Westminster Centre for Research in Veterans

University of Chester

THE ARMED FORCES COVENANT FUND TRUST

ARMED FORCES COVENANT

ONE IS TOO MANY

Evaluation Report

Contents

Abbreviations

AFC	Armed Forces Community
AFCFT	Armed Forces Covenant Fund Trust “the Trust”
CBT	Cognitive Behavioural Therapy
AUDIT	Alcohol Use Disorders Identification Test
ESL	Early Service Leaver
EQ-5D-5L	European Quality of Life Five Dimension
GAD-7	Generalised Anxiety Disorder
GP	General Practitioner
ICD	International Classification of Diseases
JISC	JISC Online Surveys
MH	Mental Health
MOD	Ministry of Defence
NICE	National Institute for Health and Care Services
NHS	National Health Service
NIVSO	Northern Ireland Veteran Support Office
OITM	One Is Too Many
ONS	Office for National Statistics
PHQ-9	Patient Health Questionnaire-9
PTSD	Post Traumatic Stress Disorder
RBL	Royal British Legion
RFEA	Forces Employment Charity
RMA	Royal Marines Charity
TSS	Tackling Serious Stress
UoC	University of Chester
VAS	Visual Analogue Scale
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
WHO	World Health Organisation
WPAI	Work Productivity and Activity Impairment Questionnaire
WSAS	Work and Social Adjustment Scale

Foreword

Anna Wright – Chief Executive Officer, Armed Forces Covenant Fund Trust

We are delighted that there is good evidence that this ambitious programme has made a positive difference through the treatments and interventions that have improved mental health and wellbeing in veterans, with lifesaving implications.

With funding from HM Treasury through the Veterans' Mental Health and Wellbeing Fund, the *One is Too Many* programme awarded £2.1M to nine projects across the UK, to organisations who have experience in working with individuals who are at increased risk of suicide.

The Trust aims to deliver high impact programmes that build on the learning from our earlier work, and from wider research. Within the *One Is Too Many* programme we were significantly influenced by the emerging learning from the Covenant Fund *Tacking Serious Stress in Veterans, Carers and Families* programme, which was designed to provide funding for innovative and new ways of working to reduce serious stress in these groups. The evaluation, available separately, showed that these projects delivered significant benefits for veterans while offering good value for money.

We wanted to further explore specific approaches that could help reduce suicide and suicide risk in veterans. At the heart of the programme we wanted to better understand the difficulties experienced by vulnerable veterans in dealing with suicidal thoughts and feelings, but who were not successfully accessing the support they need.

Some of the nine projects we supported delivered urgent support and coordinated assistance to those veterans most at risk of suicide or self-harm to help them access the care that best meets their needs. We also funded complex projects that seek, through better understanding or awareness, to reduce suicide levels in the future. This evaluation focuses on the projects that were delivering direct support to veterans.

These projects were successful in reaching veterans in need. Nearly 600 veterans took part in the projects examined in depth by the evaluators. Most were male with an average age of 45 years. The majority of service users were Private soldiers or the equivalent when leaving the Armed Forces, with an average service of 12 years. 77% reported being exposed to a traumatic event during service with an average of two each. 83% of veterans taking part in projects reported long-standing physical or Mental Health illness.

Of the findings we note particularly that the veterans engaging with the projects were encountering multiple issues within their lives that were sources of stress to them.

The evaluation has highlighted a range of wider risk factor relating to self-harm and suicide risk in veterans. We hope that these can add to and enhance the work of others, and inform policymakers, healthcare professionals, and third-sector organisations.

We are hugely grateful to Professor Alan Finnegan and his team at the University of Chester for providing this in-depth and insightful evaluation.

Quotes

I am extremely grateful to everyone on the team who got me out of a dark place. I am still here!

The programme is definitely needed here in NI. It's life-saving

Thanks to the help and therapy I have received. I am looking at a new lease of life

If I didn't get the support you gave, I wouldn't be here

They saved my life and my family

It's nice to talk and not be judged. Those of us who served in NI never had the chance to go home, a part of me was left on the dark streets of Belfast

The help I got was great, I can now go places and do things I have never done before

It helped me stop having self-harm thoughts...I now understand how my thoughts work

Executive Summary

Suicide is a devastating event, that has considerable damaging consequences on families, friends and colleagues. There is often a perception that military veterans' suicides directly correlate with the impact of serving in hostile environments. However, the factors leading to someone taking their own life are often extremely complicated and influenced by numerous situational factors and personal beliefs.

In 2021, as part of the Veterans Mental Health and Wellbeing Fund, and in recognition that more could be offered to reduce veteran suicide, the Armed Forces Covenant Fund Trust (the Trust) allocated over £2M to eight UK projects. The One Is Too Many (OITM) programme followed closely on from the Trust's Tackling Serious Stress (TSS) initiative that had produced empirical evidence to signal reductions in depression, anxiety, alcohol misuse and improvements in wellbeing. Other lessons learnt from TSS included a recognition of the wide range of ethical challenges that grant holders face and recognition that they need better preparation and support.

OITM consisted of multiple two-year projects that were designed to significantly reduce veteran suicide by gaining a better understanding of the issues, providing timely intervention including education and peer support to improve the wellbeing of veterans and engage where appropriate with their families and friends. There was a clear objective to address the possible barriers to accessing healthcare. The projects were to be delivered in a co-ordinated and targeted way and concentrated on the quality of the interventions in reducing suicide rather than the number of participants. Grant holders were given the freedom to propose a number of options, from the co-production research with bereaved families offered by The Baton and the University of Northumbria, to education programmes and collaborations. The four grant holders for this evaluation were the Royal Marines Charity (RMA), the Forces Employment Charity (RFEA), Inspire and Adferiad. Each delivered direct interventions and provided the data for this evaluation.

To launch the programme, the Trust hosted an Engagement Event held at Chester Racecourse on the 14th & 15th September 2021 including a series of workshops to help prepare grant holders for the challenges that lay ahead including ethical considerations. Grant holders were also able to specify how they wanted to connect with the Centre and with each other, and their desire for networking webinars and building networks. The event was very positively received by all attendees. The Westminster Centre for Research in Veterans (the Centre) was selected to support the grant holders and the OITM projects which started in May and August 2021. Adferiad, RFEA and RMA concluded theirs in March 2023 and Inspire in July 2023.

Engagement and Interventions

There was extensive engagement between the Centre, which included quarterly webinars with all seven grant holders. This presented a platform where they were able to share their work and showcase what was working well and how challenges were being addressed. Feedback from the grant holders indicated the value of shared learning and having the opportunity to learn from

real time data. This approach was first adopted by the Trust in its TSS initiative, and this reaffirms the positivity of using evaluators to actively engage and assist throughout the course of the programme.

The results indicate that the four OITM grant holders that provided data for this evaluation were successful in improving the Mental Health (MH) and wellbeing of the beneficiaries and reducing suicide. This in part was reflected in the significant reduction in the number of reported MH illnesses, the situational stressors and symptoms. Validated and reliable psychometric questionnaires also provided clear indication of declining levels of stress, depression, anxiety and alcohol consumption and improvements in wellbeing. The grant holders' interventions also improved the beneficiaries' social networks, increased social interactions and resulted in greater involvement in other activities that would fall under the social prescribing banner. Collectively this resulted in veterans being less dependent on others.

The four OITM grant holders offered interventions that included MH assessments, psychotherapeutic MH sessions such as Cognitive Behavioural Therapy (CBT), counselling and medication. There were group activities, social prescribing events such as Equine Therapy, peer support mentoring, life skills coaching, educational courses and practical help with housing and employment. They all seem to have achieved levels of success.

In Northern Ireland (NI), Inspire's Every Life Matters project recognised that suicidal intent is related to complex and contextualised psychosocial events and it provided a proactive, targeted and integrated approach to identify, address and reduce suicidality and concomitant risk factors, which combined prevention and intervention using a case-managed stepped-care delivery model. With 24-hour coverage including psychological and social therapies it was able to address issues including Complex Post Traumatic Stress Disorder (PTSD), alcohol misuse and relationship difficulties. Their partners included Action Mental Health to address stigma, Brooke House to support military veterans and their families, Andrew Rawling to provide suicide alertness training and social prescribing activities with Horses for People and its Equine Assisted Therapy. Collaborative work with the Northern Ireland Veteran Support Office (NIVSO) and associated NI veteran support bodies provided full NI reach. Inspire also offered an aftercare service. In Wales, Adferiad set out to prevent and reduce the risk of suicide across their peer mentoring and partner organisations. Adferiad was building on the TSS initiative in which 36% (N=79) of the participants had self-disclosed suicide risk. Adferiad partnered with Hafal and its residential MH hospitals and crisis sanctuaries to provide support to those with serious mental illness, including loneliness and isolation. Inspire also worked with Papyrus, which targets the prevention of young suicide in people up to the age of 35.

In England, RFEA operates with 20 English police forces to deliver Project Nova to support veterans who have been arrested or are at risk of being arrested. RFEA's objective is to provide specialist suicide prevention alongside the Samaritans, with staff training, the development of a toolkit for veterans who are feeling suicidal and an introduction to MH treatments. Also in England, the RMA provides through-life support for serving and former RMs and their families. Its Lifting the Lid project set out to improve knowledge and awareness to help veterans and provide employment advice, financial and benevolent support, assistance with managing MH

or dealing with substance misuse. It provides training and peer support and signposting to other services. It works in collaboration with the Samaritans and a three-step training package provided by Zero Suicide Alliance (2023) and MH First Aid. To share their results, the RMA hosted a Suicide Prevention Symposium focusing on education and collaboration.

Evaluation and Participants

Data collection was the responsibility of the grant holders, with an expectation that there would be 100% (N=597) compliance with the survey questionnaire completion, and 84% (N=503) were produced. There was a range of response rates across grant holders from the RMA which had a 99% completion rate for participant data to the RFEA with 57%. The number of exit questionnaires would always be fewer due to individuals still being on a programme and those who had disengaged; 423 exit questionnaires were obtained. The grant holder often took the opportunity to add other relevant detail to support the survey responses, and this helped identify what was working well, the problematic issues and the challenges.

The OITM veteran beneficiaries were predominately white British males; only 20 services users were women, which meant that only 4% of beneficiaries were women. This may indicate that men experienced severe MH issues and women did not, or that women did not want to access the service, or they may have been unaware of the OITM programme. Female veterans were less likely to deploy in front line combat areas, and many take on professional roles such as doctors and nurses, so they may be a less vulnerable group. The evaluation reinforces the requirement to further explore initiatives to engage with female veterans, and research is needed to examine the impact of gender-related experiences during military service on female veterans' help-seeking behaviour. Ethnic minorities were also under-represented.

The mean age of the OITM service users was 45 years old, with some differences in the mean age across grant holders, for example, NI participants with a mean age of 50 were on average older than those in other programmes. An at risk group are young men but many of this age group will not be veterans, because they are still be serving and their information data are subsumed within the British Armed Forces Regulars' data. The OITM service users' ages were younger than the overall median age of UK veterans. Whilst suicide rates begin to drop in the civilian population in those aged over 70 years old, it does however rise again from 85 onwards and these are a particularly vulnerable group due to failing health or other issues such as bereavement of loved ones and partners. The four grant holders had service users aged between 74 and 85 years old, so some were clearly supporting this group although not in sufficient numbers to get a clear insight into the demands on this veteran group.

Service History

Within a military context, there is a paucity of research on suicide prevalence and risk, and there is no consensus as to whether military service increases the risk of suicide, self-harm or suicidal ideation. There is evidence that veterans with combat experience, operationally linked trauma, injury, early service leavers (ESLs) and reservists are at higher risk of MH issues. However, factors associated with risk of suicide in veterans include: being a young male veteran (under 28 years), discharging as an ESL (within four years of enlistment), being an older (over 40 years) female veteran, or having depression or alcohol problems. These issues can be

exacerbated as veterans are poor at seeking help, often not pursuing support until they are in crisis.

The majority of service users were Private soldiers or the equivalent when leaving the Armed Forces, with an average service of 12 years. ESLs were uncommon with only 2% having served less than one year and 6% less than four years. The majority, 53%, had also served in the British Army although this was due to the high number of Royal Marines. The vast majority, 97%, had completed regular service, which would indicate that reservists were not being attracted into the programme or that they were less likely to meet the inclusion criteria. However, as many risk factors are situational stressors, age related, or aligned to MH issues such as depression or alcohol misuse, then more reservists would have been expected. Considering reservists were utilised extensively during recent operations in Afghanistan and Iraq, why they have not been engaged needs further exploration.

Seventy-six percent of the veterans had completed an Operational Tour (OT) with a mean of two each, ranging from 1 to 11 deployments, most commonly in Afghanistan and NI, both at 37% each. Also, 77% had been exposed to a traumatic event during service with an average of two each. These included incidents associated with exposure to a death and others to conflict, contact situations followed by personal attacks and incidents that can increase the likelihood of MH issues such as PTSD. Correlations confirmed a relationship between service linked trauma and those who had completed an OT. Also significant correlations were observed between the number of traumatic events experienced during service and the number of reported situational factors and number of reported symptoms on entry, which is an indication that it is the life stressors that are causing the clients to seek help.

The OITM interventions provided a personalised care plan with a combination of social prescribing activities and peer support, and recognised trauma-focused CBT intervention when required. The NHS England Op COURAGE programme, High Intensity Services, has a similar portfolio of interventions and there is emerging evidence that this is also being effective. The findings which will be highlighted below indicate that the participants had notable improvements in their overall MH and wellbeing.

Physical & Mental Health

At entry into the programme, a significant majority of the OITM participants at 83% reported long-standing physical or MH illness. This included musculoskeletal injuries (25%), and MH illnesses including depression (55%), anxiety (53%) and PTSD (51%). All of these conditions notably decreased during the programme. The psychometric questionnaire scores at entry validated the self-reported health findings; veterans were gauged as exhibiting severe anxiety and moderately severe depression. These questionnaires reaffirmed improvements against all measures at exit from the programme. The results providing an indication that a variety of interventions and/or social prescribing activities may help to improve outcomes. They also support the initial evaluation of the Op COURAGE High Intensity Service study which concluded that early peer support followed by social prescribing and clinical interventions can have good outcomes. These findings demonstrate the successfulness of these programmes for

improving the health and wellbeing of veterans. It is also clear that the projects successfully targeted and recruited the intended population.

OITM service users entered the projects with an average of 5 predisposing factors and these ranged from 1 to 15 factors. The most common factors being previous unresolved trauma (66%), traumatic exposure (53%), family stress (47%), operational factors (42%), relationship problems (39%), alcohol/substance misuse (37%) and isolation (32%). Exit details showed notable reductions in all areas and the factors had fallen from five to two. These incremental reductions clearly resulted in significant improvements to the participant's wellbeing as they faced fewer situational stressors and less causative factors. This is a clear indication of the success of the programmes that would have reduced suicide. The results also indicate that reducing/resolving even one situational stressor in a timely and effective manner can have a meaningful bearing on the individual and re-energise and motivate them to address other issues. Therefore, projects that concentrate on certain issues such as accommodation and employment can have much wider benefits.

Service users also had a mean of nine symptoms with a range of 1 to 17. Most common were anxiety (79%), low mood (87%), sleep disturbance (69%), feeling of hopelessness (67%), anger (66%), poor concentration (65%) and lack of interest (63%), symptoms concurrently linked to depression. The effectiveness of the programme was again reinforced with a significant reduction in symptoms from nine to three, improvements representing tangible advantages for the beneficiaries. There was no significant correlation between age or stress scores and number of symptoms. Further exploration and understanding of risk and protective factors are imperative to reduce relapse rates, optimise current provision, and relieve pressure on healthcare services.

