'cross family's' narrative data analysis undertaken by the research team. The left of the table demonstrates the familiarisation of descriptions from the participants narrated stories, which produced the primary data. The centre of the table demonstrates primary data reduction and the development of secondary data identified by number. The final phase of data reduction identifies the final super-ordinate themes. Figure 3 provides further clarity of the final super-ordinate themes supported by a full description.

Figure 3: Summary of findings from Phase 1



Summary of findings from phase 1

The process of narrative data reduction has identified the multiple layers of moments in time which have created a 'whole' life story and the journey to suicide. Within each data reduction phase, there are indicators for intervention, be that informal or formal, resulting in missed opportunities. The cross-family narratives all indicate a lack of knowledge regarding cultural awareness, an understanding of the presentation of mental ill health, and the ability to collaborate with the family and other service providers to manage the care of those who present as vulnerable safely.

Many individuals and their families faced challenges in accessing mental health services, leading to difficulty in finding appropriate treatment. The complexities of individual presentations, coupled with a lack of understanding of service options, contributed to confusion among families about the right approach. For those who did access services, the care received was perceived as passive, with providers unable to identify vulnerabilities and address ongoing health issues effectively. There was a perceived deficiency in trauma-informed care and understanding of the complex needs of vulnerable individuals, contributing to their isolation from services. The perceived lack of compassion and comprehension of persistent symptoms resulted in some individuals withdrawing from care.

Phase 2: Co-Production

Collaborative research, known as co-production, brings together clinicians, service providers, policy makers, researchers and the individuals who are the focal point of the study or will be impacted by its findings.

The rational for using this methodology was to harness active involvement of all critical stakeholders to shape the core findings and participate in the dissemination process.

For purpose of context, co-production as a research methodology include:

1. **Shared Decision-Making:** Co-production involves shared decision-making and power-sharing among researchers and participants. It acknowledges that each stakeholder brings unique insights and expertise to the research process.
2. **Equal Partnerships:** Co-production fosters equal partnerships between researchers and those being researched. It goes beyond traditional hierarchical structures, recognizing that diverse perspectives contribute to more meaningful and applicable research outcomes.
3. **Inclusivity:** The methodology values inclusivity, ensuring that the voices of all relevant stakeholders are heard and considered. This may involve including individuals with diverse backgrounds, experiences, and perspectives in the research process.
4. **Mutual Learning:** Co-production promotes mutual learning between researchers and participants. It recognizes that both groups have valuable knowledge to contribute and that the research process can be a learning experience for everyone involved.
5. **Applicability to Real-World Contexts:** Co-production aims to generate research findings directly applicable to real-world contexts. By involving those whom the research will impact, the methodology seeks to produce more relevant and actionable insights.
6. **Increased Trust and Credibility:** Collaboration and co-production can enhance the trustworthiness and credibility of research findings. Involving stakeholders from the beginning helps ensure that research questions are relevant, methodologies are culturally sensitive, and results are more likely to be accepted and implemented.
7. **Ethical Considerations:** Co-production emphasizes ethical considerations, ensuring that the research process respects the rights, dignity, and autonomy of all participants and includes considerations of power dynamics and potential conflicts of interest.

Method

The overall design of the research involved four co-production events, which took place across the United Kingdom. Contributors included surviving families who had encountered a military veteran suicide, representatives from the health and social care sector, statutory agencies, third sector organisations, politicians, retired military personnel, funding agencies, and other critical stakeholders.

In healthcare and social services, co-production refers to a model of service design that goes beyond service user consultation towards developing a model of service delivery intended to impact on service users and broader social systems. Collaborative co-production requires users to be experts in their own circumstances (such as participants in the current study) and capable of making decisions, whilst professionals move from being 'fixers' towards being 'facilitators'[17]. More specifically, this relates to the re-distribution of decision-making power within the relationship between provider and consumer or professional and person with the lived experience[18]

The aim of phase 2 was to use the findings from phase 1 to integrate factors such as nurturing a safe space, open communication, and compassionate engagement, to co-produce an evidence-based model of intervention. This intervention needed the capability to manage veterans who have been assessed as being actively suicidal (that is, having shared thoughts or assessed to be planning suicide) and no longer able to manage their own safety.

Considering the findings outlined in Table 5: Primary and secondary data reduction, each of the four co-production events were designed to answer a specific set of questions based on the findings of phase 1. Furthermore, each co-production event used an iterative process so that each event informed the next. For example, superordinate themes from phase 1 informed co-production event 1, co-production event 1 informed co-production event 2, etc. This method of data collection enabled an iterative and collaborative process of understanding the implications of the findings of **Phase 1** and enabled the co-development of a framework for solutions to the challenges identified.

Co-Production Event 1

This event focused on themes that related to veteran suicide only based around two superordinate themes that characterised a break down in care and the care relationship. Table 5 shows the emerging themes from across family's narrative analysis which informed the formulation of questioning for this co-production event and Table 6 shows the superordinate findings of co-production event 1.

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[17] https://qi.elft.nhs.uk/wp-content/uploads/2017/01/what_is_co-production.pdf

[18] https://imroc.org/resources/13-co-production-sharing-experiences-reflecting-learning/

Findings

Person-centred care relationship

The first theme described the desired characteristics of a person-centred care approach (involving both the veteran and their family) that should represent the core element of any model of safety and prevent breakdown in care. Within this person-centred care model, all providers should have military-specific knowledge, personal integrity, and a compassionate approach to build rapport and empower veterans and their families to engage with support whilst managing their expectations, maintaining consistency, and simplifying the care process.

Care coordinator or multi-disciplinary team

The need for a designated individual within the service provider to act as a single point of contact for the veteran and their family to navigate and oversee care on their behalf is vital. This role could be a single individual or multi-disciplinary team who would ensure continuity of care by communicating with relevant stakeholders and coordinating all aspects of the care process including assessments, referrals, treatment, and follow-up. Care coordinators should possess the characteristics highlighted in theme one (above) to build the necessary care relationship with the veteran and their family. It was argued that a holistic knowledge and understanding of all the needs of the veteran and their family unit was essential so that the designated individual could effectively advocate on their behalf.

Centralised care service

This theme described the desired characteristics of a centralised care service that would provide holistic support for the veteran and their family, which could be flexibly adapted in response to their individual and collective needs. Care within this centralised system should be co-ordinated, easily accessible, and visible, and underpinned by relevant knowledge and education. A proactive approach should be taken to provide support during the transition back into civilian life to facilitate identification of veteran status, transfer of records, assessment of needs and priorities, and development of a subsequent plan to monitor wellbeing. This would improve recognition of identified strengths and manage identified vulnerabilities.

Table 6: Co-production 1 – key themes, data capture, to superordinate themes.

Co-Production 1 (CP1)		
Key Themes from phase 1	**CP1 Questions around Service Provision and Care Co-ordination**	**Results: CP 1 Superordinate Themes**
Key theme: addressing break down in care and the care relationship. **Subthemes:** 1. Characteristics of a good care relationship 2. Characteristics of a good model of suicide prevention **3.** Care coordinator or multi-disciplinary team	Each group was asked to consider the data presented in relation to the five questions below, whilst reflecting on the key themes on the left: ○ How do services need to work? ○ What are the core values? ○ What kind of support do services need to provide to maintain hope for service users? ○ Who will provide what service? ○ How can continuity and co-ordination be maintained?	**Person-centred care relationship** ○ Military-specific knowledge ○ Compassion and integrity ○ Respect, autonomy, and realistic expectations ○ Simplicity and consistency **Care coordinator or multi-disciplinary team** ○ Single point of contact to navigate and oversee. ○ Transitional support ○ Proactive and strength-based ○ Co-ordinated and centralised **Centralised care service** ○ Responsive and flexible ○ Facilitate care continuity. ○ Accessible ○ Information provision and education

Co-production Event 2

Similar to co-production event 1, this event focused on the cross-family themes identified from phase 1 and the findings from co-production event 1. Additional themes were identified relating to indicators of risk that emerged in the journey to suicide across different life periods (pre-enlistment, military service, civilian transition, and veteran life). This event also explored the barriers to adequate identification and responses to this risk by multiple stakeholders. These themes informed solution-focused discussions during the second event to address these barriers and further develop the model of safety developed in the first workshop.

To engage the delegates better, the evidence presented at this event was powerfully enriched by bringing the stories to life using vocal narrative techniques. The voices of the participants, using direct anonymised quotes, were performed to the event participants by an actor. This proved very successful in enhancing the impact, power, and potency of the research participants' narratives on an emotional and visceral level.

Findings

Co-production event 2 identified a further two emerging superordinate themes (see Table 7).

Additional characteristics of a good model of suicide prevention

These included better identification of potential support during transition that could be implemented during different life periods (e.g., military enlistment, training, military service, and civilian transition) to promote early and ongoing assessment, effective monitoring, and vulnerability management. A specific focus was placed on better cross regional and multi-agency working, early intervention when appropriate and better management, and a more responsive approach, of mental health crisis.

Additional characteristics to address ongoing care barriers.

The need for psychoeducation and training across all levels of the veteran care sector was also identified as a significant requirement. An enhanced psychoeducational approach would seek to improve knowledge and awareness of the: impact of poor mental health; talking about suicide and recognising those that might be vulnerable. This included a consensus that specific education about military culture, and promotion of the availability and referral processes of military-specific services was required. It also identified that many of those who worked and lived within the Armed Forces veteran population remained fearful and reluctant to have open conversations about suicide, for fear of causing a suicide themselves. It was agreed that more education was needed to enable individuals to engage in open conversations about suicide as part of society's shared responsibility for suicide prevention.

Table 7: Co-production 2 – emerging themes, data capture, to superordinate themes

Co-Production 2 (CP2)		
Emerging themes that provided the evidence base for questions in co-production event 2	**CP2 Questions around Service Provision and Care Co-ordination**	**Results: Superordinate Themes from CP2**
Key theme: addressing barriers to inadequate identification of and response to indicators of risk. **Subthemes:** 1. Emerging signs of vulnerability during pre-enlistment and military service 2. Poor response to identified vulnerability by the military and civilian organisations (statutory health services and third sector charities) including during the transition to civilian life.	Each group was asked to consider the data presented in relation to the four life periods below, whilst reflecting on the key themes on the left: ○ pre-enlistment ○ military service ○ civilian transition	**1. Additional characteristics of a good model of suicide prevention** ○ Cross-regional and multi-agency ○ Mental health equal to physical health ○ Early intervention ○ Biopsychosocial ○ Daily functioning and crisis periods **2. Additional characteristics to address ongoing care barriers** ○ Education for identification and appropriate response to vulnerability ○ Challenging stigma ○ Shared responsibility for suicide awareness and prevention ○ Service promotion ○ Transitional assessment, training, and support

Co-production Event 3.

This event addressed participants' specific recommendations concerning suicide prevention. In particular, the lived experiences of military culture, mental health needs, coping strategies, and complex presentations (see Table 8).

<u>Findings</u>

Additional characteristics of a good model of suicide prevention

Views and opinions focused on wider collaboration and service eligibility, including heightening public engagement. Suggestions included nuanced and audience-dependent delivery of mandatory training and the need for collective acknowledgement of responsibility for suicide awareness and prevention across all levels of the sector that cares for veterans and wider society.

Additional characteristics of good training and psychoeducation

This event identified the need to address internal and external stigma (highlighted in the previous co-production events) and the supervision of staff within organisations that provide care. In particular, the understanding of direct lines of accountability, and for those delivering care, an understanding of what accountability is and what they are accountable for. When considering accountability, the delegates asserted that those delivering services should have robust evaluation practices in place that uses an evidence base to build service development. Most important was that service development should be built around individualistic service delivery, adopting the personalised care model, which should be underpinned with an approach of proactive engagement. Phase 1 findings identified that passive engagement, e.g. when care services fail to follow up on missed appointments or family concerns around vulnerability, was a significant cause in the suicides that were studied. Proactive engagement was described as following up every missed appointment, responding to expression of concern from families and friends and recognising that relapse can occur at any time, some having proactive pathways to return to services without having to seek re-referral.

A broader finding of this event was the need for organisations to be proactive with public health preventative strategies, such as national campaigns for suicide awareness in the veteran sector and a wider program of psychoeducation for service providers to better promote reflective practices and consideration of the services they are delivering.

The third co-production event enabled stakeholders to consider the importance of recognising vulnerability and implementing risk monitoring and understanding the need for early intervention. Comfortable conversations about suicide alongside recognition of the risks were considered necessary. Stigma was highlighted as a significant concern and a barrier to access and quality of care. In response, the collaborative solutions from the workshop focused on ensuring that services are delivered in an environment that is compassionate, non-judgemental, and de-stigmatised.

Table 8: Co-production 3 – emerging themes, data capture, to superordinate themes

Co-Production 3 (CP3)		
Emerging themes that provided the evidence base for questions in co-production event 3	**CP3 Questions around Service Provision and Care Co-ordination**	**Results: Superordinate Themes from CP3**
Key theme: ○ Participant recommendations for suicide prevention **Subthemes:** ○ Need for education to identify and adequately respond to vulnerability ○ Family integration ○ Societal attitude change and de-stigmatisation	Each group was asked to consider specific recommendations concerning suicide prevention, which included further clarification of a proposed training and education component and the barriers to accessing support and appropriate care. ○ How do we improve the recognition and identification of vulnerability within civilian and military contexts? ○ Support reintegration back into the civilian community, and the importance of proactive engagement in terms of transitional support, risk monitoring and early intervention? ○ Enable family integration in care planning and support in a holistic way terms of de-stigmatisation of mental health perpetuated in military culture?	**1. Additional characteristics of a good model of suicide prevention** ○ Collaboration and service eligibility **2. Additional characteristics of good training and education** ○ Stigma (internal/external) ○ Supervision and accountability ○ Evaluation and iterative development ○ Individualistic service delivery / personalised care ○ Ongoing/proactive engagement ○ Public health campaign

Co-production Event 4

At the time of the final event, 37 transcripts had been analysed. This represented most of the data and therefore a key emerging superordinate theme describing the full ‘journey to suicide’ across all of the suicides was extracted to inform solution-focused discussions. This event focused on the barriers that were identified from phase 1 data and previous co-production events. At this point in the study, the discussion amongst the research team focused on what a ‘safe environment’ of care could look like, or more importantly, what does ‘good’ practice look like. In particular, what factors would be necessary to create a ‘safe environment’ which prevented veterans who were vulnerable from ‘falling through the system’. Therefore, co-production event 4 focused on the barriers to care that created situations, or environments that created risk. The event specifically focused on examining those barriers at all levels of service delivery, from government policy to the frontline delivery of care.

Findings

The final co-production event culminated in developing a potential evidence-base and acknowledged vital components of the emerging concept of an environment of safety which included: (i) a knowledge of the military-specific journey to suicide, and (ii) an understanding of the complex strengths, vulnerabilities, and diverging presentations of this population that need to be identified and managed within a model of personalised care (see Table 9).

Table 9: Co-production 4 – emerging themes, data capture, to superordinate themes.

Co-Production 4 (CP4)		
Emerging themes that provided the evidence base for questions in co-production event 4	**CP4 Questions around Service Provision and Care Co-ordination**	**Results: Superordinate Themes from CP4**
Key theme: ○ Journey to suicide **Sub-themes** ○ Micro-level: cumulative vulnerability, complex presentation, suicide event via diverging pathways to suicide ○ Meso-level: contact failures (multiple stakeholders and contact points), poor identification, poor response to identification, family exclusion ○ Macro-level: lack of knowledge, training and education to identify and respond to vulnerability, stigma (military, service providers, society) **Merging themes from previous co-production events** **Key theme:** ○ Addressing remaining barriers to effective implementation of the model of safety **Sub-themes** ○ Knowledge and stigma ○ Accessibility and confidentiality ○ Funding and resources ○ Accountability	The participants were divided into 4 balanced groups, and each group was asked to consider one of the points below in relation to the themes on the left. They specifically focused on solutions to the barriers at every level of care delivery, from government policy to care delivery: ○ suicide awareness and stigma ○ accessibility and confidentiality ○ funding and resources ○ responsibility and accountability	Conceptual model of an environment of safety for suicide prevention **Two Domains - Six New Critical Themes:** **Domain 1: Psychoeducation & Training** ○ Military specific '**journey to suicide**' ○ Broader, death by suicide, trauma-focussed psychoeducation ○ Enhancing greater public awareness and challenging stigma **Domain 2: Personalised Care** ○ Proactive engagement and improving accessibility ○ Family Inclusion ○ Enhancing effective collaboration and communication

The findings from co-production event 4 identified that the essence of '***Enhancing an Environment of Safety***' is a conceptual model that require several key components:

- Enhancing proactive engagement
- Improving transitional support from service to civilian life
- Early veteran identification, risk assessment, and prioritisation
- Balanced assessments of both adversities, difficulties, vulnerabilities, strengths and resources
- Active monitoring and early intervention of vulnerability, including compassionate rapport-building and care.
- Improving collaboration and coordination between all points of contact for the veterans and their family
- Individualised, holistic, military-specific care, bespoke to complex comorbid needs and priorities
- More transparent communication and information-sharing between services and resources
- Establishing clear, robust, and appropriate referral and care follow-up, which includes relapse prevention
- Standardisation and quality assurance across services

One of the important, yet persistent narratives which emerged from both phases 1 and 2 related to the continued lack, or inadequate way of inclusion with families. This absence of family inclusion majorly compounded psychological distress and grief. Moving forward, family inclusion in care planning and treatment is acknowledged as an imperative priority. By engaging the family from the outset this ensures the following:

- Obtaining a more comprehensive view of the military/ veterans broader lived experience
- Improving insight and awareness
- Increases the probability of treatment engagement and improved efficacy
- Recognises, and improves safeguarding issues which can been addressed more readily and prioritised accordingly
- Empowering families to be part of the solution

Through the acquisition of key data from **phases 1 and 2** of this study, a new model is needed, moving forward to ideally prevent, if not, reduce the probability of death by suicide within this important, vulnerable client group. There are distinct benefits in doing so:

- Improves guidance for Healthcare Professionals and service agencies highlighting best practices in assessing, treating, and managing individuals at risk of suicide
- Ensures better, and a more consistent and evidence-based approach to care
- Reduces the likelihood of oversight, iatrogenic trauma, or inadequate intervention
- Enhances more timely interventions, with the military/ veteran, and their family at the centre of the care provision and intervention
- Improves better risk assessment and management
- Nurtures better interdisciplinary collaboration
- Considers more holistic and more co-ordinated approaches to care
- Challenging stigma through better community and public health engagement
- Challenging compassion fatigue and apathy
- Fosters an improved culture of safety and support

One of the primary objectives from the final co-production event was to develop an evidence-informed model of a safe environment to address death by suicide within the veteran population. This involves ways to improve an environment of safety which captures both domains and six critical themes as outlined in Tables 6, 7, 8, & 9 (above) and captured in Figure 4 and Figure 5.