The high levels of lack of interest and feeling of hopelessness would have presented the grant holders with challenges in getting clients motivated to be involved in any activities. That they did may be due to the focus on veteran specific services and peer support workers who provided this vulnerable group with a sense of identification with those offering the support. Research has indicated that men and women experience depression in similar ways but present their distress differently, however, the low number of women in OITM projects does not present the opportunity to assess that. The high levels of anger reported in 66% of OITM service users can lead to disruptive behaviour and reinforces the importance of initiatives such as RFEA and Walking With The Wounded's Project Nova and the contribution of the police in helping veterans get support.

Help-Seeking Behaviour and Social Isolation

Fifty-one percent of the OITM beneficiaries were identified as having previously accessed support, and on average that support came from two organisations. The most common was NHS facilities and charities, although sizable numbers went via other MH services or a GP. It was not clear from the data how many of these engagements were related to a self-harm attempt or feeling suicidal, or how many of these clients were then referred to the OITM programme. But it does reveal that some of them did not receive the support they required, or were discharged

only for their problems to resurface. That 36% self-referred to the programme clearly demonstrates how important this means of accessing support is.

Forty-nine percent of service users delayed seeking help and did so for an average of two reasons. Of these, 30% of veterans found it hard to ask for help, 18% were unaware of the available assistance and 17% did not know where to go. Improving knowledge and access to Primary Healthcare and veteran specific services together with continued investment in destigmatising MH are required to improve access to the appropriate services. Only 4% were unaware of the one day of military service inclusion criteria which is a significant improvement on research in this area. The average age of the OITM participants is lower than the population average and elderly veterans may still be unaware of the support that is available.

The OITM projects saw a significant improvement in the veterans social networks, with increases in social activities, active members of clubs and having people to rely on. There was also evidence of veterans meeting people more often. These are other indicators of the success of the projects, and signified that the grant holders had an understanding of their clients' military, health and social profile. Therefore, after an appropriate assessment they had the information to produce a personalised care plan that included ways of reducing social isolation. The participants of varying ages seemed motivated to connect with a variety of social engagement opportunities as many of the activities had a physical exertion component which potentially would have enhanced their mood and made them feel better in themselves. How this progresses over time was not identified in this programme, but the hope would be for long-term engagement, motivation and benefits.

Employment and Housing

Thirty-nine percent of OITM participants entering the programme were unemployed and 11% were retired compared to 44% in employment. Although the age range is different, the Ministry of Defence (MOD) estimates that in 2019 79% of working-age veterans were employed, and only 3% were unemployed (House of Commons Library, 2023). So there is marked difference and stable well paid employment is very important to mental health and wellbeing.

Following exit from the OITM programme, unemployment rates had fallen markedly by 7% and there was a 4% increase in employment to 48%. The projects did well to reduce unemployment as financial issues can be a significant factor in self-harming behaviour. However, 32% of veterans still being unemployed provides an identifiable area for development.

The 2021 Census revealed that a higher proportion of the household veteran population (75%) owned their accommodation outright or with a mortgage than the household non-veteran population (64%); after adjustments, the percentage of veterans in this category was slightly lower than for non-veterans. Amongst OITM participants, the number of homeowners was significantly lower at 45%, with a further 37% in rented accommodation, 3% in residential accommodation and 3% were homeless. This reaffirms that it is these situational stressors that are contributing significantly to the service users distress, and not necessarily their operational experiences.

Older veterans reported having more stable housing status, such as homeownership or renting. The results again demonstrate that some smaller groups of veterans need specific targeting and a better understanding of their life trajectory after leaving the Armed Forces is required. There were reports of improvements following the OITM programme but there is room for further progress in this area and the AFCFT's (2023b) funded Reducing Veteran Homelessness programme should provide many of the answers to address these issues.

Participant Feedback and Reflections on Serious Stress

At 94%, the vast majority of participants were satisfied across all programmes, and they rated the interventions at 9 out of 10 in relation to the positive impact on their quality of life. That 96% of service users knew how to make an official complaint was a notable increase on the 83% reported in the TSS initiative.

The Trust's OITM programme provides a reservoir of further important data to build on the lessons from the TSS initiative. The results provide statutory and non-statutory organisations with clear evidence of numerous factors that influence self-harming behaviour in the veteran population and ways of addressing those issues. These findings can therefore help to build on extant interventions and inform future programmes how best to support vulnerable veterans. The programme's systematic review (Randles et al., 2023) was the first conducted with this veteran population and builds on the TSS's aligned help-seeking behaviour systematic review (Randles & Finnegan, 2022). Combined, they provide valuable empirical evidence that can help clinicians and peer support workers to de-stigmatise MH issues. This in part is founded on the combination of therapeutic and social prescribing interventions inside a safe and receptive environment.

All survey based evaluations require high levels of data to be able to assert that the findings are valid, reliable and significant. Otherwise the commentary is more aligned to an anecdotal observation. Because grant holders were tasked with completing the questionnaires then the objective was to get 100% compliance. The overall rate of 85% therefore left considerable room for improvement. On further analysis, the response rate from RMA (99%) and Inspire (95%) were aligned to the Trust's and the Centre's expectations. That was less so with RFEA (75%) and Adferiad (57%). The results therefore are definitely aligned to the work of those with high returns and the success of the grant holders is compromised when there are less data. This strongly identifies the potential for setting performance indicators for grant holders to achieve in relation to questionnaire uptake.

Overall there were vast improvements to many of the beneficiaries' health and wellbeing which undoubtedly saved lives. However, there are significant emotional challenges for the staff providing the care to these vulnerable veterans. This raises the question of what impact this level of support has on those delivering the support, many of whom have no or minimal MH training, and who cares for the carers. A recommendation is that this should be explored as a future research project and governance measures implemented to ensure the safety of those delivering the care as well as those receiving it.

To better understand the provision of support and care for veterans, this necessitates understanding the unique lifestyle and specific culture within the Armed Forces Community (AFC). With help-seeking behaviour being poor, then identification with a particular charity such as Royal Marines with the RMA appears to be a particularly useful way of tackling this conundrum. Overall, many of the findings reinforce the compelling case for local community hubs and as demonstrated in the concept of the Trust's Veterans Places, Pathways and People programme.

Limitations

Only 4% of the programme's beneficiaries were women, and there was a gap regarding support to older veterans. Veterans who disengaged from OITM projects did not have their views captured. Despite increased awareness of veteran suicides, there is a paucity of research and the OITM background systematic review has been published in *British Medical Journal Military Health* (Randles et al., 2023). However, there remains a limitation in not having a better understanding of the lived experience of family members and friends who have been impacted by suicide in the veteran community and the support services available. The work undertaken by The Baton and the University of Northumbria as part of the overall programme should prove illuminating.

Summary

It would be remarkable to reveal in the conclusion to this OITM report that no veteran involved in the programme had taken their own life. However, this is not the case, and to the distress of all those involved, a colleague decided that suicide was the only option available. This again highlights the incredible challenges faced in trying to support those former vulnerable teammates who cannot envision a future that is worth living for. However, the OITM programme has made a positive difference. This report is a clear demonstration of treatments and interventions that have improved mental health and wellbeing and undoubtedly saved lives. The OITM programme's flexibility and responsiveness to referrals, which were aligned with multiple levels of collaborative networking and connectivity between grant holders, was impressive. When delivered in a suite of interventions within a personalised treatment and intervention programme, then the results were overall successful in reducing the situational stressors that can lead to self-harming and suicide. Furthermore, with ongoing empathetic peer support the result for the majority of clients was notable improvements in MH and wellbeing. These findings combined with the evidence from the TSS initiative, collectively provide vital information to help grant holders shape their current provision to maximise support to vulnerable veterans and their families.

The OITM programme has illustrated suicide risk factors leading to veterans' self-harm, suicide risk and protective factors and these can now inform policymakers, healthcare professionals, and third-sector organisations of a direction of travel that has palpable benefits. The OITM findings may facilitate the development and implementation of preventative and intervention strategies to best support the MH and wellbeing of UK Armed Forces veterans in crisis. Clearly,

many of the factors causing the clients so much distress were due to the current situation rather than anything that had occurred in their military career.

That 96% of the questionnaires were from men may reflect that men experienced severe MH issues, or that women did not want to access the service or complete the study questionnaire. As a new initiative, there may be a requirement for better promotion of the service because female veterans may have been unaware of what was available. In addition, there remains a need to further explore initiatives to engage with female veterans and understand the impact of gender-related experiences during military service on female veterans' help-seeking behaviour.

This report is therefore building a reservoir of information and can assist future research to explore the impact of these portfolio interventions over a prolonged period. A 6 to 12 month post exit data collection within a longitudinal study presents many advantages for determining long-term benefits, as would enhanced qualitative data captured through interviews with beneficiaries, their families and staff. Furthermore, future evaluations should consider the utilisation of a cost-benefits analysis.

Following on from the TSS study, this evaluation presents very positive evidence of the success of the OITM programme. Reductions in depression, anxiety, alcohol misuse and improved health and wellbeing can only be beneficial. There are clear indications of better social interactions. The report re-emphasises the importance of providing timely and skilled care within a setting where beneficiaries feel safe. There is evidence that the grant holders clear dedication, enthusiasm, intelligent application of resources alongside participant engagement led to widespread accomplishments. The only caveat is that the quantity of data from grant holders ranged considerably, and these conclusions are easier to confirm when the data returns were high.

OITM has provided a bedrock for the grant holders to forge lasting collaborative partnerships that can be extended to working with other authorities and organisations, governmental agencies, professional bodies, charities, businesses and appropriate networks. Most importantly it presents another example to those veterans and their families who need functional help and choice in where they can obtain the support, care and intervention they require.

The evaluation recommendations are on page 91 and in the shortened form infographic on page 16.

RECOMMENDATIONS

Grantholder Engagement

Larger AFCFT grants should utilise the project evaluators' experience to actively engage with the programme and have a role in supporting grant holders.

Caring for the carer

A standardised training package for those delivering care combined with mandatory governance structures. Research can also help ensure the safety of those delivering the care as well as those receiving it.

Help-seeking and stigma

Assessments should capture details surrounding the factors that negatively impact on help-seeking behaviour. Novel support with peer mentors who provide individually personalised support, drop-in centres, Community Hubs together with engagement with the Police and Emergency Services may prove helpful in addressing stigma. Entry into programmes should continue to be though multiple routes including self-referrals, statutory bodies or Charities.

Under represented and minority groups

Programmes to include a strategy for reaching under-represented and minority groups or design specific programmes for these groups.

Assessment

The situational stressors contributing to the client's distress should be identified in the assessment process to ensure appropriate treatment and promote successful outcomes.

Employment and Accommodation

Programmes that improve employment and accommodation and gain a better understanding of veterans' life trajectory will have a positive impact.

Interventions

Future programmes include a mixture of interventions that suit particular beneficiaries including social prescribing activities.

Evaluation

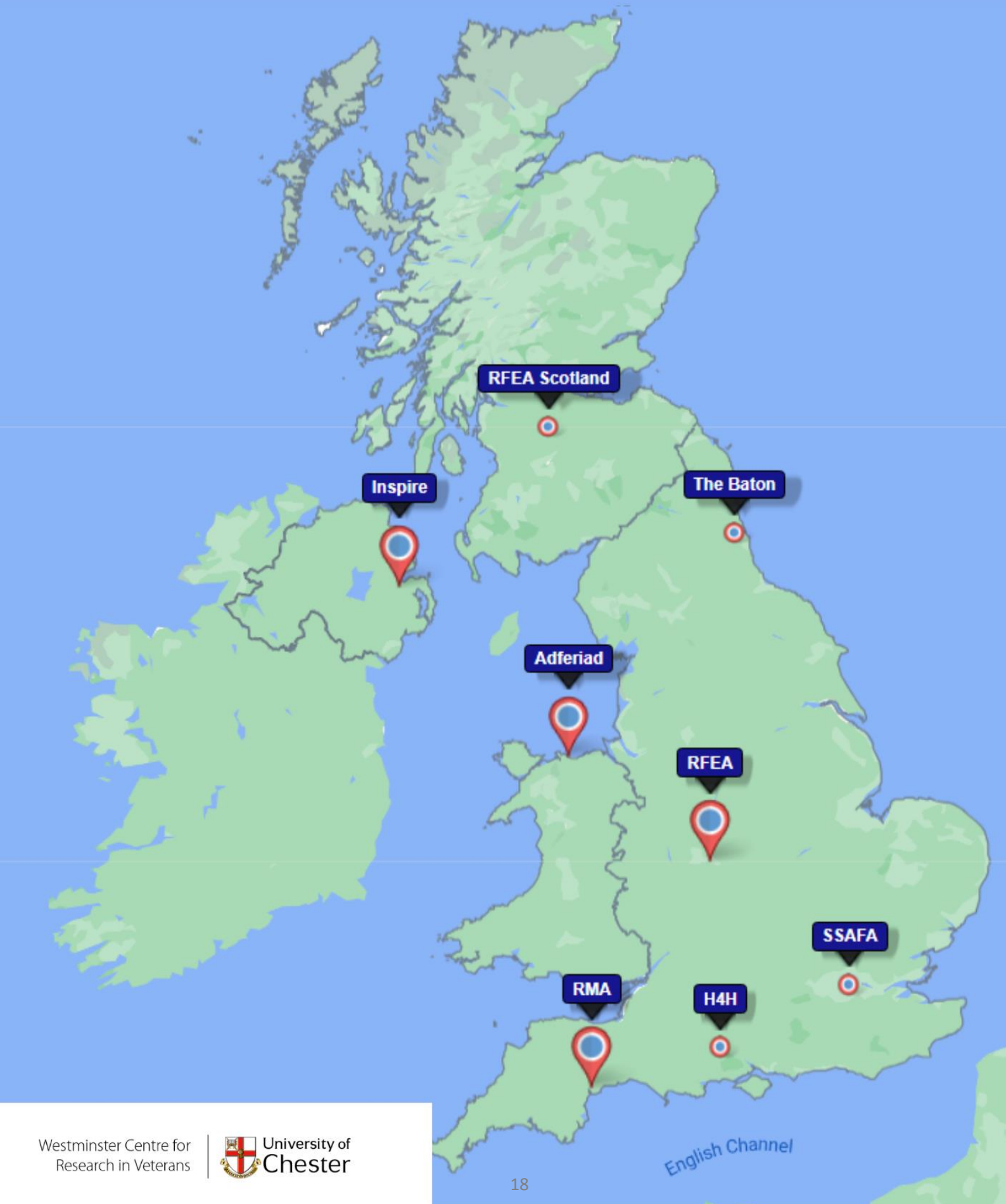
Utilise a consistent data set in programme evaluations to determine effectiveness over time. Data collection performance indicators aligned to financial remuneration would improve the number and quality of survey returns. Large grants would benefit from a specific economic evaluation.

Introduction

In April 2021, as part of the Armed Forces Covenant Fund Trust's (the Trust) Veterans' Mental Health (MH) and Wellbeing Fund, the One is Too Many (OITM) 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. Collaborative working was expected as part of this programme. Projects were required to show that they were likely to reduce suicides in veterans. The grant holders were required to provide direct assistance to those who were at significant risk and were not accessing support; or to deliver a project that would have a clear and demonstrable impact on suicide prevention. Grants were provided to eight organisations consisting of Inspire in NI, Adferiad in Wales, SSAFA and the Samaritans; the Royal Marines Association (RMA), Help for Heroes, The Baton, the Forces Employment Charity (RFEA) in England, and Walking With the Wounded in Scotland (see Figure 1). Their locations are in the infographic on page 18.

Figure 1. OITM Grant Holders

Grantholder Locations



These organisations adopted different approaches. For example, some partnered with other specialised associations that were knowledgeable and skilled in suicide prevention. Others, focused on research and educational projects. See Table 1.