Figure 4: Outline of the iterative process through phases 1 and 2: Themes and Domains

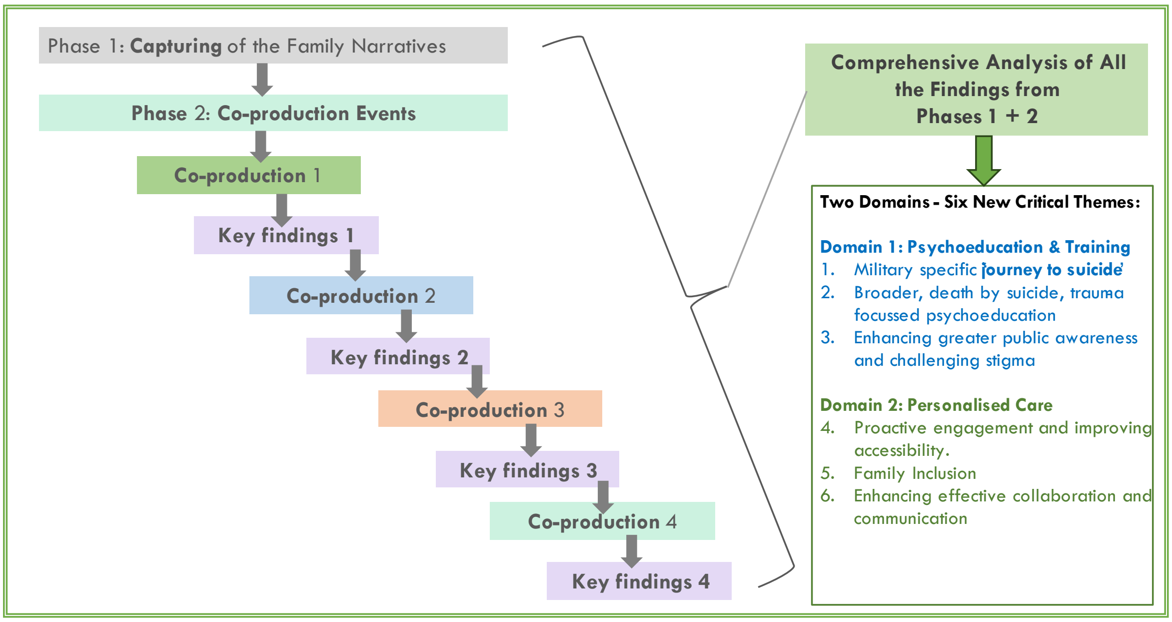
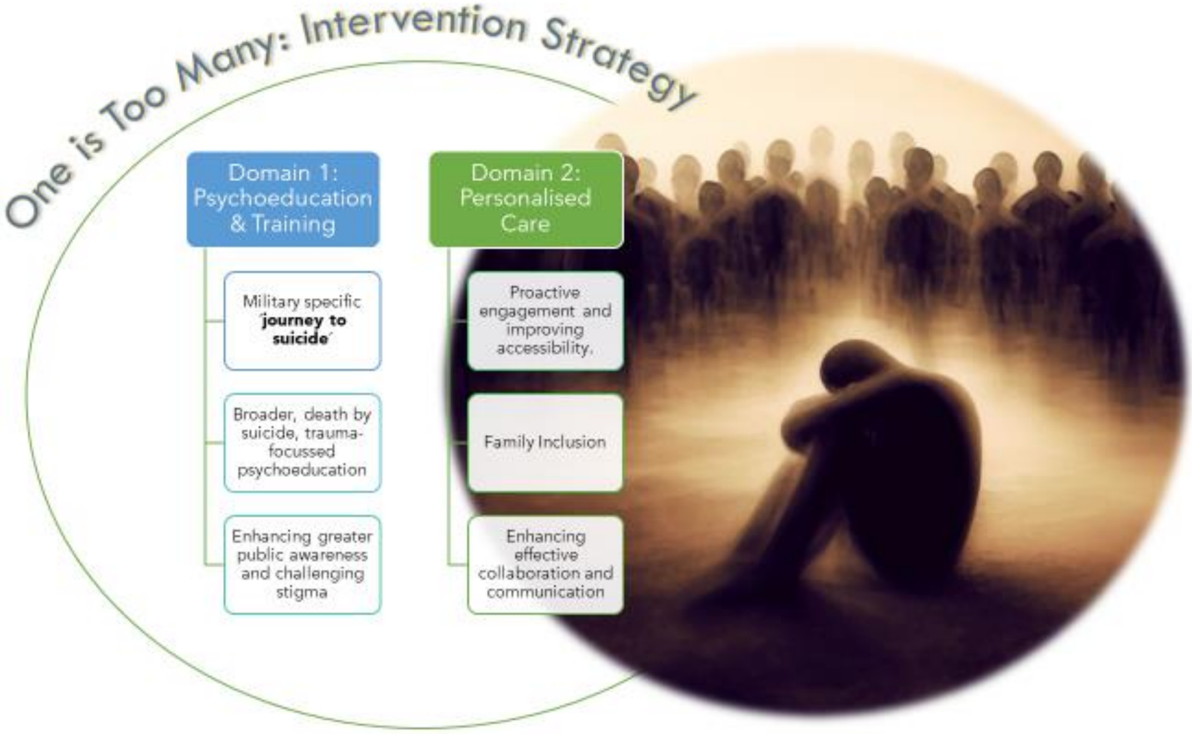


Figure 5: One is Too Many – Intervention Strategy: Enhancing an Environment of Safety



In summary, developing a safe environment for the delivery of services is essential for creating a systematic and evidence-based approach to suicide prevention, ensuring that those delivering services are equipped with the necessary tools and knowledge to address this complex public health issue. How to implement this model of safety and reflect on your own organisations service delivery is explored further in phase 3.

Phase 3: Suicide Prevention: A Framework for Creating a Safe Environment

Introduction

Phase 1 and 2 of this project have identified the factors associated with suicide within the veteran population and, through a series of co-production events, have also identified potential solutions that could be put in place. This Framework presents those findings and adopts the 'safety planning-type intervention' approach[19] and Principles of Personalised Care (NHSE, 2018). The Framework is designed to be used by organisations to support reflections on approaches to suicide prevention in the organisation and aid the creation of a 'safe environment' in which those who are vulnerable, and under care, are assured that a 'blanket of safety' is wrapped around them and those that care for them. This is significant because the 'One is Too Many': Veteran Suicide Understand-Identify-Prevent study identified that healthcare providers demonstrated an overall lack of knowledge with regards to the military community, specific care failures, which included a passive and non-compassionate approach with limited accessibility and availability of relevant support to address military-specific issues. Additionally, it was also identified that care services consistently demonstrated poor collaboration and communication between stakeholders over a significant period and failed to work effectively with families excluding them from care decisions and processes.

About the Framework

The Framework adopts the principles of the Armed Forces Covenant[20] and outlines two domains and six sub-domains required to reduce the risk of suicide (as previously shown in Figure 5). Each domain and sub-domains are explored and included in the framework document as a guide to the background and evidence-base for practice. The framework is supplied with a self-assessment tool (Figure 6) and a workbook at Annex A so that organisations can evaluate their processes against the best practices identified in each domain.

Furthermore, this Framework is intended to be used widely by health and social care providers and designed to act as guidance for stakeholders involved in the commissioning and design of services, plus those involved in care provision and service delivery. The principles align with those in contemporary policy relating to suicide prevention, in particular; The Suicide and Self Harm Competence Framework[21] NHS England's Self Harm and Suicide Prevention[22] and the Personalised

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[19] Safety planning-type interventions for suicide prevention: meta-analysis Chani Nuij, Wouter van Ballegooijen, Derek de Beurs, Dilfa Juniar, Annette Erlangsen, Gwendolyn Portzky, Rory C. O'Connor, Johannes H. Smit, Ad Kerkhof and Heleen Riper, The British Journal of Psychiatry (2021) 219, 419–426. doi: 10.1192/bjp.2021.50

[20] https://www.gov.uk/government/collections/armed-forces-covenant-supporting-information

[21] https://www.rcpsych.ac.uk/improving-care/nccmh

[22] https://www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention

Care Framework[23]. It includes guidance for integrating key pillars and related domains into current service provision, training, and pathway development.

Self-Assessment Tool

In order to undertake self-assessment of your organisation, a self-assessment tool is provided at Figure 6 that should be used in conjunction with the workbook at Annex A. The self-assessment tool is designed to support any organisation in reflecting on the information provided in this framework model. The tool is designed to help organisations reflect and identify where they might create a safer environment. We have dispersed the tool at points throughout the document to help with self-assessment.

How to use this Toolkit

The toolkit can be used as a self-assessment measure to help identify good practice (where we are now) and as a quality improvement tool providing practical advice and guidance, gathered from phases 1 and 2 on what has been discovered about 'what good looks like'. The toolkit is structured under five domains (see **Error! Reference source not found.**) with each domain outlining descriptions of the behaviours, activities or processes required to ensure that organisations are embedding safety and good practice into their approach to suicide prevention and creating an environment of safety. The workbook at Annex A provides worksheets to undertake this assessment and develop action plans for service improvement.

The toolkit is intended to be used by organisation leaders at system, place and neighbourhood levels, and those stakeholders involved in the design and delivery services. This includes those in the NHS, local authorities, the Voluntary, Community and Social Enterprise (VCSE) sector and representatives of people with lived experience.

Whilst reflecting on the evidence provided with regards to training and education, using the self-assessment tool (**Error! Reference source not found.**) please consider the description of what good looks like in relation to your organisation, and using the following tables apply a maturity score and consider what actions might be required to develop your services.

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[23] https://www.england.nhs.uk/personalisedcare/

Figure 6: Self-Assessment tool scoring matrix

Domains – 5 areas of focus within the tool

Levels of Maturity -Each description can be scored on a scale of 1 to 4 where 1 indicates emerging maturity and 4 indicates embedded and sustainable maturity

No.	Level of Maturity	Description of Maturity
1	Emerging	Strategic plans and processes are under discussion but not formalised or adopted. Delivery is mostly ad hoc and is not co-ordinated across the system or sectors
2	Developing	Strategic plans and processes are in active development. Some delivery is aligned to strategy and supported by cross sector partnerships
3	Maturing	Strategic plans and processes are adopted, enabling effective cross sector partnership and providing governance. Delivery is co-ordinated in most localities of the system
4	Embedded	Strategic plans and processes are fully adopted, embedded and governed. Delivery is sustainably commissioned and integrated throughout the system

Developing an environment of safety

The framework for an environment of safety emerged from the co-production events described earlier in phase 2 of this study (see Figure 5). The model consists of two domains, and the findings of this study suggests that organisations that address both domains will create a safer environment for their service users and potentially reduce suicide.

1. ***Domain 1: Psychoeducation and Training***

   The need to update and add veteran safety to existing suicide prevention strategies in service provision. The framework highlights best practice across multiple teams where communication and follow up is essential in reducing risk of suicide. There are specific nuances related to veterans that require to be built into education and training of staff. What this framework also adds is focus and commitment from service providers to the systemic events in a person's health care journey within and across multiple service providers.

2. ***Domain 2: Personalised Care***

   The framework supports and advocates personalised care as laid out by NHS England (2018) including NHS constitution principles. The framework addresses suicide as a whole systems approach with continuity and communication at the centre. Commitment is needed to ensure a process of assumed order and responsibility to 'wrap around' the person and family. The framework refers to the first three of six evidence-based components from NHSE personalised care approach:

   i. Shared decision-making
   ii. Personalised care and support planning
   iii. Enabling choice

This section will now present five areas from the two domains above to reflect on. Each of the five sections should be considered a self-assessment exercise, where best practice is considered alongside current practice using the self-assessment tool at Figure 6 and the workbook at annex A to record scores and develop action plans.

Domian 1: Psychoeducation and Training

Overview/description:

To deliver a model of safety, there needs understanding of the associated risk factors in a military-specific context necessary to underpin any assessment of need. Therefore, to recognise and understand the nuances of complex presentations, training and education is designed to help recognise the '**journey to suicide'** as told by bereaved families from their lived experience. Importantly for care providers, understanding **cumulative vulnerability, coping capacity, and risk factors** is essential to then identify potential barriers that will make accessing and engaging with support services more difficult for the veteran and therefore implement solutions in response to this.

This section is to be understood in conjunction with The Integrated Motivational Volitional (IMV) Model of Suicidal Behaviour[24].

1: Military Specific Journey to Suicide

This focuses on the journey to suicide in relation to:

- **Military history and pre-enlistment history** - cumulative sources of vulnerability experienced by veterans in both civilian and military.
- **Positive factors** are reasons for living that protect against the experience of cumulative vulnerability.
- **Complex presentations** –The presentation of cumulative vulnerability, in terms of comorbid trauma related presentations
- **Imminent risks?** And concealed and unconcealed presentations by veterans

Suicide prevention strategies for service providers need to include awareness of the cumulative vulnerability experienced by military personnel over time. This includes a focus on identifying what leads to vulnerability and how challenges manifest. Stakeholders can meet to discuss local areas provision and support facilitation of understanding and improve access through creative engagement.

Military History

When considering initial assessment, it is recommended that service providers ensure that all staff are educated sufficiently so that they can accurately assess military related trauma and combat experience and feel comfortable discussing this with veterans. Staff should be able to confidently discuss each area of assessment highlighted in Table 10.

Table 10. Psychoeducational requirements for understanding military history.

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[24] https://royalsocietypublishing.org/doi/pdf/10.1098/rstb.2017.0268

Primary psychoeducation themes	Specific Content Material
Multiple deployments	General life threat* Combat exposure Civilian violence exposure (especially children)
Service deaths	Combat deaths* Suicide contagion*
Occupational stressors (Harsh culture/discipline and task orientated)	Bullying Abuse Institutionalisation (break down to build up)
Job demands and expectations	Role satisfaction (personal and professional) Higher rank and increased responsibility Disillusionment
Adverse transition – premature discharge	Administrative discharge Medical discharge Premature voluntary resignation
De-institutionalisation	Record transference Reintegration preparation and support Veteran identification
Acquired maladaptive coping (military help-seeking stigma)	Concealment No discussion Denial Suppression
Avoidance behaviours	Substance use* Distraction/deflection Aggression/recklessness
*** Combat exposure and views of death are important areas to explore as well as high pain tolerance, endurance, and impulsivity (supported by alcohol and substance misuse). These are 3 of 8 volitional factors for suicide in the motivational stage of the Integrated Motivational Volitional (IMV) Model of Suicidal Behaviour**[25]	

Pre-enlistment history

Those working with veterans also need to understand pre-enlistment history and adverse events throughout their life course, as well as the issues that can arise during and after transition from military service to civilian life. Both can lead to an increase in vulnerability and service providers should ensure that all staff are educated so that they can confidently discuss each area of assessment highlighted in

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[25] O'Connor RC, Kirtley OJ. The integrated motivational-volitional model of suicidal behaviour. Philos Trans R Soc Lond B Biol Sci. 2018 Sep 5;373(1754):20170268. doi: 10.1098/rstb.2017.0268. PMID: 30012735; PMCID: PMC6053985.

Table ***11***. These are essential components of understanding as described in the pre-motivational phase for suicide in the Integrated Motivational Volitional (IMV) Model of Suicidal Behaviour and enhance the findings of the accumulative factors for suicide[26].

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[26] O'Connor RC, Kirtley OJ. The integrated motivational-volitional model of suicidal behaviour. Philos Trans R Soc Lond B Biol Sci. 2018 Sep 5;373(1754):20170268. doi: 10.1098/rstb.2017.0268. PMID: 30012735; PMCID: PMC6053985.

Table 11: One is Too Many – Intervention Strategy: Enhancing an Environment of Safety

Primary psychoeducation themes	Specific Content Material
Challenging parental Relationship	o Early divorce o Bereavement o Absenteeism, or abandonment o Harsh or neglectful treatment (often represent Traumatic Event exposure)
Interest in the military	o Military cadets/education o Family military background o Early enlistment (often with friends) o Parental disapproval/concern about suitability
Personal characteristics	o Introverted (shy/loner) vs extraverted (cheerful/popular) o Antisocial/deviant behaviour (substance use, aggressive behaviour, low academic achievement, truancy, or expulsions) o Strong will/morality/perfectionism o Negative self-perception (low self-esteem) o Anxious/avoidant attachment style
During and post-service relationship disruption	o Strain and breakdown o Infidelity o Domestic abuse o Child custody issues o Bereavement o Social isolation
Criminal Justice System	o Arrests and imprisonment o Learned behaviours/worsen condition (self-harm, suicide attempts, substance misuse)
Life Stressors and Negative repercussions	o Threats to employment/lack of employment o Financial concerns o Housing issues o Lost identity/reintegration o Low mood o Social isolation

Positive factors – reasons for living

Reasons for living mitigate the risk of poor outcomes and develop capital such as household relationships, education and skills, and access to social networks. More critical is the person's ability to identify what these positives are, and more importantly, how to nurture and enhance them further. During the assessment, the positive factors outlined in

Table ***12*** should be considered and built upon in any subsequent care and safety plan. The person must recognise and name these as reasons for living as opposed to clinicians assuming that positive factors are protective factors. Essential features include the veteran naming who is their confidante and advocate. This is important from a safety perspective, to facilitate access to the named person(s) who would help them access support and provide motivation.