The UK National Institute for Health and Care Services (NICE) guidelines (2018, 2019) state that consideration should be given to measuring activities designed to prevent suicide. These include the introduction of constructive, meaningful preventive activities (for example, education and physical activity) rather than focusing on suicide numbers alone. To that end, the Trust commissioned the University of Chester's (UoC) Westminster Centre for Research in Veterans (The Centre) to support the grant holders and to complete an independent evaluation of the OITM programme which concluded in March 2023. The focus of this report is the four organisations that provided active beneficiary support and data from their projects, these being Inspire, Adferiad, RMA and the RFEA. This evaluation sought to reveal the impact and effectiveness of the OITM programme, including identifying trends and risk factors such as age, gender and military-specific details (e.g., branch, service length and rank). The evaluation pursued evidence of social isolation, poor help-seeking behaviour, and sought to identify the situational factors causing distress and potentially influencing self-harming behaviour or suicide.

Organisation	Project Title	Amount	Project Description
Walking With The Wounded	Positive Futures - Scotland	£300,000	Walking with the Wounded in Partnership with Veterans' First Point aims to reduce suicide risk by supporting veterans with significant MH problems find and retain meaningful and fulfilling roles in their communities, fully supported by the organisation's new individual placement support officers. The focus was Scotland.
Adferiad Recovery	Left of Boom - Suicide Reduction	£285,013	In Wales, the Adferiad Left of Boom aims to reduce and prevent suicide by vulnerable veterans through providing a bespoke peer mentoring service across Wales, specifically addressing this risk within veterans. The project benefits from Change Step's networks and experience and provides timely interventions to those least likely to access the support they need
Inspire	Every Life Matters	£300,000	The Northern Ireland based Every Life Matters programme will take a proactive, targeted and integrated approach to identify, address and reduce suicidality and concomitant risk factors, combining prevention and intervention using a case-managed, stepped-care delivery model tailored to older Northern Ireland veterans.
The Baton	Veteran suicide: Understand Identify-Prevent	£299,894	In partnership with Service families who have been bereaved by suicide, this project will co-produce a foundation of evidence and a model of safety to support other grant holders to develop their services and integrate them with statutory healthcare across the UK, to provide long-term support to reduce suicide.
Help for Heroes	Veterans' Suicide Awareness & Self-Help (SASH)	£300,000	Help for Heroes will change how support for veterans suffering from MH difficulties are accessed by empowering families and peers to help save the lives of those at risk of suicide. The project will upskill and educate, facilitating better help-seeking behaviour in at-risk individuals.
RFEA - The Forces Employment Charity	Project Nova - One is Too Many	£100,000	Project Nova - One is Too Many will reach more veterans who are at risk of suicide by reaching out to veterans who are in contact with the Police, with the One is Too Many message. They aim to become a centre of excellence for support to suicidal veterans.
RMA	Lifting the Lid Suicide Prevention Pathways	£250,250	Building upon the success of their Lifting the Lid campaign, this project will embed community-based support pathways, enhance professional skills and reduce stigma amongst the Corps family through developing best 'prevent and recovery' practice tailored to the unique experience of Royal Marines, encouraging those at risk to engage with services
SSAFA	SSAFA Samaritans Partnership	£300,000	In partnership with the Samaritans, SSAFA will produce an ambitious strategy informed by dedicated scoping, consultation and user research to maximise combined expertise, knowledge and services to reach veterans in need.

Table 1. Grants Awarded under the One is Too Many programme - Total Awarded £2,135,157

Malcolm, a RM Veteran, in his 50's (not real name), approached the Transition Support Worker in RMA-TRMC in the summer of 2022. He presented initially with issues in his workplace which were causing increased levels of stress and anxiety and problems within his relationship and was seeking support in trying to manage through this situation. Through a holistic assessment the Transition Support Worker rapidly realised that the primary issue was alcohol dependence and that this has led to exacerbated issues at work and inability to manage without alcohol. At our case discussions meeting, something we have incorporated through the OITM project from our best practice learning, an inter-team referral was made to the Addiction Nurse Specialist (ANS). Following a bio-psychosocial assessment, the ANS was able to establish that a high level of intervention was required to enable Malcolm to safely stop alcohol use and begin rehabilitation/recovery work. The quickest way to achieve this would be to fund a stay in an Addiction Rehabilitation that had the resources to detoxify safely too. On gaining consent and collaboration from Malcolm regarding the treatment plan, the ANS sought authority from the Dir. of Health & Well-being in RMA-TRMC for the substantial funding required for this stay. Unfortunately, Malcolm was not in a position to find the funds himself, his desperation was compounded by his livelihood and family life being at stake. Once funding had been approved, Malcolm embarked on his stay for detox and several weeks rehabilitation to commence the Recovery process in a supported environment.

On assessment, the ANS had established that there were some trauma issues that indicated that trauma-focused therapy was indicated, however it was imperative that the alcohol issue was addressed initially to enable Malcolm to be in a psychological space to work in therapy. On discharge from the rehab facility, the referral for the MHVRP was made inter-team and accepted which allowed the therapy to commence, running in parallel with recovery from alcohol

. The Recovery Support Worker from the RMA-TRMC has been pivotal in Malcolm's recovery, visiting him and his family at home and offering ongoing support. This support remains ongoing and accessible to allow Malcolm to have the optimum chance of change in his life whilst being supported. To date, Malcolm has been supported by four pillars of the H&WB team which has involved at multiple staff at varying times – true collaboration and partnership within the charity.

Background

In Great Britain, there are approximately 2M veterans who had previously served in the British Armed Forces (Office for National Statistics (ONS), 2022). To help in supporting them, an Armed Forces Covenant (2022) was introduced to ensure that those who serve or have served in the Armed Forces and their families are not disadvantaged for their military service. The support is offered in a variety of areas, such as education, employment, and health.

NHS organisations provide veterans' healthcare throughout Great Britain and Northern Ireland. This includes offering veterans in Great Britain access to veteran specific priority treatment for conditions directly attributable to their military service. Under this banner, NHS England introduced Op COURAGE: The Veterans Mental Health and Wellbeing Service (NHSE, 2021) which provides veterans with a full range of specialised MH support including partnerships with community/voluntary third-sector services.

Suicidal Ideation, Self-Harm and Suicide

Suicidal ideation or suicidal thoughts is the term used to describe intrusive thoughts and feelings a person has about taking his or her own life (Mind, 2023). Some individuals in mental distress engage in self-harming behaviour as a coping mechanism to alleviate their negative thoughts (Mental Health Foundation, 2022). Notably, self-harm is an intentional behaviour, and those who self-harm may not have suicidal motives (Samaritans, 2020). MH issues such as anxiety, depression, and PTSD are strongly associated with an increased risk of suicide (Too et al., 2018). Notably, a history of suicide attempts is the most significant risk factor associated with suicide (World Health Organisation (WHO), 2021). Complex MH problems, triggered by previous trauma, can lead to impulsive behaviour, resulting in difficulties in managing emotions and increasing the risk of suicidal ideation or self-harm (Too et al., 2018).

Office for National Statistics (2022) data reveal that in 2021, there were 5,583 suicides registered in England and Wales, equivalent to a rate of 10.7 deaths per 100,000 people. Of these 74% (N=4,129) were men which is the equivalent to 16.0 deaths per 100,000 and for women there were 5.5 deaths per 100,000. Among females, the age-specific suicide rate was highest in those aged 45 to 49 years (7.8 deaths per 100,000), and among males it was highest in those aged 50 to 54 years (22.7 deaths per 100,000). Suicides were lowest among people aged under 20 and over 70. See Figure 2.

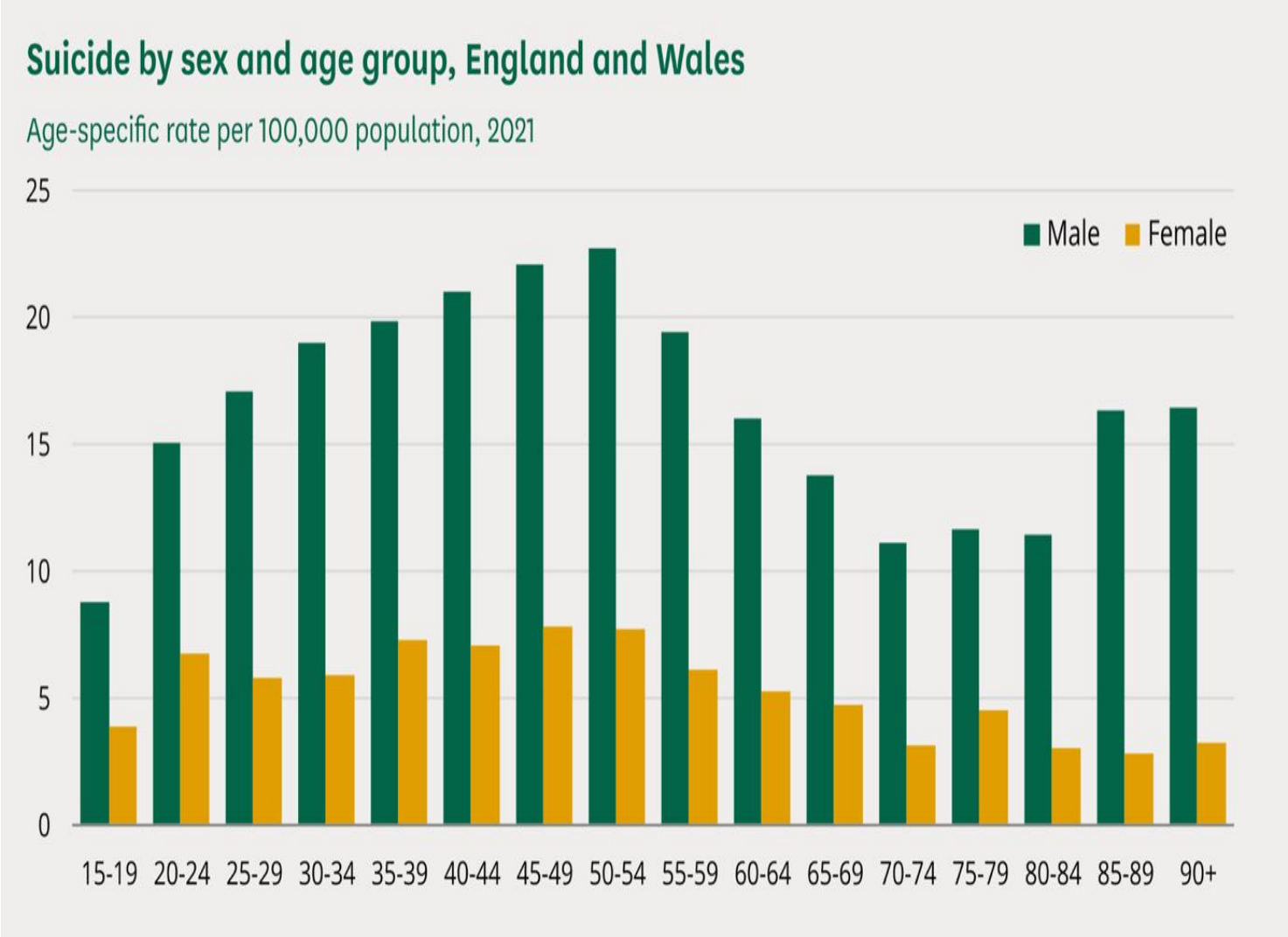


Figure 2. ONS Data

In England, in all but one of the previous 11 years, the lowest suicide rate was in London (6.6 deaths per 100,000), and the highest rate was in the North East with 14.1 deaths per 100,000. (ONS, 2022). In Northern Ireland in 2021, the rates were higher at 14.3% (Northern Ireland Statistics and Research Agency, 2022) and there were a probable 753 suicides registered in Scotland in 2021, which is a decrease from 805 in 2020 (Public Health Scotland, 2021). Evidence suggests that suicide rates in the serving population are lower than those in the general population (Bergman et al., 2017; MOD, 2017). This may be due to service personnel being in full time employment, having a strong sense of camaraderie, unity, and interdependence that is fostered across the Armed Forces. The most noted vulnerable group were Army males aged under 20 years of age. Suicide rates for females in the Armed Forces were too low for statistical analysis (MOD, 2017).

However, the rate of male suicide in the regular British Armed Forces increased from 7 per 100,000 in 2015 to 12 per 100,000 in 2019 (MOD, 2022). The recent rise in UK armed forces male suicides was highest among males aged under 24 years and those aged over 40 (MOD, 2022) and highest in the British Army.

Depression and alcohol abuse are strongly correlated (Finnegan et al., 2014) and a significant number of those who perform suicide have a primary diagnosis of alcohol or other drug dependency (Amiri & Behnezhad, 2020). The social contexts and causes of self-harming behaviour are complex, although usually associated to a number of situational stressors (Schyder et al., 1999). Some obviously want to die, and they are at extreme depths of despair, (White, 2010) whilst others want to influence someone, or use this method as a form of help-seeking behaviour (Bancroft et al., 1976). The effect on family and friends is devastating, and is a highly sensitive issue within the Armed Forces (House of Commons Defence Committee, 2005).

Military Stressors

A career in the British Armed Forces may result in service personnel being deployed on operational tours and being separated from friends and family (Ashcroft, 2017). Some may have been exposed to stressful and traumatic situations and previous exposure to trauma (such as experiencing conflict, disaster, violence, and abuse) increase the risk of developing MH problems (Ashcroft, 2017, WHO, 2021). Despite the challenges faced during service life, most ex-servicemen and women leave and transition from the British Armed Forces to civilian life without any issues. However, some experience MH problems including depression, anxiety and alcohol abuse (Finnegan et al., 2018; Finnegan & Randles, 2022) In the general UK population, stressful life events such as financial problems, unemployment and major relationship instability are considered to be high-risk factors of suicide (Royal College of Psychiatrists, 2020, Mind, 2023). These issues extend to veterans who may face challenges with seeking employment (Fulton et al., 2018), housing (Fleuty et al., 2021), relationships problems (Gribble & Fear, 2019) and social isolation (The Royal British Legion (RBL), 2014). Specific veteran subgroups are assessed as being at greater risk of developing poor MH, including Early Service Leavers (ESLs) (Bergman et al., 2016), those who experience combat (Fear et al., 2010), those who sustain injuries, and reservists (Harvey et al., 2012). Uncertainty remains regarding why people leave the British Armed Forces early although low rank, serving in the British Army and dissatisfied with their career (Finnegan et al., 2014), and high levels of childhood adversity (Buckman et al., 2013) are factors.

Predisposing Factors and Symptoms

Any programme that is aimed at reducing suicide must have a clear insight into the situational stressors associated with the client's lifestyle that may be causing depression, anxiety or other MH problems. Previous civilian studies have shown that stress and depression were associated with multiple interacting factors such as physical illness, family or relationship problems, social isolation, employment, and poverty (Cruwys et al., 2014; Hughes et al., 2017; Lund et al., 2010; NIMH, 2018; Vos, 2016). Similarly, within the Armed Forces (irrespective of rank, age, and gender), common underpinning factors associated with MH issues include family or relationship problems (Bohman et al., 2017; Lindert, Weisskopf & Spiro, 2018; Finnegan et al., 2014), and occupational issues that are not military-specific, such as unemployment (Finnegan, 2011; The RBL, 2014; Theorell et al., 2015). Some veterans also found the transition from military to

civilian life difficult, especially in the presence of financial, housing, and employment difficulties (Ashcroft, 2014, 2017).