Table 12: Psychoeducational requirements for understanding positive factors: reasons for living.

Primary psychoeducation themes	Specific Content Material
General	○ Work ethic/employment functioning ○ Hobbies ○ Realistic expectations ○ Resilience/adaptive self-coping strategies
Military belonging	○ Understanding lived experience (individual) ○ Connection/camaraderie ○ Enjoyment/achievement
Social networks	○ Close family/partner/friends ○ Seek advice/support ○ Care advocacy ○ Motivate recovery ○ Relationship reparation

Complex presentations

Cumulative vulnerability can manifest into a complex range of needs that are multi-faceted and result in challenges that impact functioning in many areas of day-to-day life. This complexity may present barriers to help-seeking and require support and coordination from a variety of service providers to enable help to be co-ordinated at the same time. When assessing and determining need, the requirements outlined in Table 13 should be considered.

Table 13: Psychoeducational requirements for understanding complex presentations.

Primary psychoeducation themes	**Specific Content Material**
PTSD Related	○ Intrusions, arousal, and reactivity ○ Anxiety ○ Paranoia
Depression	○ Low mood ○ Poor self-care ○ Self-injurious thoughts and behaviours (suicidal ideation, self-harm, multiple suicide attempts, voluntary or Section 136 hospitalisations)
Substance-use related	○ Alcohol dependency* ○ Drug use* ○ Psychosis and mania
Physical Health	○ Unexplained illness (e.g., migraines, rash, non-epileptic seizures) ○ Pain/injury (e.g., chronic military related or non-military related accident) ○ Stress (e.g., weight loss, fatigue) ○ Occupational/daily functioning (e.g., disturbed routine, difficulty concentrating)
Personality/Behaviour Change	○ Emotional numbing/flat affect ○ Social isolation and withdrawal ○ Criminal or reckless behaviour - Prison as a safety behaviour - Section 136 - Symptom related crime (e.g., while under the influence of substances or for money to obtain substances, during manic/psychotic episode etc) - AWOL or aggressive/abusive episodes ○ Excessive spending/gambling debt
Emotional Distress	○ Shame/guilt (e.g., avoidance, withdrawal) ○ Anger/frustration (e.g., quick temper, helplessness)* ○ Low self-esteem (e.g., perfectionism, worthlessness)*

Complex needs are defined by the All-Party Parliamentary Group (APPG) on Complex Needs and Dual Diagnosis[27] as someone who has two or more of the needs shown in Table 14 and those needs will usually be severe and longstanding. In conjunction with the veteran specific needs shown in

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[27] All-Party Parliamentary Group (APPG) on Complex Needs and Dual Diagnosis: https://m.moam.info/factsheet-1-complex-needs-and-dual-diagnosis-turning-point_6479fde6097c4770028c0932.html

Table ***13***: Psychoeducational requirements for understanding complex presentations, organisations should also consider the wider definition of complex need in Table 14. If a veteran has two or more of any of the needs identified in both tables, they should be considered to have complex needs.

Table 14: All-Party Parliamentary Group (APPG) definitions of needs that contribute to complex presentations.

Mental health issues	Substance misuse issues	A diagnosis of mental health and substance misuse issues	A physical health condition	A learning disability	A history of offending behaviour	A physical disability
Employment problems	Homelessness or housing issues	Family or relationship difficulties	Domestic violence	Social isolation	Poverty	Trauma (physical, psychological, or social

Imminent warnings signs of suicidality

The previous section identified what factors need to be considered by any organisation that assesses or provides services to individuals and their families. In particular, the focus is on the conversations that should be happening when an individual first enters a service in either the statutory or the third sector.

The next section highlights the knowledge and skills employees should have when working with individuals and their families daily so that they are aware of the subtle signs and symptoms of imminent suicidality in addition to knowledge of evidence-based theories of suicide. Information in this framework serves as an additional guide to education and training to help individuals and their families create a positive and supportive environment and plan of safety through engaging in conversations about suicide.

Table ***15*** highlights that many of the warning signs will be relatively subtle and not readily noticeable during a discussion with an individual in a care setting; indeed, some do not present these at all. The care approach must engage meaningfully with the families and friends as described previously to understand fully the individual's wellbeing. Because subtle messages are often shared with different people, the veteran's perspective, and confidante/ advocate/ family/ other views matter to help with the assessment.

Table 15: Educational requirements for understanding Imminent warnings signs of suicidality.

Primary psychoeducation themes	**Specific Content Material**
Verbal indicators	Expressed fatigue, helplessness, worthlessness, or a wish to die, masked farewell or sudden expression of love, discussion of death preparation, religiosity or the afterlife, specific intent related to a suicide method or location identification
Behaviour/Personality change	Tidying of finances or house upkeep, disturbed daily routine, or acting out of character including stopping of hobbies, lack of communication, increased irritability or low mood as well as sudden improvement in mood or symptom presentation,
Evidence of specific plan and intent	Reference specific suicide method (e.g. stated choice of or access to specific method, evidence of prior research and/or previous attempts) Reference specific suicide location (e.g., picked specific method, familiar or unfamiliar environment) Suicide correspondence: pre-planned or spontaneous suicide note/video/text/call before death. ○ Reason: to provide information to aid discovery, say goodbye and/or provide explanation of suicide cause ○ Impact: family member/significant other witness and/or attempt to prevent suicide, discovered suicide aftermath, or received third party notification of suicide

The findings of phase 1 identified two distinct pathways to suicide within the veteran population: (i) concealed, and (ii) unconcealed. When considering the latter, it is important to acknowledge that individuals can present with both aggression and behaviour that is challenging to the care provider, as well as passive and avoidant behaviour. What is most important is that all the behaviours outlined in Table 15 and Table 16 are considered as vulnerable behaviour and not an individual being deliberately troublesome. This may require service providers to reconsider how to manage behaviours which challenge service provision, such as zero-tolerance policies and determine between deliberate disruptive behaviour and behaviour that is signifying distress requiring help.

Table 16: Educational requirements for understanding concealed and unconcealed pathways to suicide.

Unconcealed pathway (identification and disengagement)	○ Initial concealment of vulnerability and self-coping ○ Unsuccessful concealment (reached crisis point) and identification of vulnerability. ○ Overt clinical symptoms and/or behaviour/personality change ○ Prolonged attempted help-seeking but gradual disengagement and deterioration
Concealed pathway (hindsight identification)	○ Successful concealment of vulnerability ○ Sub-threshold symptoms and/or subtle behaviour/personality change ○ Family minimisation of subtle signs/symptoms and disjointed organisation insight ○ Hindsight identification of assumed cumulative vulnerability and deterioration

Summary

All staff involved with working with veterans or in any form of service delivery involving veterans should have knowledge of the factors associated with suicidality within the veteran population, the imminent signs of suicidality and how to understand reasons for living.

Key points:

- Support and encourage staff to speak openly about suicide.
- Understand civilian and military adversities and explore fully in any initial assessment.
- Understand the importance of reasons for living and have meaningful conversations around living and dying.
- Understand and identify the subtle signs of suicidality.
- Adopt and educate staff with an evidence-based theory of suicidality.
- Remember:
  - **Identify** the risk.
  - **Understand** the reasons why.
  - **Prevent** by building a plan of safety with the family around identified reasons for living.

All factors to be looked at in context with the IMV Model[28] to determine increased risk through an evidence-based model of suicidality, expression of accumulative factors, propensity for 'entrapment' and transfer to enactive phase when volitional moderators are active.

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[28] O'Connor RC, Kirtley OJ. The integrated motivational-volitional model of suicidal behaviour. Philos Trans R Soc Lond B Biol Sci. 2018 Sep 5;373(1754):20170268. doi: 10.1098/rstb.2017.0268. PMID: 30012735; PMCID: PMC6053985.

Self-Assessment Tool Exercise 1: Military Specific Journey to Suicide

Using the self-assessment tool at Figure 6 and the workbook at Annex A, please reflect on the best practice presented in this section and the 'what good looks like' and the 'pause for thought' statements in the box below. Please record your scores and your action plan in the workbook.

What Good Looks Like?

Training and education surrounding suicide awareness with military/ veteran populations is important in preventing (or even) reducing the loss of a loved one. Being cognisant of the 'journey towards' suicide is important in better understanding internal, external, relational, and systemic factors that may have contributed towards suicide seen as the only option for the military veteran. Four aspects are critical: understanding vulnerability, ascertaining the individual's capacity for coping, comprehensive risk assessment, and challenging stigma and prejudice. Remember, when we assess clients, the importance of obtaining a 'balanced' history; not just what is going 'wrong' in the military veteran's life, but also, 'What is going right? What is working? What are you currently doing that maybe helpful?" If we don't sufficiently capture the military/ veteran's authentic lived experience, we end up with an insufficient understanding of the critical issues, with the increased probability that an incorrect plan of care is implemented. Establishing a safe space is imperative.

Pause for thought:

I said, well you should complain, you know, you can't be treated like that. Mum, you don't understand the army, you know, they're just dismissive of it, isn't it? The last thing you do is complain. [Participant 2]

But I think Afghanistan scarred his mind, in some way … he was showing signs of PTSD when he came back, apparently. But knowing our [anonymised] he wouldn't have elaborated on it, because he enjoyed his time with them… But he would have kept things in. [Participants 18]

One of his friends in the army has said that he had said, [anonymised] has said to him on occasion, something about erm, oh it would be doing me a favour if I got blew up in Afghanistan and then immediately followed it with, oh I'm only joking mate, I'd never do that to my mum or my sister and that's the only reference I know, that was before they went to Afghanistan [Participant 8]

2: Challenging Stigma

The journey to suicide featured evidence of internal and external stigmatisation. Internal stigmatisation presented as a belief in the individual that help-seeking or poor mental health is a weakness or detrimental to career progression (whilst in the military). These internal beliefs resulted in the development of maladaptive coping strategies. This sub-domain focuses on stigma and the role stigma plays in creating barriers to care within service provision. Reducing stigma may in turn reduce the barriers to accessing, engaging and delivering effective support. In particular, service providers need to:

- explore and explain negative stereotypes surrounding the military community to empower staff to tackle this issue.
- assess, manage, and respond to the potential lack of awareness of military culture.
- understand internal stigma and the barriers it presents to accessing care.
- effectively manage the complex presentations.
- continually evaluate the effectiveness of training and education in practice with a focus on positive outcomes for service users.

<u>Military Culture</u>

Table 17 outlines the military experiences and that can both fuel stigma or be the cause of stigma. It also outlines the stigma that exists around mental health and suicide. As previously highlighted, stigma must be considered from an external perspective, those that stigmatise others and an internal perspective, false beliefs that some judgment will be made if help is sought. Unconscious bias surrounding suicide and the fear to address suicide in an open conversation, perhaps for fear of initiating a suicide, is a misplaced concern, and those working with veterans need to be informed and confident in addressing stigma and be able to speak openly and confidently about mental health and suicide.

Table 17: Psychoeducational requirements for understanding and challenging stigma

Primary psychoeducation themes	Specific Content Material
Military culture	Military experiences and impact - Awareness of military training, operational deployments and deployment history, duties, rank and hierarchy, transition and reintegration, peer support and camaraderie - Specific experiences and needs of minority groups (LGBT+, female, ethnicity, care leavers), tri-services, and different discharge types (early service leavers, administrative or medical discharge) - Common mental health disorders and comorbidities experienced by military populations. - Military help-seeking: stigma and maladaptive coping strategies Negative connotations of seeking help for mental health (sign of weakness and/or negative career repercussions) Mental health problems misattributed as aggression, substance misuse, or as a consequence of childhood adversity without acknowledging complex presentation and role of cumulative vulnerability.
Mental health and suicide stigma	Mental health - Awareness and understanding of unconcealed and concealed signs/symptoms and treatment of common mental health disorders - trauma, grief, and the manifestation of maladaptive coping strategies (such as aggression and substance use) o Overturn stereotypes within this such as mad, bad and sad societal stereotype Suicide - Staff can engage in open conversations about suicide. o Know what language to use and how to ask questions and respond according to level of distress (prompt, appropriate, compassionate) - Dispel myths related to suicide help-seeking behaviour Stigmatised death - Suicide vs non-suicide deaths o Suicide a sign of cowardice or selfish, o negative treatment/reactions towards family members/significant others after suicide deaths o Language: avoiding the term ‘committed suicide’, or ‘commit suicide’ – this is archaic terminology from when suicide was a criminal offence, consider death by suicide, or completed suicide.

The need for awareness and normalisation of mental health and suicide at all levels of society is vital to improve proactive identification and intervention. A positive cultural shift is required to de-stigmatise help-seeking and promote an active and collaborative treatment approach where all individuals are collectively accountability for suicide prevention and intervention. This is a given in all suicide prevention policy and recommended in NICE quality standards for suicide prevention[29]. Table 18 outlines the wider strategic approaches that could be adopted to challenge stigma.

Table 18: Psychoeducational requirements for challenging stigma

Prevention	**Need for cultural change towards increased awareness and normalisation of mental health and suicide in society and military-specific cumulative vulnerability.** - Remove stigma of help-seeking o Improve access to support (normal reaction, part of military role/life) o Consider and address barriers to support - Importance of a collaboration and communication in treatment approach o Promote cooperation instead of competition between service providers and a shift towards connecting services (cross-regional and multi-agency cooperation) o Consider a system with a single information point and data sharing policy to exchange knowledge, skills, resources, and standardised education and training to help address military-specific issues - Promote collective responsibility for proactive safeguarding and early intervention at all levels o Shared accountability: be suicide aware and ensure every contact counts and is positive o Active safeguarding by creating conversations/asking questions to listen and identify o Be responsive to signs of vulnerability (see it, hear it, validate it, create hope) - Establish clear agreements of accountability at all levels of service provision to prevent fragmentation of care - Service provider accountability for overall care governance and worker wellbeing to address compassion fatigue o Commitment to regular reflective supervision o Reviewing caseloads to ensure manageability/capacity to support individuals. Caseload capping. o Staff training, supervision, and support (identify and manage signs of burnout, occupational stress, compassion fatigue etc) o Awareness and adherence to armed forces covenant commitments (and other care commissions/bodies etc)

Summary

Internal stigmatisation manifests as individuals viewing help-seeking or mental health issues as weaknesses, leading to maladaptive coping strategies. The focus is on reducing stigma to overcome barriers to care, suggesting actions for service providers, such as addressing negative stereotypes about the military community, managing awareness of military culture, understanding internal stigma, and continually evaluating training effectiveness. The importance of acknowledging military experiences that fuel or result in stigma is highlighted, emphasising the need for an open and confident conversation about mental health and suicide. A positive cultural shift towards destigmatised help-seeking is essential in promoting collaborative treatment, and collective

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[29] https://www.nice.org.uk/guidance/qs189/resources/suicide-prevention-pdf-75545729771461

accountability for suicide prevention This aligns with suicide prevention policies and NICE quality standards.

Self-Assessment Tool Exercise 2: Challenging Stigma

Using the self-assessment tool at Figure 6 and the workbook at Annex A, please reflect on the best practice presented in this section and the 'what good looks like' and the 'pause for thought' statements in the box below. Please record your scores and your action plan in the workbook.

What Good Looks Like?

In considering service intervention, good practice in this area should incorporate the following factors:

1. What does the current academic literature highlight that could help maximise understanding and improve awareness. This should also involve asking critical questions such as: "Is what we are doing evidence-based?" "What do we actually know, and what do we 'think' we know?"; "What impact is what we are doing having on individuals and their families?"; "Do we get sufficient, and authentic feedback from service users and their respective families?"
2. Do you have the right leadership, strategy, and governance procedures in place? If not, how might you acquire these?
3. Are existing services 'fit for purpose'? If not, which Commission Agencies could be approached to help facilitate this?
4. Within existing service provision, do you have the right workforce balance and skillsets available? If not, what additional training and education may be required to try address this?
5. Are you making best use of available technologies to improve access, service provision, inclusivity, and engagement? If assistance is needed in this area, how might you go about this? What resources might you be able to connect with?

Pause for thought

Something has happened in that meeting that's got into [anonymised] head and has made him, you know, really upset. The company sergeant major did say, that in his statement says he looked visibly upset, but he just sent him back to his unit and said not to worry about it, get on with it. [Participant 8]

As the years progressed, his mental health took a massive nosedive. He was having time off; he went absent without leave. Me and his dad got him appointment at [place name] Barracks at [place name], which was the mental health hospital for the Army. [Anonymised] went in, seen this really old Army officer and he just told [anonymised] just to man up, just chucked him a load of leaflets. This is what you signed up for, you need to man up. Never went back. [Participant 1]

Domian 2: Personalised Care

Overview/description:

Pre-existing risk factors for veterans can be exacerbated during the transition from the Armed Forces into civilian life. This is identified and referred to as 'cumulative vulnerability'. Domain 1 focuses on the educational and training requirements of a workforce. Domain 2 focuses specifically on how that knowledge is applied through proactive engagement and accessibility to services and care. Central to this is the requirement for service providers to consider the policies and procedure that will be required to strategically, and operationally, address the elements needed to embed a personalised model of care which is underpinned by suicide prevention in policy and practice.