The TSS initiative was a major study with the veteran's population that identified that in 970 participants, there was a mean of five predisposing factors with a range of 0 to 16 factors. The most common factors being family stress (54%), previous unresolved trauma (54%), traumatic exposure (54%) family issues 40%), relationship problems (35%) and isolation (35%). Exit details showed notable reductions in all areas except for physical issues. Following exit from the TSS projects, the average number of reported factors by veterans had fallen from 5 to 3, with a range of 0 to 12 reported factors. What was also clear was the accumulative presence of situational stressors. On entry 3% had reported no factors but this had risen to 16% on exit from the projects. These incremental reductions would clearly make a significant improvement to the participant's wellbeing and results demonstrated that the TSS interventions reduced the levels of situational stressors/factors . See Figure 3.

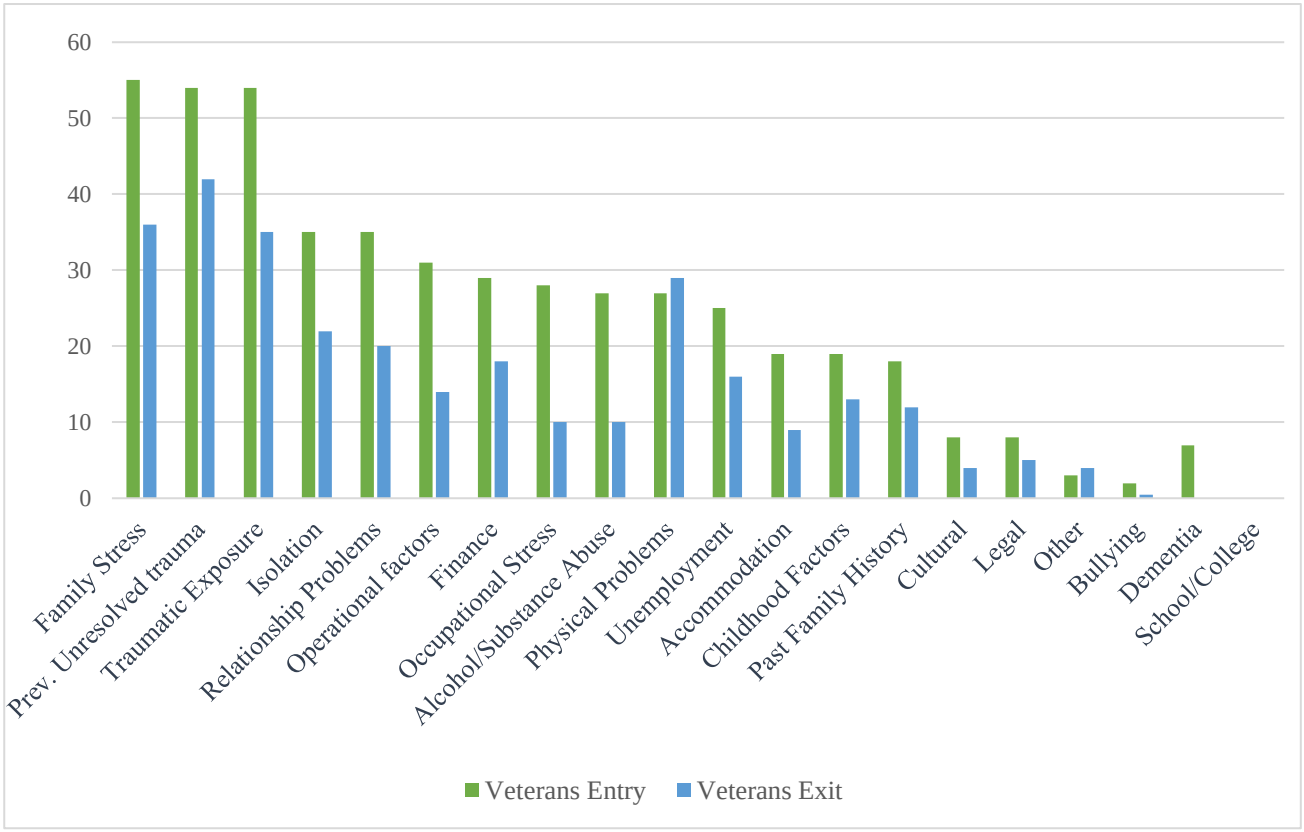


Figure 3. Factors affecting veterans at entry and exit

TSS also showed veterans reported an average of 10 symptoms. They reported anxiety (80%), sleep disturbance (75%), loss of confidence (70%), and poor concentration (64%), symptoms that are concurrently linked to depression (NICE, 2015; NHS, 2016; WHO, 2018). The effectiveness of the projects was again reinforced with a significant reduction in symptoms from 10 to 4 and these improvements represent palpable benefits for the participants.

Suicide Bereavement in Families

The impact of suicide on family members can be devastating. (Levi-Belz, 2015). Unfortunately, there are instances when suicide in the Armed Forces may be perceived as a dishonourable death and may in turn negatively impact the wider support network of the AFC (Harrington-LaMorie et al., 2018). Bereaved family members may face increased shame, isolation, or distress in comparison to civilian families impacted by suicide (Harrington-LaMorie et al., 2018). Therefore, is important to acknowledge and understand how suicide exposure affects family members. For the Fallen (2023) is a UK organisation that offers bespoke support for the families of serving personnel and veterans following suicide. Service family members from For the Fallen who have been bereaved by suicide are working in partnership with The Baton and the University of Northumbria as part of the OITM programme to co-produce an evidence model of safety framework. It is anticipated that the framework will help provide support to other grant holders and enhance their current service provision, and that the model will be incorporated into statutory healthcare to prevent suicide on a long-term basis.

Help-Seeking Behaviour

A reluctance to seek help is a prominent theme within veterans (Randles & Finnegan, 2022) who often have little awareness of, and willingness to utilise veteran-specific MH services (Mills, Fear & Stevelink, 2023). Instead, veterans are more likely to use friends or colleagues and family members as sources of support (Mills, Fear & Stevelink, 2023). The willingness of veterans accessing MH support has been shown to be impacted by several factors, including stigma, a military culture of stoicism and self-reliance, and factors associated with operational tours such as previous combat exposure (Randles & Finnegan, 2022).

It is unknown whether serving in the British Armed Forces increases the risk of suicide, or whether previous underlying issues, difficulties, or experiences increase the risk of suicide among veterans. To better understand veteran suicides and following an agreement with the Office for Veterans' Affairs, the MOD and the ONS have agreed to formally document the number of Armed Forces veterans who die by suicide. Currently there is no monitoring system in place to record the number of reported suicides within the veteran population. Instead, data on veteran suicide is collected from longitudinal cohort research studies exploring specific veteran cohorts. The new reporting method will help identify and capture veterans' suicide rates from the recent veterans' question in the 2021 Census and match it with ONS-held data on suicides. To that end, this report provides the first systematic review of suicides and suicidal ideation in veterans of the British Armed Forces.

Prevalence and Risk Factors of Suicide and Suicidal Ideation in Veterans who Served in the British Armed Forces: A Systematic Review

Background

What is already known on this topic is that despite recent investment into preventing UK veteran suicides, there is a lack of research in the context of the British Armed Forces. Research into the

factors resulting in suicide in the military veteran population has yet to reach a consensus. The United States of America has produced a significant amount of the research in a country where suicide is identified as a national health crisis, but in the UK there is little research regarding veterans from the British Armed Forces.

A Systematic Review was conducted and articles that discussed these subject areas were eligible for review: suicide; suicidal ideation; prevalence, or risk factors among British Armed Forces veterans. A total of 10 articles met the inclusion criteria and were analysed.

Introduction

The possibility that suicide may be associated with military veteran status is clearly troubling, and there remains no consensus as to whether military service increases the risk of suicide, self-harm, or suicidal ideation (Kapur et al., 2009; Miller et al., 2009). The available research is concentrated on a small number of countries and there is a lack of consistency with contradictory conclusions. However, there is evidence that military veterans present with high levels of MH difficulties (Finnegan & Randles, 2022; Iversen et al., 2009, Seal et al., 2009), and that they were poor at seeking help, often not pursuing support until they were in crisis (Randles & Finnegan, 2022). Factors that are associated with risk of suicide in veterans include: being a young male veteran (under 28 years), discharging as an early ESL (within four years of enlistment), being an older (over 40 years) female veteran, or having depression or alcohol problems (Bergman et al., 2022; Harden & Murphy, 2018; Rodway et al., 2022). The literature also suggests that veterans who experienced adverse life events before enlisting, or who have difficulties adjusting to civilian life, may be at higher risk (Rozanov & Carli, 2012).

Currently, there is a scarcity of research on suicide prevalence and risk in veterans in a UK context. This extends to learning lessons from the veteran's time within the British Armed Forces, although there are some indictors from active-duty research. These include the identification that the situational stressors of relationship issues, family problems and occupational stressors were the primary significant factors leading to depression in serving personnel (Finnegan et al., 2014), or for some young men the primary stressor is a desire to leave the armed forces but this is curtailed by their terms and conditions of service (Finnegan et al., 2010) and service-personnel's self-harming behaviour is correlated with alcohol misuse (Crawford et al., 2009).

One of the countries with a large body of literature on suicide prevalence, risks and interventions amongst the veteran population is the United States. Veteran suicide in the US has been identified as a national health crisis, with an average of 16 veteran suicides per day (US Dept of Veterans Affairs, 2022). In 2020, there were 6,146 veteran suicides, a slight decrease from the trend that has seen a year-on-year increase since 2006. The suicide rate for veterans was 57% greater than for non-veterans, with 71% using firearms (US Dept of Veterans Affairs, 2022). Canada has a similar picture to the US, with the risk of suicide for both male and female veterans being consistently higher than in the Canadian general population (Simkus et al., 2019). In contrast, Australian male veterans have comparable suicide rates to non-serving males, although the suicide rate is significantly higher in female veterans (Jones et al., 2020). Dutch (Rijs &

Bogers, 2015) and Swedish (Pethrus et al., 2017), veterans have a comparable suicide risk to their respective general populations. Switzerland is somewhat unique in that it has a suicide rate of just below the European average (Värnik et al., 2008) and has the 16th highest gun ownership in the world (Small Arms Survey, 2020). Regarding method of suicide, 37% of male suicides in Switzerland utilise firearms (Värnik et al., 2008). Within the UK veteran population, one might speculate that suicide by firearms is low due to lower availability and higher restrictions. However, firearms extend to incidents of "Suicide by COP" or law enforcements assisted suicide (Hutson et al., 1998; De Similien & Okorafor, 2017), and whilst rare, when involving UK military veterans they are high profile events (Clay, 2022). This suggests that suicide prevalence within the veteran community is dependent on the specific country in which they reside and may be influenced by contextual factors.

There has been a significant investment into suicide prevention in UK veterans with this Trust's OITM initiative being a leading initiative (AFCFT, 2020), and a pledge to better document veterans whose cause of death is listed as suicide (Gov.UK, 2021). In addition, the withdrawal of troops from Afghanistan in 2021 has raised concern regarding MH and potential suicide risk (Bryant et al., 2021, House of Commons Defence Committee, 2023).

METHODOLOGY OF SYSTTEMATIC REVIEW

Systematic Literature Search Strategy

This systematic review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021). Literature searches were conducted using PsycINFO, Medline, and CINHAL databases. See Table 2. The selected databases offer a variety of indexes that provide comprehensive and up-to-date peer-reviewed publications. Grey Literature was also included as part of this review to allow the inclusion of reports commissioned by organisations related to veterans including the Forces in Mind Trust, the Trust, MOD, and the RBL. Each country's governmental literature was also searched for potential statistical information. Reference lists of reports and articles were also manually searched as was *British Medical Journal Military Health* for any additional articles. There were no database limitations applied to the search. Due to the focus on the British Armed Forces, all publications were written in English and the earliest article in the original search dated back to 1980.

Inclusion-Exclusion Criteria

Articles that discussed suicide and suicidal ideation prevalence or risk factors among British Armed Forces veterans were eligible for review. Self-harm and associated synonyms were included in the search terms. However, self-harm was only included when it was discussed as a risk factor for suicide or suicidal ideation and not when discussed independently. Any form of review such as a Systematic Review or Rapid review was not included. However, the reference lists were manually searched for any additional articles. Those discussing prevalence and risk factors for attempted suicide were also included due to the intent of completing suicide.

Articles that solely discussed serving personnel were not included in the review. In some publications, the findings for serving personnel and veterans were combined. Therefore, it is

difficult to extrapolate data specifically related to veterans due to the combined nature of the results. However, publications that presented serving personnel and veterans' data separately were eligible for review.

Search no.	Field	Search Words
S1	Title	Veterans or ex-servicemen or ex-serving or ex-soldiers or ex-military
S2	Subject	United Kingdom or UK or England or Britain or Scotland or Wales
S3	Subject	Suicide or self-harm or self-injury or suicidality or suicidal or self-harming or suicidal ideation
S4	S1 AND S2 AND S3	

Table 2: Search parameters of the literature review

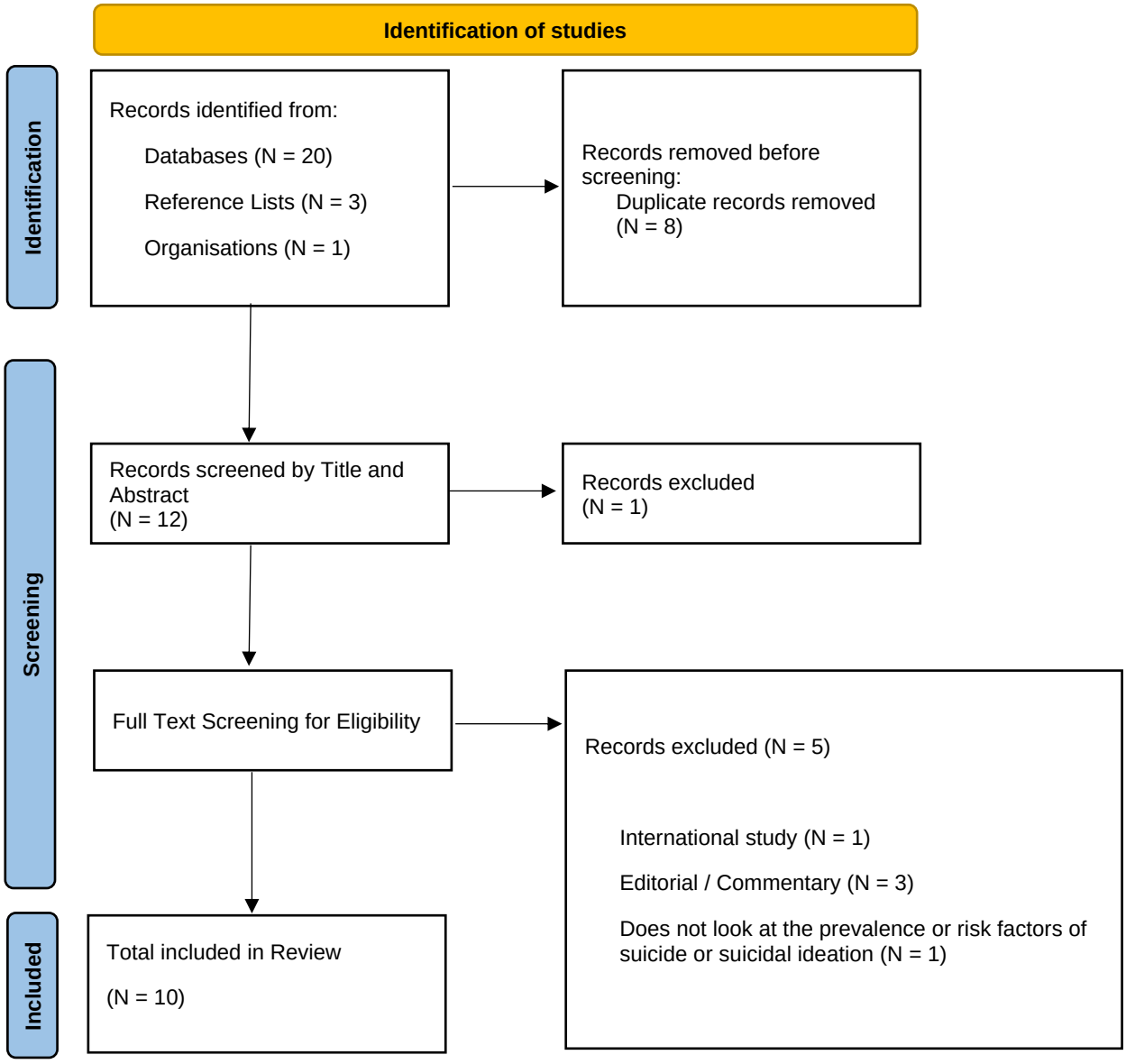


Figure 4: PRISMA flow diagram of literature review publication selection

Results

The 10 included articles were published from 2008 to 2022. Of these, nine were quantitative articles and one adopted a mixed methods approach. See Figure 4. Quantitative studies consisted of self-reporting surveys and database searching. The qualitative approach in the mixed methods study utilised interviews. Three studies directly compared the veteran population with a demographically matched civilian population. The current narrative considers the prevalence of suicide and suicidal ideation within the UK veteran population and also explores the risk factors that are within the included publications, see Appendix A.

Prevalence

There was a significant lack of research directly comparing the prevalence of suicide and suicidal ideation in the veteran community with the civilian population. However, in the research available there was found to be no significant difference in rates of suicide (Bergman et al., 2017; Bergman et al., 2022, Kapur et al., 2009). However, there was found to be increased risk in specific sub-groups such as different age categorises and ESLs. Rodway et al., 2022 found that veterans had a marginally lower risk of suicide, though this difference was not significant. Death by suicide has been found to range from 6.6 – 7.6% of overall veteran deaths and for civilians range from 7.8 – 8.4%, which highlights the small difference between the two groups. Bergman et al. (2017; 2022) matched the civilian comparison population in areas such as age, gender and socioeconomic status with that of the veteran population to produce a highly valid comparison, which ensured that any differences were more likely due to veteran status. However, there was no information on personal factors that could influence suicide risk such as combat exposure and alcohol misuse.

In addition, statistics presented by the MOD explored the deaths of veterans who had been deployed to the Gulf and Falklands conflicts. Those deployed in the Gulf were found to have a statistically decreased risk of suicide compared to the general population (Randles et al., 2023). Veterans deployed to the Falklands were found to have a 33% decreased risk compared to the UK general population (MOD, 2014). However, it is possible that there may have been suicides that were missed within these statistics because categories that may include suicidal deaths such as accidental deaths or deaths associated with drug/alcohol misuse were not included. These statistics appeared to match by age, but did not consider gender or socioeconomic status, both of which could potentially influence rates of suicide.

Methods of Suicide

The method of suicide most commonly used amongst the UK veteran population was found to be hanging and strangulation (Kapur et al., 2009, Randles et al, 2023). However, the method used did not differ from that of the civilian population, with differences only found across genders regardless of veteran status (Bergman 2017). The least common method of suicide amongst veterans was found to be firearms with as few as 2% utilising this method (Kapur et al., 2009, Randles et al, 2023), and male veterans were less likely to use firearms than male

civilians (Bergman, 2017). This contrasts with the USA where firearms are the most common method of suicide (U.S. Dept of Veterans Affairs, 2022), likely due to higher accessibility.

Risk Factors

There were numerous risk factors for suicide and suicidal ideation in UK veterans including factors related to demographics such as age and gender, service history such as deployment, transition into civilian life, MH disorders such as PTSD and a history of self-harm. The lack of literature suggests that there may potentially be risk factors that have not been fully explored or have been missed.

Demographics

Demographically, the age of the veteran was found to be a risk factor, though the age at which this may be has differed across the literature. Bergman et al. (2017) found that risk was lower in younger veterans but higher in those over the age of 40. In contrast, Kapur et al., 2009 found that the younger veteran groups were at two to three times higher risk than the civilian population with veterans aged 30-49 being at lower risk. This was also supported by Rodway et al., 2022. However, the latter two studies did not control for socioeconomic factors, something that Bergman et al. (2017) ensured and this could explain the contradictory findings. In support of Bergman et al., (2017), Harden and Murphy (2018) found that veterans aged between 35 – 44 and 45 – 54 years old were more likely to report suicidal ideation. However, this sample only included veterans who were seeking treatment thus the results may be skewed; it may be that younger veterans are least likely to seek help and therefore are at higher risk of suicide.

In addition to age, gender was also found to be a risk factor, particularly among female veterans who were found to be at higher risk of suicide than female civilians, there were no statistical difference between male veterans and female veterans (Bergman et al.., 2017). This could be due to females adopting the masculine and stoic culture surrounding the military meaning that they are less likely to seek help for MH difficulties and are, therefore, at a higher risk for suicide than female civilians. Yet, Rodway et al., (2022) found that overall, males were at an increased risk for suicide, however due to the veteran population being predominantly male it is possible that this demographical difference may skew the results. Furthermore, there were significant interaction effects between gender and age among veterans with younger male veterans and older female veterans being at higher risk of suicide and/or suicidal ideation (Bergman et al., 2022; Rodway et al., 2022).

Service History and Transition

The service history of the veteran, that is, their experiences during their time in the military has been observed to be a risk factor. For example, veterans who served in the Royal Navy or RAF were at a reduced risk of suicide compared to those who had served within the British Army (Rodway et al., 2022). In addition, those veterans who experienced what they believed to be classed as a morally injurious event were more likely to report suicidal ideation suggesting that those involved in combat may be at increased risk of suicide (Williamson et al., 2021). However, more recent research indicates that those deployed on combat operations were at a decreased risk of suicide (Rodway et al., 2022), and this is supported by fatality statistics from the Gulf

and Falklands wars showing that there is little to no difference compared to the general population (MOD, 2014; MOD 2021). An increase in suicidal ideation or suicide risk may be due to the symptoms such as nightmares and flashbacks that veterans are experiencing following a morally injurious event, rather than the exposure to the event itself (Brewin et al., 2011).

ESLs were significantly more likely to report suicidal ideation and be at higher risk of suicide (Harden & Murphy, 2018; Rodway et al., 2022) This specifically applies to those who had not completed basic training, those who served for less than 10 years or veterans who have been medically, administratively or dishonourably discharged (Rodway et al., 2022). In addition, there are significant interaction effects between ESL's and demographics with an increased risk in older age groups and female veteran ESL's (Bergman et al., 2017). Furthermore, some research implies that it may be difficulties during the transition that leads to an increased risk of suicide and/or suicidal ideation. Veterans who rejected the prospect of civilian life were more likely to report suicidal thoughts, plans and/or have made previous suicide attempts (Brewin et al., 2011). In addition, unemployed veterans were also at an increased risk of suicidal ideation (Harden & Murphy, 2018), which further highlights that difficulties during the transition may be an increased risk factor for suicide and suicidal ideation, although the research is currently limited.

Mental Health and Self-Harm

Veterans who took longer to seek help for MH difficulties reported more suicidal ideation (Harden & Murphy, 2018), which supports the idea that veterans often fail to seek help until they are in crisis. As expected, mood disorders were found to be associated with increased risk of suicide, with veterans at a marginally higher risk compared to the general population although this difference was not significant (Brewin et al., 2011). PTSD increased the risk of suicide in veterans compared to the civilian population and was found to be significantly related to suicidal thoughts, plans and previous attempts (Bergman et al., 2022; Brewin et al., 2011) This risk was found to be associated with the symptoms of those who were diagnosed with PTSD such as living with a consistent paranoia and fear of death, with the exposure to a traumatic experience alone not necessarily associated with an increased risk of suicide (Brewin et al., 2011). This may be related to the help-seeking behaviour of the veteran population who often believe they can self-manage any MH symptoms. Furthermore, UK veterans who died by suicide were found to be at a non-significantly lower risk than their civilian counterparts of having a diagnosis of alcoholic liver disease (Bergman et al., 2022), however this is focused on heavily excessive drinking to the point of liver damage and therefore may be different when looking at general alcohol misuse. Although these risk factors are not surprising, there is limited research into the associations of MH with suicide risk and suicidal ideation.

Bergman et al. (2019) found that 18% of veterans who died by suicide had a previous history of self-harm. These associations were lower in younger veterans under the age of 30 and higher in older veterans over the age of 50. In addition, 50% of veterans who had previously self-harmed also had a secondary diagnosis of a MH disorder, with 37% having a diagnosis of a mood disorder. Mood disorders have been found to be associated with an increased risk of suicide (Bergman et al., 2022), therefore it may be that there are significant interaction effects between self-harm, MH and suicide risk.

Conclusion

There is a scarcity of research regarding the prevalence and risk factors of suicidal ideation and suicide in veterans who served in the British Armed Forces, with direct comparisons with the civilian population being even less evident. Risk factor research within a British Armed Forces context was also limited, with some literature conflicting. The results revealed that veterans' suicide rates were found to be comparable to those of the general UK population. The method of suicide most commonly used was found to be hanging and strangulation. The use of firearms was recorded in 2% of suicide cases. Demographic risk factors were often contradictory with some research stating there was risk in older veterans and some in younger veterans. Those deployed on combat operations were at lower risk of suicide. Research also identified that veterans who took longer to seek help for MH difficulties reported more suicidal ideation and mood disorders and were associated with an increased risk of suicide.

These peer-reviewed research publications revealed that UK veteran suicide prevalence is broadly comparable to the general population whilst highlighting differences across international armed forces. Veteran demographics, service history, transition and MH have all been identified as potential risk factors of suicidal ideation and suicide. Research has also noted that female veterans are at higher risk of suicide than their civilian counterparts, however veterans are predominantly male, which could skew results and indicates the need for investigation. There has been some recent investment into the female veteran population, which is welcome as additional research is clearly required.

Current research is limited and further exploration of suicide prevalence and risk factors in the UK veteran population is required to inform policy and provide targeted support. Vulnerable individuals during transition to civilian life were found to be risk of suicide. Transition was under researched despite ESLs being at increased risk of suicide and suicidal ideation. Research into associations in suicide risk with MH and self-harm is minimal, with only one article found that looked into previous history of self-harm in veterans who died by suicide.

Case Study

Introduction:

Client was a 38-year-old male veteran from Northern Ireland seeking support for severe mental health challenges. He has a partner and four children, and his background was marked by a history of service related and early developmental traumatic experiences. The latter began when his parents separated, and thereafter he experienced physical abuse at the hands of his mother's partners. He spent his formative years in various foster homes, lacking a stable and nurturing environment.

In addition to his challenging upbringing during service in Iraq and in Afghanistan the client experienced significant, intense, and prolonged traumatic events involving sustained threat to life, traumatic loss of life and witnessed traumatic death and injuries to friends and colleagues, leading to the development of post-traumatic stress disorder (PTSD). His experiences during combat were prolonged and intense. Following his return home, the client felt that he was not adequately supported by the military, leading to feelings of betrayal and anger. He described himself as being "dishonourably discharged," which further exacerbated his sense of injustice. He became the primary carer for his father throughout his illness and up to his death some three years ago aged fifty-six, which he found difficult.

Presenting Symptoms:

The client exhibited symptoms consistent with severe chronic PTSD and likely complex PTSD (CPTSD), attributable to his adverse childhood experiences. He experienced acute PTSD symptoms, including intrusive re-experiencing of traumatic events – memories, hypervigilance, and nightmares. Furthermore, he struggled with themes and fear of rejection, abandonment, and resentment, feeling betrayed by various people and systems in his life. He displayed difficulty regulating his emotions, which lead to angry outbursts and actions that damaged his relationships.

Treatment

Treatment involved a phased approach, focusing initially on establishing stability and safety, psychoeducation about trauma, emotional regulation techniques, alongside increasing self-awareness and self-care practices. Having established a strong therapeutic relationship and clear boundaries trauma-focused therapy targeted and processed traumatic memories challenged negative beliefs, attributions and instilled healthy and adaptive coping strategies. A case managed approach with a dedicated, veteran friendly case manager ensured ongoing co-operation and collaboration with the Community Mental Health Team (CMHT) and other relevant organizations to ensure a seamless continuity of care while monitoring risk and or clinical deterioration. With the onset of a sustained period of stability and moving towards a planned ending , the client was linked up with local veterans' charities, one of which introduced him to cold water swimming which he reported had a very positive impact on his mental health. Through that organisation he became involved with a veteran's scuba diving support group which again he reported was an extremely positive experience.

Conclusion:

The client self-reported that he is now happier and more content, physically he feels fitter, has lost weight and is sleeping better and overall has a much more positive view of himself and the future. He is now an active member of two local veterans' groups. Symptoms of PTSD have reduced significantly and are no longer debilitating.

The clients case highlights the severe impact of childhood trauma, compounded by military experiences, and perceived rejection and betrayal on his mental health. An overall Case managed approach linking in and developing healthy support and social networks adjunctive to psychological therapy to address his complex PTSD, emotional regulation and self-awareness have together contributed to sustained recovery.

Aims and Objectives

Aim

The aim of the evaluation was to indicate the overall impact and effectiveness of the OITM programme, including its achievements and challenges.

Objectives

The objectives were to:

1. Identify trends and risk factors (including gender, age, and previous rank) and indicate if vulnerable groups were more prone to significant MH issues (for example, whether aspects of their life or military service contributed to self-harming or potential suicide.

2. Determine whether aspects of civilian and previous military life, the support of the NHS and veteran-specific medical services, operationally linked stressors, and stigma were significant contributing factors affecting access to veteran services.

3. Evaluate the effectiveness of the OITM programme and propose areas for development.

4. Gauge participants' views regarding their satisfaction with the projects in the OITM programme and the impact on their quality of life.

The OITM evaluation will provide insights into areas such as social isolation, help-seeking behaviour and provide indicators of the situational factors causing distress and potentially self-harming/suicide. The evaluation intends to provide recommendations to help improve health outcomes and reduce determinates of poor health for military veterans. The results of the OITM evaluation may help to inform recommendations for policy changes and practice in health, local authorities, the MOD and charities.

Methodology

The OITM evaluation adopted a mixed-methods approach via a survey questionnaire that allowed participants to add written comments to support their answers. The survey was administered at Entry (Timepoint 1: entry into the OITM programme) and Exit (Timepoint 2: leaving the OITM programme). The evaluator results present recommendations for improving health outcomes and wellbeing. Thereby supplying potential information and recommendations to inform policy changes in health, local authorities, the MOD and charities. The OITM questionnaires are a modified/shortened version of the questionnaires employed in the TSS initiative. This common measurement framework (CMF) and the data collection model have been produced and published (Finnegan et al., 2023b). The programme started on 1st April 2021 and concluded on 31st March 2023.

The OITM grant holders offered a variety of projects including a mixture of psychological therapies, alcohol support, coaching, educational sessions, peer mentor case management and social prescribing. The programme delivery varied from clinical personnel to psychosocial teams and peers.

Literature Review

A systematic literature review was then completed and published in the *British Medical Journal Military Health* in May 2023. See details on page 26.

Sample Size and Eligibility Criteria

Veterans who satisfied the eligibility criteria (that is, vulnerable veterans experiencing suicidal thoughts and feelings and at risk of suicide or self-harm) entered the OITM projects via multiple routes, including self-referrals, charities, or statutory bodies. The grant holder's estimations of their OITM programme beneficiaries were Inspire at 368, Adferiad 100, RMA 1060 and RFEA 375.