The framework of safety acknowledges that veterans may present with complex behavioural problems that may not fit with the service access criteria such as anger, problematic alcohol use, social care problems or an ambivalence towards any help offered. These behaviours may contradict service provider policies (such as 'zero tolerance' policy), however, service providers need to be mindful that a rigid or dogmatic application of policy does not undermine the creation of a safe environment that prevents suicide. This is supported by the 'No wrong Door' policy, which is underpinned by 'safeguarding is everybody's responsibility'[30,31].

Service providers need to adopt a cultural shift in thinking with regards behaviours which challenge service provision, viewing them more as vulnerabilities, rather than problematic individuals. Within this study, the findings identify that in all the veterans that died whilst under care, the behaviours described above were observed in the weeks before their deaths. Thus, service providers should seek to develop strategies and interventions to manage veterans receiving services from their provision who display challenging behaviours. Rather than push them away, appropriate policy, procedure and implementation strategies should be developed to work intensively with the individual and their families and wrap a 'blanket of care' around them, enabling a team around a family approach to care provision and safeguarding.

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[30] https://www.nhsconfed.org/system/files/2022-12/No-wrong-door_vision-for-MH-learning-disabilities-and-autism-services-in-2032.pdf

[31] https://www.nhsconfed.org/system/files/2022-12/NHS%20Confederation%20parliamentary%20briefing%20-%20No%20wrong%20door%20-%20a%20ten-year%20vision%20for%20mental%20health%20learning%20disability%20and%20autism%20services.pdf

3: Accessibility and Engagement

This sub-domain focuses on meaningful engagement with veterans by underpinning care with a framework of safety for suicide prevention. Enabling easy and flexible access to support and engagement in service provision should be pro-active when military personnel are leaving the Armed Forces and re-settling into civilian life. In addition, veterans can be transient between other service providers such as the NHS, military charities, prison and probation services and emergency services. Therefore, when considering transition, and the risks that they involve, any movement from one service to another should be considered a transition. This is always a period of vulnerability and those service providers involved in any transfer need to ensure that safeguarding measure are in place and that referrals are co-ordinated with a follow-up in place to ensure continuity of care and importantly, a safe transfer. Table 19 outlines what service providers should consider when wanting to improve access to services and engagements with services users.

Summary

individuals, and their families require a service which is identifiable, accessible and positively engages with them in a way which is non-judgemental, compassionate and validates their experiences. Furthermore, service providers and their staff require knowledge and understanding of local Armed Forces communities.

Table 19: Improving service accessibility and engagement.

Prevention	Consideration should be given to transitional support, ensuring there is an established care coordinator to act as a single point of contact to oversee an individual's care and onward referrals. - Local service provision and information regarding accessibility and the proposed services on offer. - Registering with a GP; - Assessing discharge needs, facilitating access to individualised support, and performing welfare checks after a specified period of time - Education and understanding on the physical, social, and psychological challenges and identity challenges faced when moving from the Armed Forces to civilian life - The benefit of joining a veteran's association Ensuring records, safeguarding measures, and support are transferred, updated, and followed-up to ensure individuals are never without support at any stage of the referral, treatment, support, or discharge process. Service providers should ensure that there are policy and procedures to prioritise veterans within care organisations and services. This policy should include: - Baseline strength and vulnerability assessments A safeguarding alert system should be implemented throughout the service providers policies in line with local and national safeguarding legislation.
Rapport building and compassionate care	Service providers should take time to build rapport and trust with the individual and their family members as part of a person-centred, compassionate, and integrated care approach. This approach should include: - non-judgemental, authentic, consistent, respectful, empathetic, and support the individual to have active involvement in their own care - Ensuring readiness and motivation to begin treatment to maximise treatment engagement and outcomes. - Appropriately facilitated by ensuring simplicity within the care process and that individuals and the care providers have realistic expectations about the nature of support. Service providers should have access to veteran lived experience in the planning and co-production/development of their services
Eligibility and Inclusivity	There is a need to widen the eligibility criteria for available services so that military personnel and their families can access support to address their specific complex needs and priorities. - Services should not exclude individuals from treatment with: - multiple comorbidities, - non-combat or service-related needs, It is important for service providers to recognise that veterans may be occasionally reluctant or unlikely to identify themselves as veterans. Providers should ensure services and support are inclusive for those with potentially unique needs, experiences, and barriers to accessing and engaging with care. This includes: - minority groups - individuals from different generations or war eras - discharge types (for example, early leaver, administrative or medical discharge)

Self-Assessment Tool Exercise 3: Accessibility and Engagement

Using the self-assessment tool at Figure 6 and the workbook at Annex A, please reflect on the best practice presented in this section and the ‘what good looks like’ and the ‘pause for thought’ statements in the box below. Please record your scores and your action plan in the workbook.

What Good Looks Like?

The need for personalised care has been identified as one of the key findings from this research study. Tailored care and treatment, generally improves health outcomes. By placing the military veteran at the heart of care delivery empowers individuals to engage more actively, whilst encouraging empowered, and informed decision-making. Not only is tailored care better for the individual, but research also supports it being more cost-effective, and promotes greater health and well-being. What personalised care does is place the military veteran at the heart of the process, recognising their uniqueness, their individual expertise; it enhances a greater dignity and autonomy for the individual, whilst at the same time, improving the quality-of-care provision.

Pause for thought

There’s definitely a gap somewhere where… there’s got to be someone who these complex PTSD veterans can be pointed in the direction of and say, you know, he’s difficult, he does go on drink benders and obviously drugs. So he’s going to need a little bit more compassion [Participant 4)
Nobody helped him, you know. He wanted help…he tried everything possible to get the help for himself and not to do what he did. But it just wasn’t there, the help wasn’t there for him or for us, like even if he wasn’t trying, we were all there saying somebody help us please, for years, years and years and years.[Participant 2]

He did try and commit suicide in prison,.. parents found out about that through a friend that was visiting. The prison didn’t ring and let them know. So when they went in, [anonymised] was crying his eyes out saying I thought you didn’t care about me, but the prison hadn’t even told them. [Participant 11]

4: Families

A key aspect of care which underpins this framework is the unique insight the family have into the daily support and care that they provide for their family member. They are, therefore, pivotal in safeguarding decisions, collaboration and communication with service providers. When working with families, safe-care provision should be carried out in line with local and national safeguarding policy and procedures. The Triangle of Care provides guidance and a related self-assessment to support organisations with good practice in this area[32].

The Information Sharing and Suicide Prevention: Consensus Statement[33] is also a supportive resource for healthcare providers and practitioners and should be integrated into organisational suicide prevention plans.

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[32] https://carers.org/downloads/resources-pdfs/triangle-of-care-england/the-triangle-of-care-toolkit.pdf

[33] https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention/information-sharing-and-suicide-prevention-consensus-statement

Table ***20*** identifies factors that should be considered when working with families in relation to care decisions, care planning, and safeguarding. The present study found that health care providers find it very difficult to include families in care, citing barriers such as GDPR and patient confidentiality. However, it must be remembered that family members will usually be delivering the majority of care and organisations must develop the ability to include them in that care process so that their voices are heard.

Table 20: Strategy for Improving the Inclusion of Families in care planning, delivery and decision making.

Communication and transparency	In conjunction with best practice, professional guidelines: - Agree with the person how and when to communicate with family members and enable informed consent to share information. - There is a need to find a balance and relay to family if consent has changed as per the persons instruction. - This approach should work towards a relationship of openness where the individual and their family feels comfortable sharing information with those identified. - Actively facilitate and encourage family to sit in on sessions as a source of support. - Service providers should invite and listen to concerns and refer the person receiving care to services on their behalf, especially during crisis, or when they may have reduced capacity or motivation to make their own care decisions.
Holistic support and recognition	Family members should be welcomed as an additional resource to holistic care provision. Service providers should emphasise shared caregiving responsibility to help reduce any experiences of distress or isolation and promote collective accountability for suicide awareness and prevention. Holistic care should include principles of Making Every Contact Count[34] for individuals and family members to safeguard their own mental health and personal wellbeing during help-seeking and treatment. - This should include connecting the family with trauma-informed, military-specific bereavement support if a death does occur. - Delivery of bereavement response by suitably qualified people with lived or learned experience and understanding.

<u>Summary</u>

Service providers and their staff need to think about communication styles and inclusion of family as a 'whole' when assessing the needs of an individual. A systemic family approach to assessment has the potential to reduce presenting symptoms of an individual, support the health and wellbeing of those who are providing round the clock care for individuals at risk of suicide, and importantly, become the eyes and ears of assessment.

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[34] https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources

Self-Assessment Tool Exercise 4: Families

Using the self-assessment tool at Figure 6 and the workbook at Annex A, please reflect on the best practice presented in this section and the 'what good looks like' and the 'pause for thought' statements in the box below. Please record your scores and your action plan in the workbook.

What Good Looks Like?

There are several distinct advantages in involving families and loved into care provision when working with military veterans.