Survey Design

The questionnaire was designed by the Principal Investigator of the Trust's TSS initiative. The rationale being that this would reflect the similarity between the programmes and provide the opportunity to amalgamate the two datasets. The online survey captured core key demographics (that is, age, gender, sexuality, ethnicity), military-specific details (that is, branch, cap badge, rank, service length), current illnesses, situational stressors, predisposing symptoms, help-seeking behaviour, social networks and activities, housing and living arrangement and employment status. In addition, the survey included tick boxes and Likert scale questions to assess outcomes and demonstrate changes at programme entry and exit.

Entry data were collected via a 38-item Jisc Online Surveys questionnaire (Jisc, 2022).[1] Survey questionnaires are an effective and viable option to gain feedback on multiple factors and provide participants with active participation in the process. The entry questionnaire was completed by the grant holders and the exit questionnaire by grant holders or beneficiaries. The questionnaire consisted of tick box answers to questions relating to predisposing factors and symptoms, treatment, social networks, employment, housing and accommodation. These were supplemented with Visual Analogue Scale (VAS) and Likert scale questions. The exit questionnaire also collected data on overall participant satisfaction and lessons learnt. Both surveys included text boxes in which participants could add written content on significant events or express their concerns about problematic issues, and this was analysed using qualitative content analysis. The entry survey took approximately 15 minutes to complete and the exit survey 12 minutes to complete. Both surveys underwent an internal and external verification process with academics, non-health professionals and service users associated with the AFC.

Grant holders were advised to complete the entry questionnaires as soon as possible after the initial assessment. Information would be fresh in their mind, and this would reduce any backlog and be more manageable. The exit survey also offered the grant holder the option to reveal programme satisfaction; this facilitated the evaluation of outcomes and monitoring of programme quality information. Respondents were also asked to detail the three most positive and negative elements of the OITM programme. The small amounts of written texts provided by respondents were analysed via Content Analysis (Burnard, 1991) using the NVivo software package V.12.

The grant holders were also given the option to include scoring from validated and reliable psychometric questionnaires. These scores were only provided if they had been utilised as part of the grant holder's assessment process and were not administered purely for evaluation purposes. Grant holders were asked to record the total number of validated and reliable psychometric questionnaires administered and the associated scores. The psychometrics that were identified as being part of this process were also included to establish feasibility and sustainability by assessing physical health (PH) and MH. The psychometrics included the Patient Health Questionnaire-9 (PHQ-9) (Manea et al., 2015), Generalised Anxiety Disorder-7 (GAD-7) (Spitzer et al., 2006), Work and Social Adjustment Scale (WSAS) (Mundt et al., 2002), Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) (Tennant et al., 2007), Work Productivity and Activity Impairment Questionnaire (WPAI) (Reilly et al., 1993), Alcohol Use Disorders Identification Test (AUDIT) (Bohn et al., 1995), and the EuroQol and Five-Dimensional Questionnaire (EQ-5D-5L) (EuroQol Group, T. E., 1990). The Centre obtained copyright permission for these tools.

[1] Westminster Centre for Research in Veterans (2018). Tackling Serious Stress Questionnaires. https://www1.chester.ac.uk/westminster-centre-research-veterans/research/serious-stress-veterans-carers-and-their-families

Data Collection, Management, Storing, Sharing and Governance

SPSS software (IBM, 2023) has been designed to enable statistical tests and analysis. The database has been set up behind an institutional firewall protected repository. This accommodates datasets in a wide variety of formats ensuring integrity, reliability, safekeeping, security and confidentiality. The questionnaires were coded with a unique participant identifier to ensure participant confidentiality and to ensure the correct matching of the completed entry and exit surveys. Following submission, the survey questionnaires were quality checked and when required referred back to the grant holders for further clarification. Risks are managed through the establishment of a robust two-way communication forum with programme staff.

Data Analysis

Completed survey questionnaires were downloaded and exported from the Jisc online survey portal and input into the IBM SPSS Statistics software database V27 (IBM, 2023). Quantitative data analysis included descriptive statistics of frequency distributions, paired-sample t-tests facilitated comparisons between the completed questionnaires at programme entry and exit. Appropriate bivariate correlations supported the exploration of relationships between variables to identify multifactorial causes of poor MH outcomes in veterans entering the OITM programme. The following values were used to interpret and determine the strength of the correlations. The latter comprised negligible correlation: 0.00 – 0.10, weak correlation: 0.10-0.39, moderate correlation: 0.40 – 0.69, strong correlation: 0.70 – 0.89 and very strong correlation: 0.90 – 100. For all analyses, a p-value of <0.05 was considered statistically significant (Schober et al., 2018).

Establish Training Material, Website and Helpline

The questionnaires and evaluation information materials were developed following significant consultation with clinical, military and lay personnel, members of the research team and a pilot study. Internal verification of the questionnaires has been completed with academics, admin staff and AFC family members. These processes were intended to ensure consistency in the interpretation of any question sets. The OITM SPSS database (IBM, 2023) is compatible with other government, academic and health service configurations enabling data to be compared, contrasted and benchmarked if required.

During the individual grant holder meetings, grant holders were provided with online demonstrations regarding the online dashboard survey. The demonstration helped facilitate optimal data handling of all required fields with ease and legibility. Most importantly, the demonstration helped familiarise all grant holders with the online dashboard survey with site navigation, data input and survey submission.

The Centre has a generic email (WCVeterans@chester.ac.uk) with the intent to answer queries as soon as possible and within 48 hours (on working days). The distance and isolation of some

delivery partners needs to be further assessed, together with online support options, and telephone helplines. The UoC's project administrator has extensive experience working with the military and was the primary point of contact.

Webinars

The Centre hosted webinars every two months. In addition, online webinars were introduced from February 2022 through to January 2023 to discuss the OITM projects, deliver study updates, and to share learning and highlight ongoing challenges.

Case Studies

Finally, the UoC research team suggested that grant holders should try to provide case studies as well as photos throughout the duration of the programme help exemplify their projects and outputs. Case studies from the four grant holders can be found embedded throughout this report.

Engagement Event

The AFCFT hosted an OITM Engagement Event held at Chester Racecourse on the 14th and 15th of September 2021. This provided an opportunity for the grant holders, AFCFT and UoC staff to meet and discuss their projects. Help for Heroes did not attend (but did send an apology) and Inspire joined over Microsoft Teams. See the infographic on page 40.

Throughout the duration of the presentations, a live illustrator (Jack Brougham via Microsoft Teams) captured the key elements by creating graphic illustrations. This provided a unique way of bringing together the key themes discussed.

Feedback was provided from the results of TSS initiative and a series of workshops were designed and coordinated by AFCFT and UoC staff to help prepare grant holders with future grant applications and scenarios they may face throughout the duration of their projects. Sonia Howe and Alan Finnegan provided an Ethics workshop and Carol Stone and Lottie Ainsworth-Moore a workshop on scenario planning.

The UoC research team and grant holders clarified issues and addressed concerns regarding programme specifics, the online dashboard survey and data input through discussion and consultation. Those grant holders that were previously involved with the TSS initiative (Adferiad, Inspire and Walking with the Wounded) discussed their experiences and challenges regarding client disengagement, referrals, data management, and managing and supporting clients who are fearful of exiting programmes.

Grant holders expressed the desire for webinars, with the intent of networking; these provided good insights into grant holder activities and discussion on what was working well, the positive outcomes, developments, and also the challenges. The OITM Engagement Event was very positively received by all attendees.

ONE IS TOO MANY:

TARGETED SUPPORT FOR VETERANS WHO ARE AT RISK OF SUICIDE.

SSAFA / The SAMARITANS.

INSPIRE.

•WALKING with the WOUNDED / VETERANS 1st POINT.

HELP for HEROES

The ROYAL MARINES CHARITY.

•RFEA - The Forces Employment Charity.

•CHANGE STEP / NEWID CAM

The BATON / UNIVERSITY OF NORTHUMBRIA.

THE ARMED FORCES COVENANT FUND TRUST

The AFCFT One is Too Many Engagement Event (14th and 15th September 2021) at Chester Racecourse

Ethics

The OITM evaluation received ethical approval from the UoC's Faculty of Health and Social Care Research Ethics Committee on the 20th of April 2021 (RESC0219-958), and no further amendments were required. The study was underpinned with support from the standing Centre Expert Reference Group.[2]

[2] Westminster Centre for Research in Veterans – Expert Reference Group - https://www1.chester.ac.uk/westminster-centre-research-veterans/who-we-are/external-committee-members

Case Study

Name of beneficiary: Mark

Age: 50's.

Background: At the age of 16, Mark joined the British Army which had been his life-long dream. However, 9 months into service, Mark went 'Absent Without Leave' and for the first time tried to take his own life. Much later, Mark was arrested. Mark has PTSD.

Referral Route: Self-referral. Mark first heard about Project Nova in 2015 following an incident with his fiancé that led to him handing himself into the police. At the time, Mark was given a leaflet by the desk sergeant detailing Project Nova's service. A while later, Mark called the number on the leaflet and within 10 minutes of the call, the regional caseworker had met with him.

Support Provided: Mark says that Project Nova saved his life and explains that as a soldier, and as somebody who feels they are really strong, it is hard to engage in support, but his Caseworker introduced him to Mindfulness, specifically how to control his thoughts.
He says that since receiving support, his life is getting progressively better. He is learning how to control his PTSD but explains that you can break a leg, you can break an arm, and he can cope with that pain, but he recognises that the mental pain, both that of his own, and that he believes he causes in others, is very different.

Mark says that for 30 years he fought to stay alive, but with the support of Project Nova he no longer continues to fight. He says his biggest achievement is getting through this and of living a happy life.
In a video of Mark's story he tells other veterans experiencing similar thoughts and feelings, "You can do it, you can get there, and you can control your mind. Just don't quit". This video can be viewed here on the OiTM website.

Results

The OITM projects started in May and August 2021, with the evaluation data being received from 1st October 2021 to the 31st of March 2023. Summary data is in the infographic on page 45.

Questionnaires

The grant holders submitted 503 entry questionnaires, and 423 exit questionnaires. See Table 3. The disparity between the number of entry and exit questionnaires is primarily due to ongoing support within the programme and those who had disengaged.

			ENTRY QUESTIONNAIRES	EXIT QUESTIONNAIRES
Ser	**Grant Holder**	**Participants**	**Completed**	**Completed**
1	Adferiad	115	66	62
2	Inspire	150	142	111
3	RFEA	142	107	63
4	RMA	190	188	187
5	**TOTAL**	597	503	423

Table 3. Questionnaire completion rates

Age, Gender and Sexual Orientation

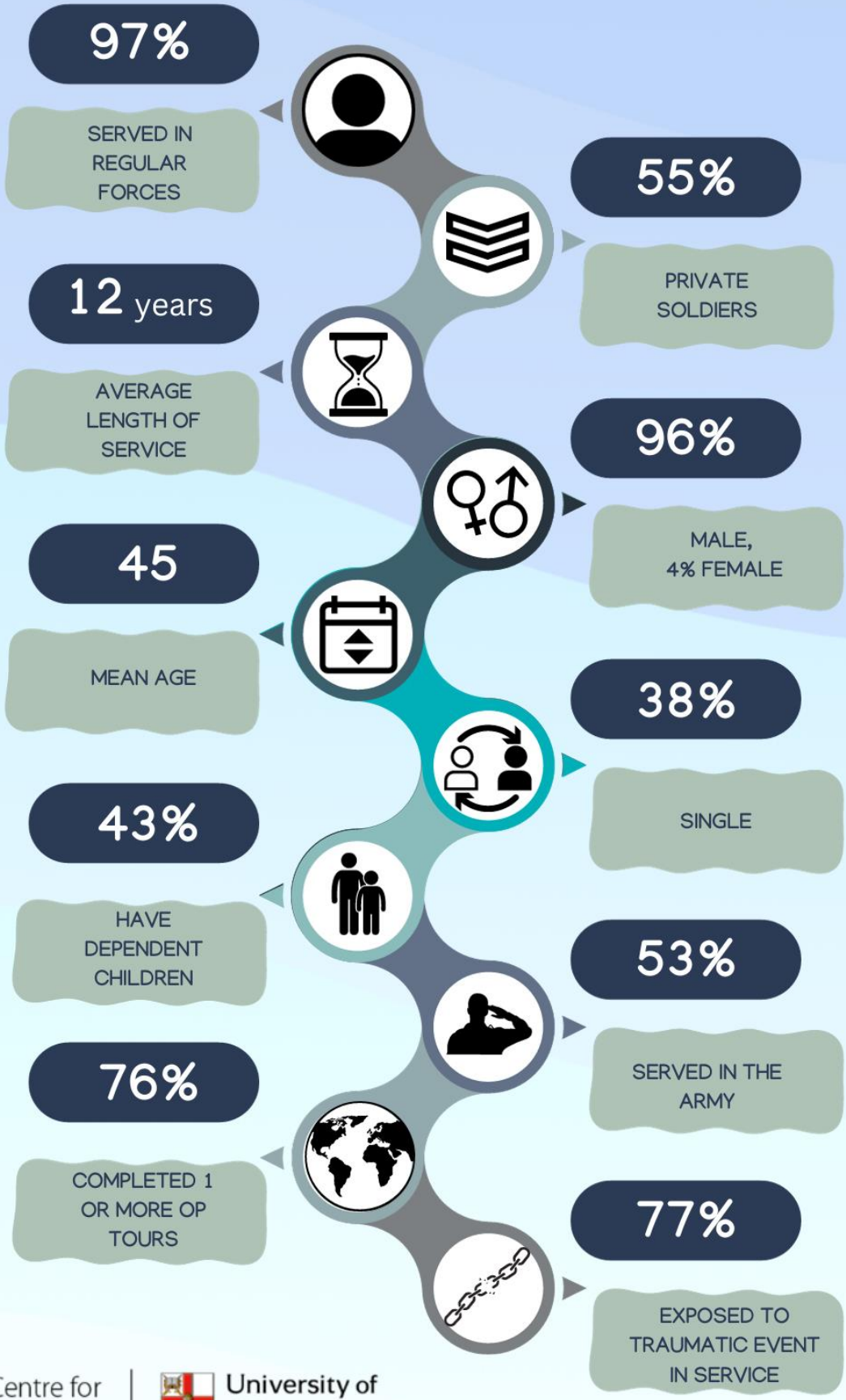
The programme participants were 96% (N=483) male and 4% (N=20) female with a mean age of 45 years. See Table 4.

Ser	Grant Holder	Mean Age	Range	Male ♂	Female ♀
1	Adferiad	47	21-75	63 (96%)	3 (5%)
2	Inspire	50	21-85	130 (92%)	12 (9%)
3	RFEA	43	24-74	102 (95%)	5 (5%)
4	RMA	43	18-81	188 (100%)	/
5	**TOTAL**	45	18-85	483	20

Table 4. Age and gender reported by grant holders

Sexual orientation detail was provided for 472 participants and 99% (N=465) were heterosexual. There were N=7 from the LGBTQ community.

RESPONDENT SUMMARY



Relationship Status and Children

The most common relationship status from the 471 participants who answered this question was single at (38%, N = 181), followed by married (32%, N = 150). See Table 5.

Ser	Grant Holder	Single	Married	Divorced	Civil partnership	Widower	Other
1	Adferiad	34 (53%)	10 (16%)	6 (9%)	10 (16%)	3 (5%)	1 (2%)
2	Inspire	35 (25%)	56 (40%)	13 (9%)	13 (9%)	3 (2%)	20 (14%)
3	RFEA	61 (58%)	14 (13%)	15 (14%)	9 (9%)	1 (1%)	5 (5%)
4	RMA	51 (31%)	70 (43%)	12 (7%)	8 (5%)	/	21 (13%)
5	**TOTAL**	181 (38%)	150 (32%)	46 (10%)	40 (8%)	7 (1%)	47 (10%)

Table 5. Relationship status reported by grant holders

Information was provided on 459 participants regarding dependent children. Of these, 56% (N=258) of veterans had no dependent children and 43% (N=201) had dependent children (up to the age of 16). See Table 6.

Ser		Dependent children		Living with veteran				Providing regular financial support	
		Yes	No	Yes	No	Sometimes	Other	Yes	No
1	**TOTAL**	201 (44%)	258 (56%)	99 (52%)	48 (25%)	35 (18%)	10 (5%)	171 (96%)	6 (3%)

Table 6. Dependent children

Ethnic Background and Religion

The veteran participants were 97% (N=484) White British, and of the total number of participants five were White Irish, two were Mixed race, one was Asian British, five were 'other' and missing data accounted for six.

Regarding religious denomination, grant holders reported that 70% (N=224) were Atheist, 25% (N=81) were Christian, 1% (N=2) were Muslim, and 4% (N=11) selected 'other' as their answer. Missing data was N=185.

Service History

Rank, Length of Service, Exposure to Traumatic Events and Reason for Discharge

Veteran participants were predominately from the Army 53% (N = 267), with Royal Marines at 38% (N=192), Royal Air Force 4% (N=19), Royal Navy 4% (N = 21), Merchant Navy 0.2% (N=1), and 'other' was 0.6% (N=3).

Those who served in the Regular service were 97% (N=486), Reserves/Territorial Army were 2% (N=12). 'others' were 1% (N=5). Significant differences were seen between the four grant holders. Details per grant holder are in Table 7.

Ser	Grant Holder	Army	Royal Marines	Royal Air Force	Royal Navy	Merchant Navy	Others
1	Adferiad	51 (77%)	–	6 (9%)	9 (14%)	/	/
2	Inspire	131 (92%)	1 (1%)	5 (4%)	2 (1%)	/	3 (2%)
3	RFEA	85 (79%)	3 (3%)	8 (8%)	10 (9%)	1 (1%)	/
4	RMA	/	188 (100%)	/	/	/	/
5	**TOTAL**	267 (53%)	192 (38%)	19 (4%)	21 (4%)	1 (0.2%)	3 (1%)

Table 7. Service reported by grant holders

Of the 478 participants who answered this question, veterans were predominately Private soldiers or equivalent when they left the Armed Forces (55%, N = 262) (see Figure 5). The mean length of service in the Armed Forces was 12 years (N=66, median =10; mode =6; SD =7.52; range 1 to 32 years). Grant holders provided information about length of service for 66 of their clients. Of these, 3% (N=2) were ESLs (those who had served for less than one year), 6% (N=8) had served for less than four years, the remaining had served for up to 25 years.

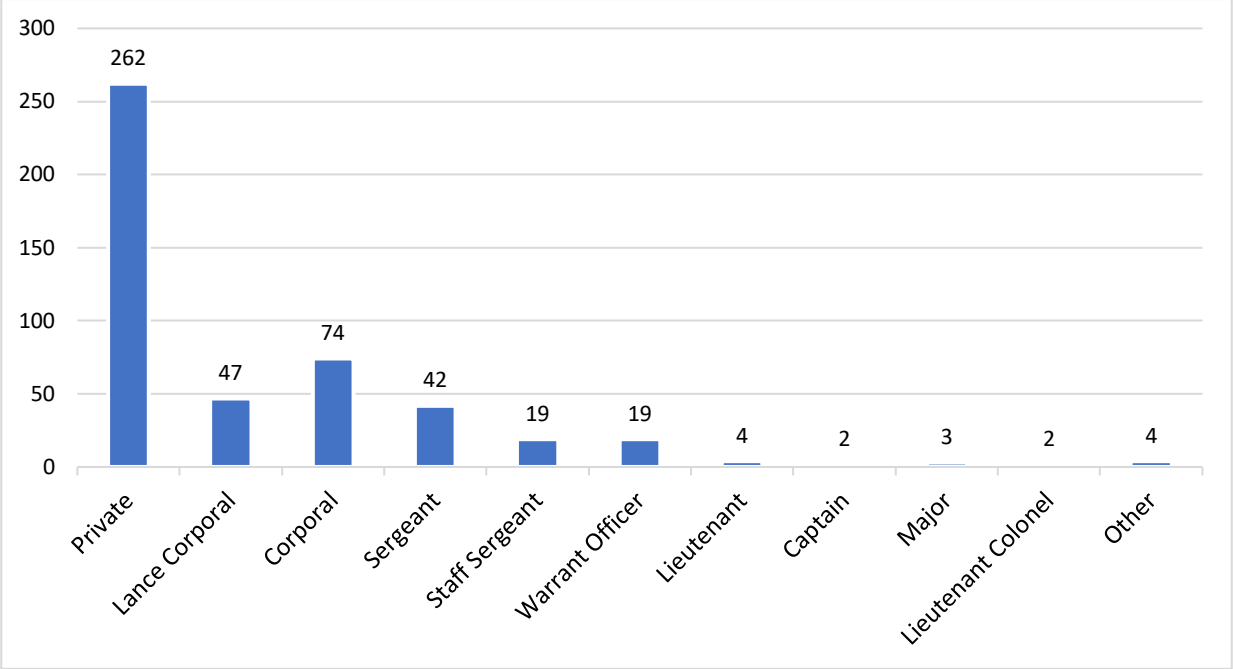


Figure 5. Veterans' rank on entry into the programme

Operational Tour Profile

Of the 479 participants who answered this question, the majority 76% (N=362) conducted OT, 24% (N=117) did not. The mean was two operations per veteran (median = 2; mode =1; SD = 1.76; range 1 to 11 OT). From the same sample of 479 participants, the most common OT was in Afghanistan at 37% (N=176), followed by NI 37% (N=175), Iraq 26% (N=121), the Balkans 11% (N=50), 'Other' 9% (N=43), the Falklands 4% (N=18), Sierra Leone 4% (N=19). OTs were not mutually exclusive. See Figure 6.

A significant relationship was observed between whether a veteran had conducted OTs and service linked trauma ($X^2(2, N=465) = 108.89$, $p < 0.05$), and although relationships were observed between the number of OTs and service linked trauma, this was not significant ($X^2(10, N=305) = 8.963$, $p=0.536$).

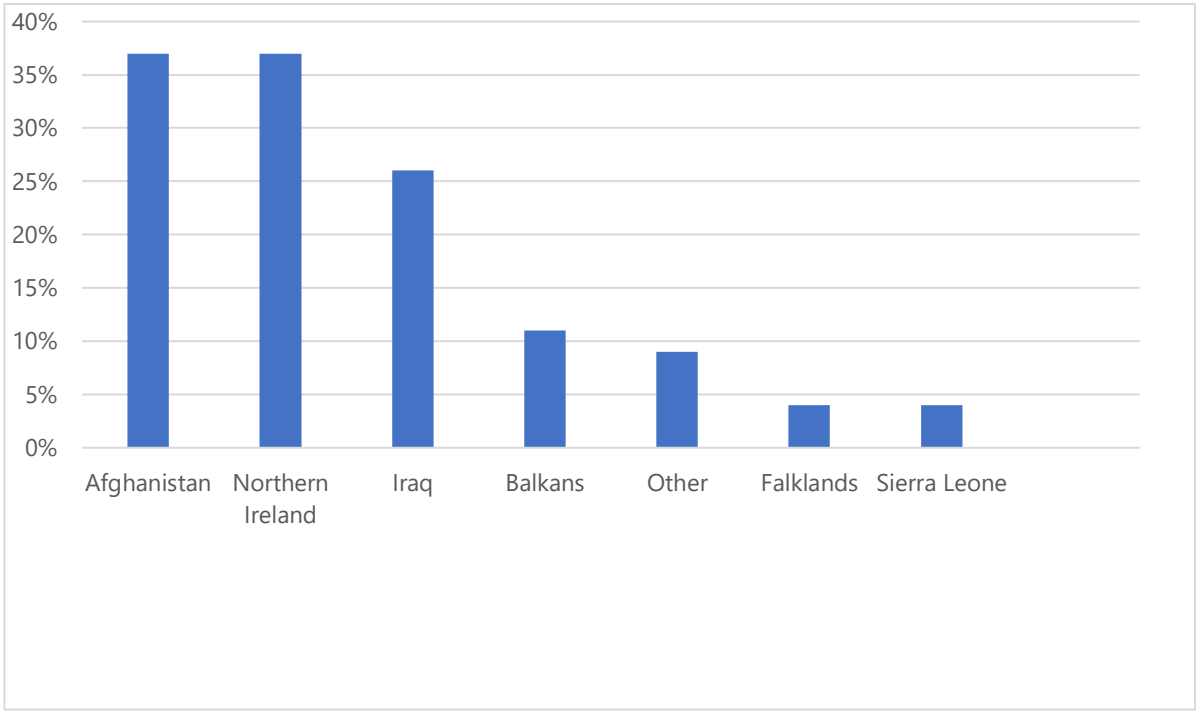


Figure 6. Location of operational tour

Veteran Trauma related to Military Service

Seventy-seven percent of veterans reported exposure to a traumatic event during their service (N=367), with a mean of two events (median = 2; mode =2; SD =1.75; range 1 to 5 traumas). No traumatic events were reported by 23% (N=110) and no data was supplied by 26. Traumatic events (which are not mutually exclusive) were primarily reported as being conflict/contact situations 58% (N=289), followed by personal attack 29% (N=146), abuse 23% (N=116), and accidents 23% (N=113) (see Figure 7). The mean rating of the most traumatic event reported was graded at 9, ranging from zero (minimum distress) to 10 (maximum distress). There was a significant correlation between number of years served and number of traumatic events experienced ($r(402)=0.295$, $p=< 0.05$), indicating the longer the service, the greater number of traumatic events experienced.

A significant correlation was observed between the number of traumatic events experienced during service and depression scores on entry ($r(450)=0.237$, $p=< 0.05$), and a correlation was also observed between traumatic events experienced and anxiety ($r(450)=.170$, $p=0.097$), but this was not significant.

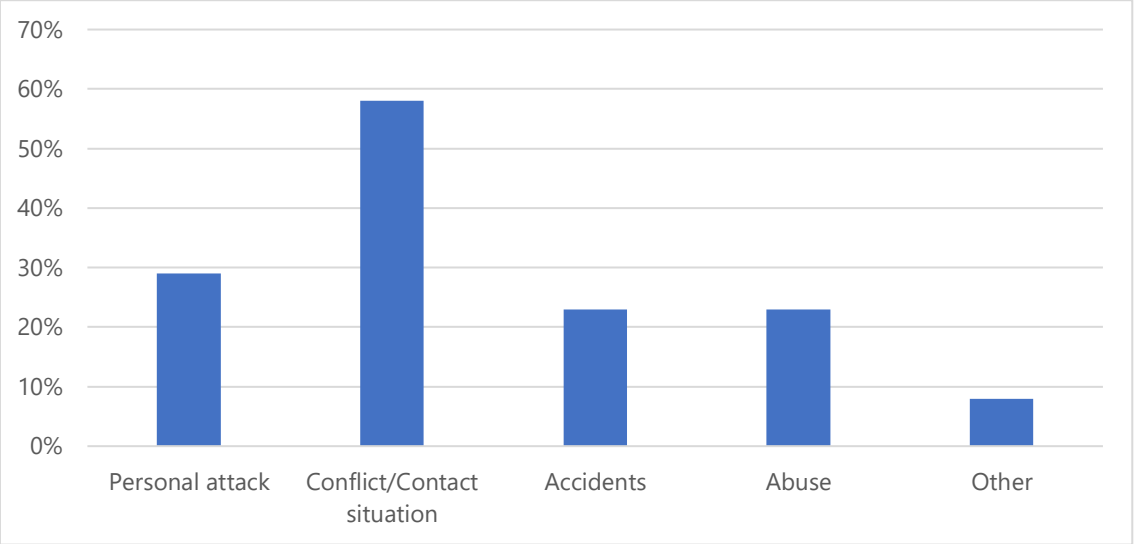


Figure 7. Type of traumatic events experienced by veteran participants during service.

Grant holders provided extra written details about 41 beneficiaries who described their exposure to traumatic events. These were primarily associated with exposure to death (59%, N=24), bullying (5%, N=2), training (5%, N=2), sexual assault (5%, N=2), threatening behaviour (5%, N=2), insect bites (5%, N=2), stalking (2%, N=1), family bereavement (2%, N=1), bombings (2%, N=1), kidnap (2%, N=1), military court action (2%, N=1), childbirth (2%, N=5) and operational injury (2%, N=1).

Veteran Reasons for Discharge

Of the 473 responses to this question, the most common reasons for leaving the Armed Forces were end of the contract (32%, N=152), premature voluntary release (PVR) 25% (N=119), medical discharge 25% (N=116), and 'Other' 15% (N=70), the latter primarily being due to PH or MH problems (see Figure 8).

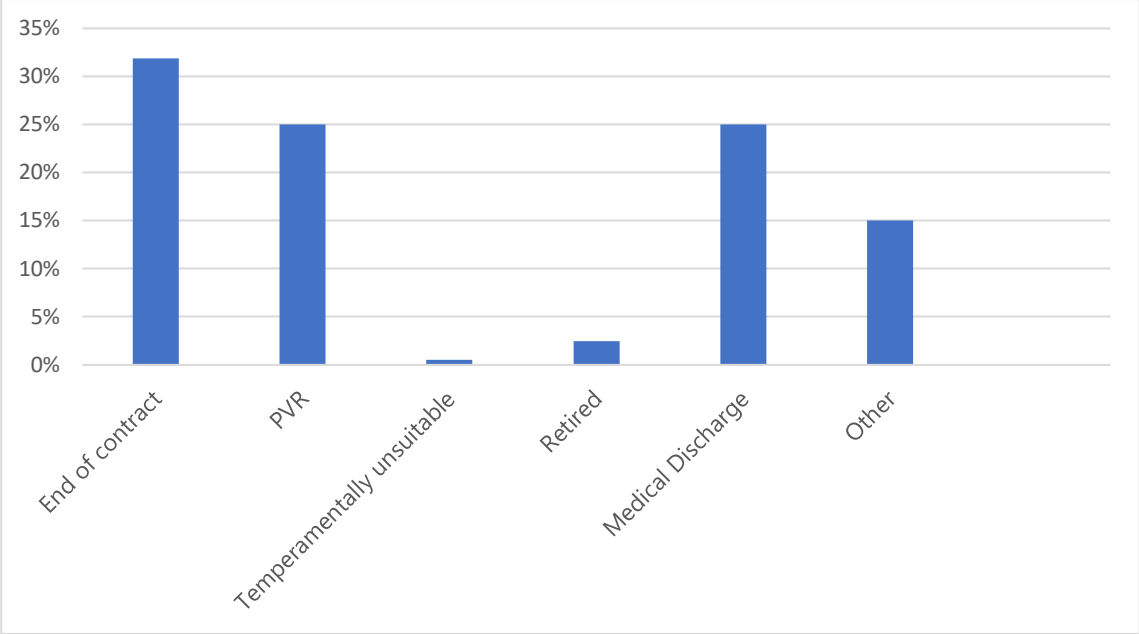


Figure 8. Reasons for discharge

The physicality and exposure to traumatic scenes commonly experienced by military personnel led to PH and MH issues (see Figure 9).