1. Increases emotional support, which reduces feelings of loneliness, isolation, low-mood, and anxiety.
2. Shared decision making – using a collaborative approach assists with acknowledging individual, gender, cultural, religious, etc., considerations to ensure preferences and values are considered.
3. Advocacy – there maybe occasions when family, and loved ones, can advocate on behalf of the military veteran. The advantage of this ensures rights and wishes being respected.
4. Monitoring Updates – obtaining feedback from family can often provide useful feedback and triangulation in determining what is working, what needs to be adjusted, and what might need to change.
5. Enhancing compassion – involving family can assist with challenging loneliness and isolation, and can be useful for validating lived experiences, and sharing of experiences.
6. Improves knowledge sharing – family can often provide useful insights, with the opposite also being true.
7. Improving communication – effective communication is often very important for all parties. By reducing misunderstandings, this in turn also helps improve outcomes.
8. Helps reduce caregiver burden and fatigue – Involving families in care decisions can often assist in reducing stress and burden on family and caregivers, minimising the sense of becoming overwhelmed.

Involving family and loved ones in care provision fosters more holistic, patient-centred care increasing the probability of better outcomes and satisfaction.

Pause for thought

You just don't exist for them. There's that feeling of not existing, and I think if there's a family member with PTSD. I think well, I just think they should be completely drawn into this. This is a whole problem…The repercussions impact everybody so much that they also need to be in on the plan, on the game, you know, on the care plan. Let's get them… you know, this is a whole family thing or whatever. Does that make sense? [Participant 2]

They just wanted [anonymised] out so they had a free bed. They don't talk to the family, who's witness to everything that's going on. They don't want to hear us. And we said, that had to change, they should come and talk to the family and ask their opinion, what's going on? There is a lot of things that need to change. [Participant 20]

5: Collaboration and Coordination of Care

Enabling collaboration and coordination across service providers and multi-disciplinary teams is crucial to the development of a personalised model of care, underpinned by the principles of suicide prevention within this document. All service providers delivering care to the veteran community should aim to collaboratively deliver a personalised and holistic care approach to address all health and social care needs and comorbidities. Standardised components of a personalised care model should include centralisation of internal systems and policies involving a common framework for assessments and care delivery and a joint IT infrastructure to communicate and manage records.

A recurrent finding from all co-production events was the need for care coordination. A care coordinator could be responsible for co-ordinating aspects of care, with an overview of the case and in a position to advocate for the service user and their family. The care coordinator could be part of a multi-disciplinary health and social care team or independent, such as a social prescribing link worker. It was felt that the care-coordinator should have lived or learned experience in the veteran sector, but that could be as a former serving member of the Armed Forces, or as a family member. Most importantly, the care-coordinator must have appropriate training and education to advocate for the needs of the individual and their families. Care-coordinators should seek to improve the simplicity, clarity, inclusivity, and continuity of support to ensure individuals and their families feel listened to and are able to quickly gain access to the appropriate service provision as this will go some way to avoid repeated engagement and discharge from services, commonly known as the 'revolving door' effect. Table 21 identifies the factors that should be considered to underpin a collaborative and co-ordinated approach to care.

Summary

Implementing a holistic model of care through collaboration and coordination of multiple service providers will create a layered model of safety for suicide prevention and creating a team around the individual veteran and family. Care coordination requires staff to be appropriately educated and trained to meet the expectations of the individuals, their families', and the governance of the service providers, in line with national and local laws, policies and procedures. Service providers who foster this approach to care coordination will significantly reduce gaps in service provision, and support transition between service providers and help support the reduction of suicide.

Table 21: Holistic Care, shared communication and care-coordination.

Holistic care	This approach should consider the following: - Undertake a comprehensive assessment of their social, mental and physical health, addressing the knowledge and education requirements outlined in domain one. - Have a clear understanding of the stability of current housing and financial situation. - Understand the stability of family dynamics. - Integration into a supportive community, such as community or interest-based activities, peer-to-peer networks or befriending programs. - Ensure that all staff within a multi-disciplinary team have access to historic and current assessed need, as well as an up-to-date plan of care. - Ensure that care plans are handed over effectively to a named person when the individual is transferred between services. 24-hour availability of support, ensuring that the individual and their family are fully aware of: - a telephone support line - digital or smart-based support such as a mobile phone app - in-person services Provide a strength-based approach to care which includes exploring expectations, resilience building, positive goal setting and instilling hope. A time or funds limited approach should be avoided at all costs: - Recognise the non-linear process of recovery and possibility of relapse. - Recognise the increased period of waiting for support during or after discharge from a service. - Service providers should consider prolonging the discharge process following treatment for relapse. - All service providers should consider to what extent their service places an expectation of self-help. - Actively monitor recovery and reach out, so that those that are vulnerable are never left without care. Veteran aware treatment facilities and care approaches tailored to individual or collective family needs: - Aim for a flexible approach to treatment as opposed to time limited, or session limited approaches. - Avoid inflexible care pathways – aim for personalised care, based on individual need. - Ensure inclusion of services that have shared understanding or knowledge of trauma-informed approaches or veteran-specific issues. Maintain proactive regular contact with the individual and their support network. - Schedule welfare or support appointments to monitor wellbeing. - Offer support to build a rapport whilst assessing for readiness to engage with complex treatment. - At the point of admission to support services the veteran may not be ready to cope with intense psychological therapy. - Consider emotional regulation to help cope with symptoms of distress and trauma. - All missed appointments for individuals and family must be followed up.

Table 21: Holistic Care, shared communication and care-coordination (continued)

Shared communication	This should include: - Transparent data sharing agreements with the individual, their family. - clear assessment and record management of medical and military history, treatment plan and progress. - Re-affirm consent and explore confidentiality at every contact. Staff accountability for preparing for any interaction with the individual and their family should meet the individuals' expectations and include: - Reading, understanding, and updating records to prevent story retelling and re-traumatisation. - Treatment disengagement and to increase treatment efficacy.
Care Co-ordination	The coordinator acts as a single point of contact to navigate the referral process and access to different service providers and oversee all aspects of their care. Coordinators should: - improve: the simplicity, clarity, inclusivity, and continuity of support. - ensure individuals and their families feel listened to. - ensure individuals and families are able to quickly gain access to the appropriate service provision. - Help avoid the need for telling their story multiple times. - Liaise with relevant stakeholders. - remain a consistent individual or set of individuals within team with appropriate supervision, training, and awareness of clear clinical boundaries. - Ensure succession planning is in place to maintain continuity during annual or sick leave absences.

Self-Assessment Tool Exercise 5: Collaboration and Coordination of Care

Using the self-assessment tool at Figure 6 and the workbook at Annex A, please reflect on the best practice presented in this section and the ‘what good looks like’ and the ‘pause for thought’ statements in the box below. Please record your scores and your action plan in the workbook.

What Good Looks Like?

Holistic care is essential as it recognises the interconnected nature of health and well-being. There are distinct advantages in adopting a comprehensive approach with the military veteran at the centre of this care. Holistic care recognises the importance of emotional and mental well-being, through promoting greater mental health awareness, providing emotional support. Enhancing coping strategies, strengthening internal, external, and relational resources, reducing stigma, and challenging prejudice. Furthermore, holistic care empowers wellness and well-being, and reduces healthcare disparities by considering cultural, social, spiritual, and economic factors that may influence health and outcome.

Pause for thought

What I can’t understand is with [Anonymised] medical files, PTSD, high suicide risk and it wasn’t just once or twice, it was a lot of paperwork, why wasn’t something done prior to his release? That I do not understand at all. Because to me surely that, you know, well I don’t know, I can’t understand that, they just, he went to [prison name], did his 28 days and then straight into civvy street so to speak. [Participant 1]

Nobody helped him, you know. He wanted help…he tried everything possible to get the help for himself and not to do what he did. But it just wasn’t there, the help wasn’t there for him or for us, like even if he wasn’t trying, we were all there saying somebody help us please, for years, years and years and years.[Participant 21]

Summary/Conclusion

This One is Too Many (OiTM) study underscores the critical importance of learning the lessons from failures in service provision within military/ veteran populations who carry out death by suicide. Powerful narratives from surviving families and loved ones highlight multiple layers of tragedy. Clearly, there is insufficient understanding within the existing care provision around the journey towards suicide, and what systems and procedures need to be in place to identify, understand, and prevent death by suicide in this important population and beyond.

Involving families and loved ones into care provision is essential, as is the incorporation of personalised care. Multiple families repeated similar narratives of being excluded and disconnected from support systems. This creates a twin traumatisation – iatrogenic (trauma perpetrated in the name of care), and re-traumatisation (the re-activation of previous memories of adverse life experiences). Promoting better levels of education and training is essential moving forwards.

What seems also imperative is a committed drive towards challenging stigma – the stigma of negative attitudes, beliefs, and stereotypes. Stigma is harmful often resulting in creating barriers to seeking help and can have a profoundly devastating impact on families and loved ones. Addressing stigma is vital in promoting greater levels of inclusivity, improving accessibility, and how best to maximise support and better resources. Improving psychoeducation and greater advocacy promotes richer levels of empathy and compassion.

A key message from this study is:

Identify

Understand

Prevent