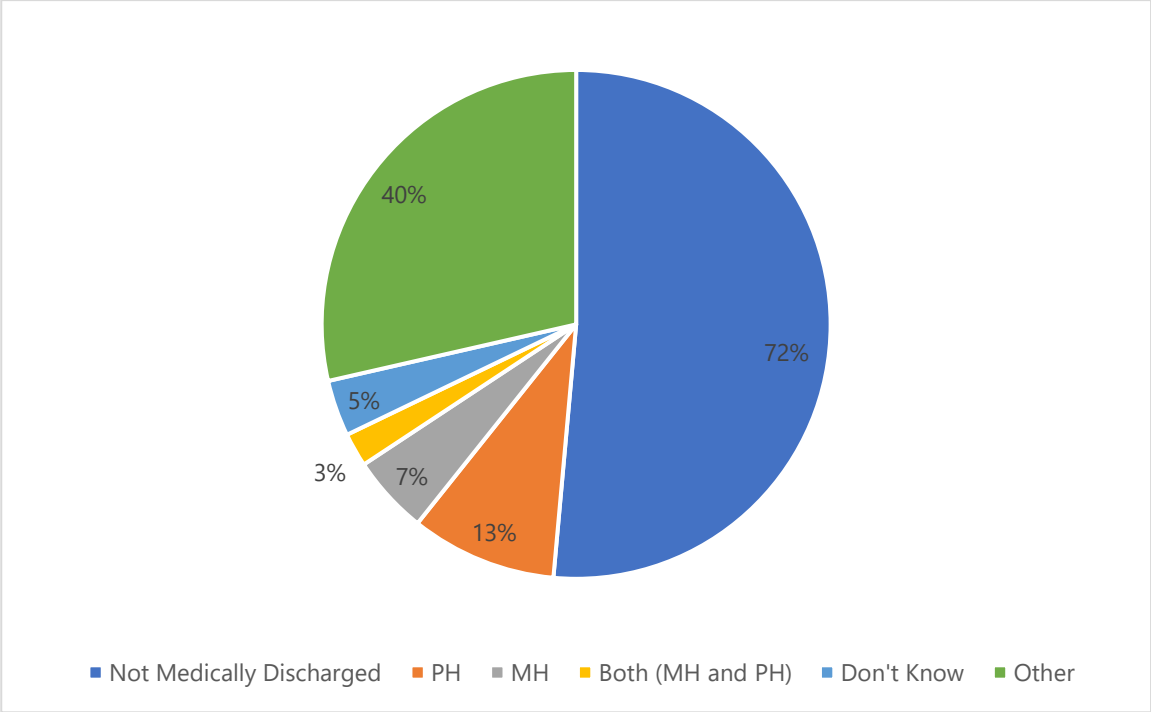
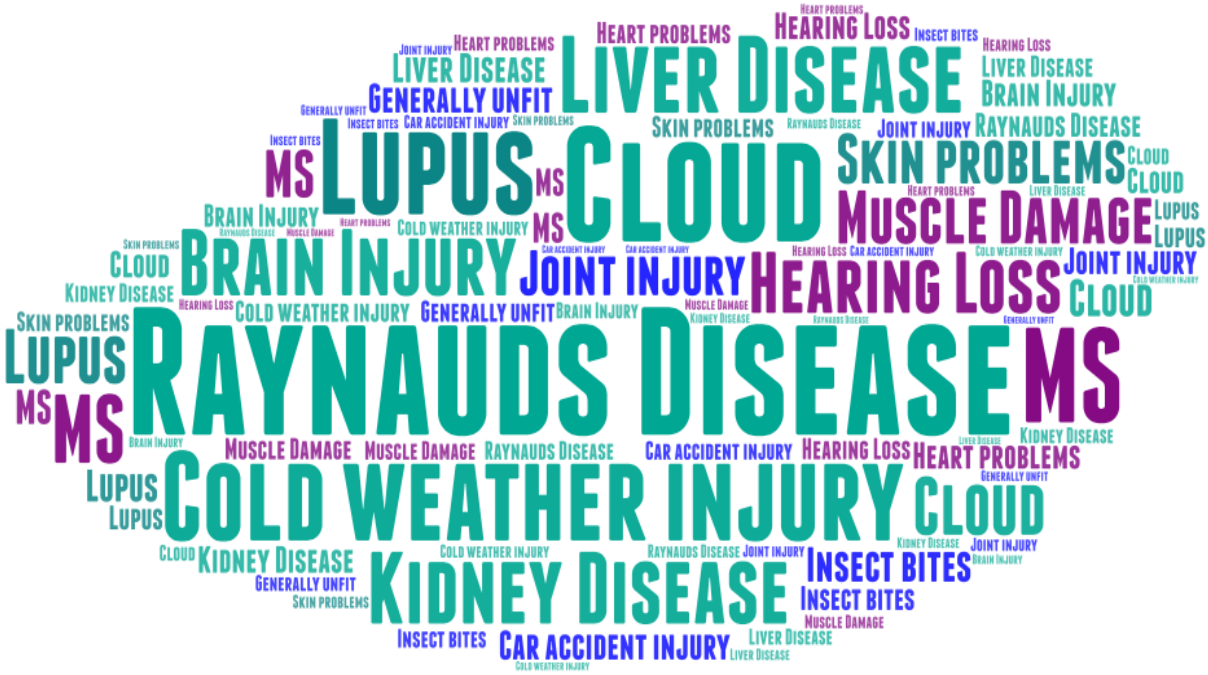


Figure 9. Veterans' medical discharge details

Regarding physical health, open ended comments provided by grant holders are shown in Word Cloud 1.



Word Cloud 1. Physical health

Physical and Mental Health

Of the 474 veteran participants who provided this information, 83% (N=393) self-reported long-standing PH or MH problems. They were affected by an average of two illnesses (median 3; mode 4; SD 1.61; range 1 to 7). The most common being depression (55%, N=275), anxiety (53%, N=267), PTSD (51%, N=257), and musculoskeletal/back problems (25%, N=126). See Figure 10.

A significant correlation was observed between the number of traumatic events experienced during service and depression scores on entry (r(450)=0.237, $p=< .05$), and a correlation was also observed between traumatic events experienced and anxiety (r(450)=0.170, p=0.097), but this was not significant.

Following exit from the OITM programme, of the 354 participants who answered this question, 75% (N=265) reported long-standing physical or MH problems, indicating a reduction from 393 at entry to 265 at exit, with a range of one to seven reported illnesses. There were decreases in self-reported depression 35% (N=147), anxiety 37% (N=156), PTSD 40% (N=170) and musculoskeletal problems 15% (N=66). See Figure 10 and Table 8.

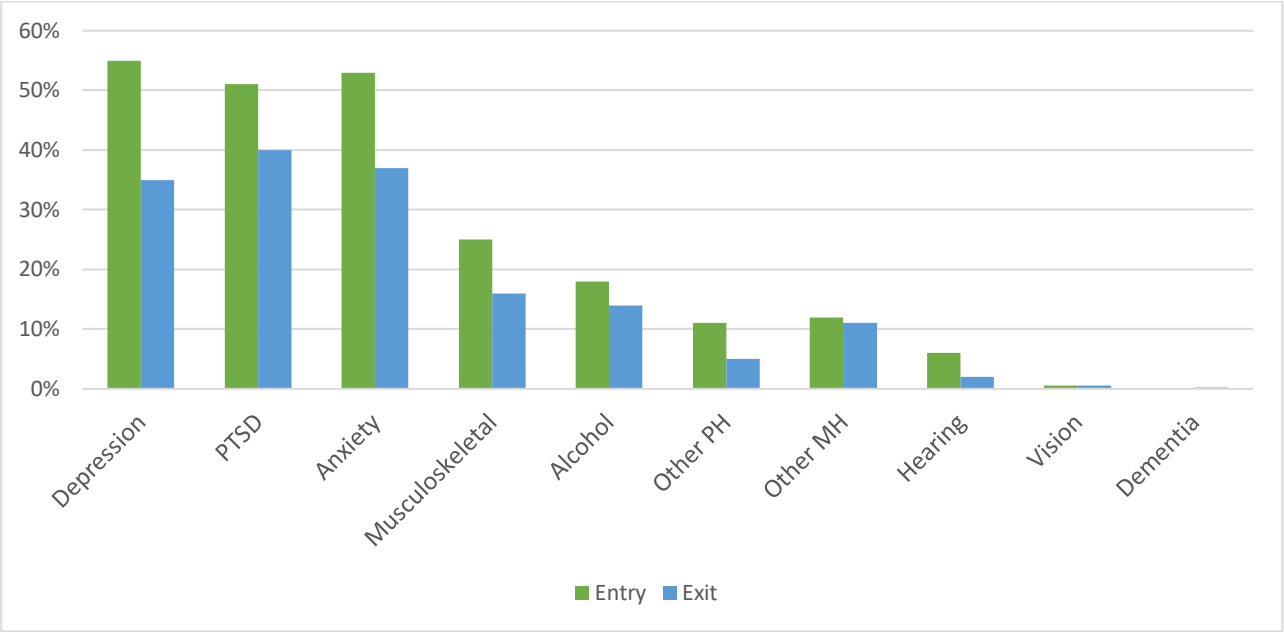


Figure 10. Types of issues or illnesses affecting participants (pre and post)

Ser	Grant Holder	Entry/ Exit	Musculoskeletal	Hearing	Depression	Anxiety	PTSD	Alcohol & Drugs
1	Adferiad	Entry	27 (41%)	7 (11%)	42 (64%)	42 (64%)	37 (56%)	20 (30%)
		Exit	23 (37%)	4 (7%)	31 (50%)	34 (55%)	30 (48%)	12 (19%)
2	Inspire	Entry	36 (25%)	10 (7%)	77 (54%)	87 (62%)	108 (76%)	24 (17%)
		Exit	21 (19%)	2 (2%)	28 (25%)	34 (31%)	57 (51%)	17 (15%)
3	RFEA	Entry	25 (23%)	7 (7%)	75 (70%)	57 (53%)	52 (49%)	27 (25%)
		Exit	4 (6%)	/ /	32 (51%)	30 (48%)	33 (52%)	19 (30%)
4	RMA	Entry	38 (20%)	5 (3%)	81 (43%)	81 (43%)	60 (32%)	18 (10%)
		Exit	18 (10%)	3 (2%)	56 (30%)	58 (31%)	50 (27%)	13 (7%)
5	TOTAL	Entry	126 (25%)	29 (6%)	275 (55%)	267 (53%)	257 (51%)	89 (18%)
		Exit	66 (16%)	9 (2%)	147 (35%)	156 (37%)	170 (40%)	61 (15%)

Table 8. Self-reported illnesses by participant veterans at entry and exit

Although changes were observed at exit, with veterans self-reporting fewer illnesses, a paired samples t-test indicated this was not significant (t (269) = 1.67, p =0.096).

Predisposing Factors and Symptoms

Grant holders indicated that most participants had self-reported high stress levels upon entry into the projects. Grant holders estimated a mean of 9 on a scale ranging from 0 (no stress) to 10 (maximum stress).

Predisposing Factors

A mean of five predisposing factors were reported by veterans upon entry with a range of 1 to 16 factors (median = 4; mode = 4; SD = 3.00).

The most common predisposing factors on entry were: unresolved trauma (66%, N=334) traumatic exposure (53%, N=268), family stresses (47%, N=235), operational factors (42%, N=209), and relationship problems (39%, N= 195). Exit details showed notable reductions in all areas with increases in only dementia. The pre and post reported factors are in Table 9 and Figure 11.

Serial	Factors	Veterans			
		Entry (N= 503)		Exit (N=423)	
		N	%	N	%
1	Previously Unresolved Trauma	334	66	114	27
2	Traumatic Exposure	268	53	88	21
3	Family Stress	235	47	80	19
4	Operational Factors	209	42	41	10
5	Relationship Problems	195	39	71	17
6	Alcohol/Substance Abuse	188	37	88	21
7	Isolation	159	32	54	13
8	Finance	147	29	43	10
9	Childhood Factors	137	27	40	10
10	Legal	120	24	19	5
11	Past Family History	119	24	45	11
12	Physical Problems	101	21	33	8
13	Unemployment	86	17	34	8
14	Occupational Stress	86	17	18	4
16	Accommodation	77	15	25	6
17	Cultural	44	9	10	2
18	Other	11	2	20	5
19	Dementia	0	0	2	1

Table 9. Self-reported factors at entry and exit by participants

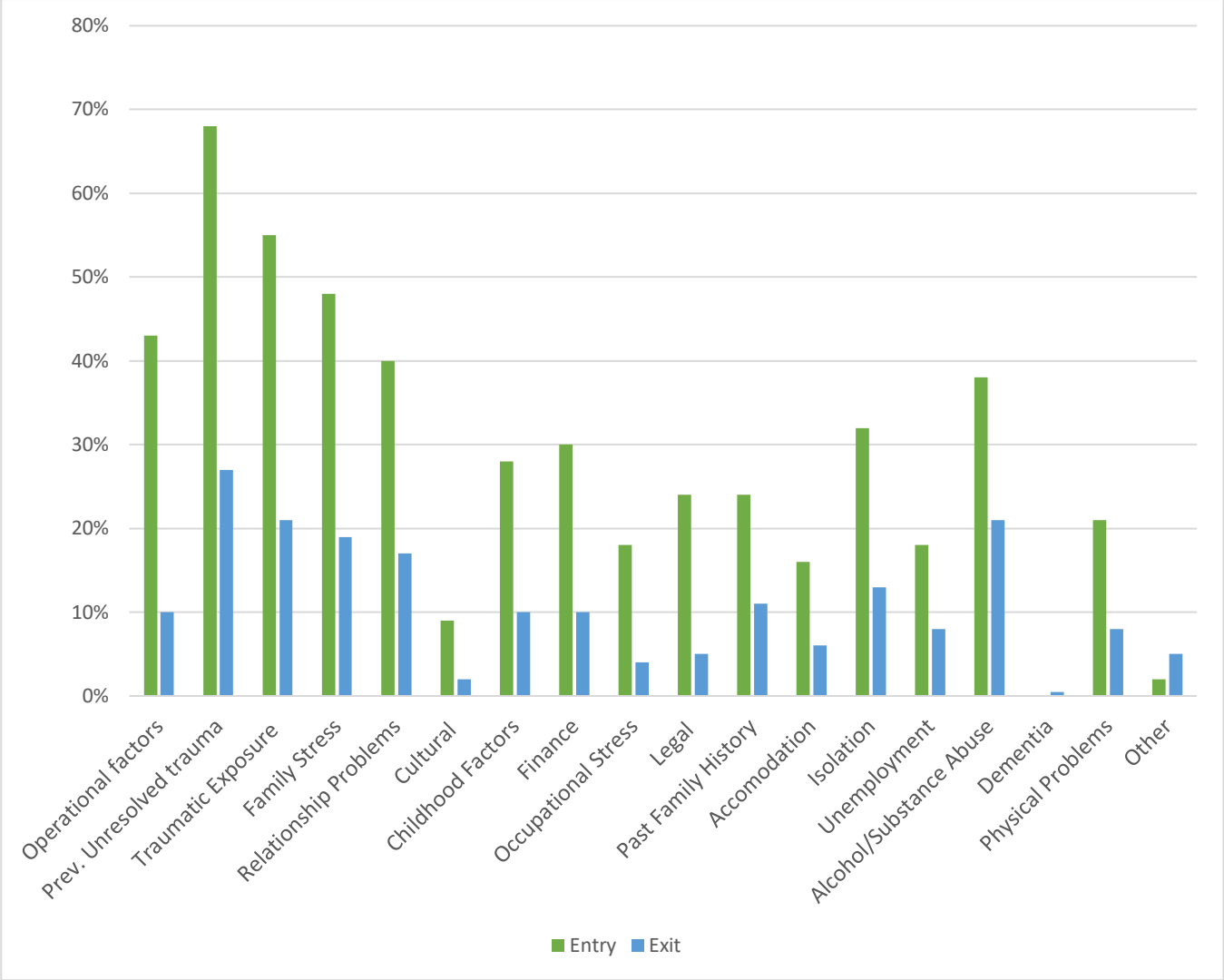


Figure 11. Number of reported factors by participants at entry and exit

Regarding self-reported VAS stress levels on entry, correlations were observed between the self-reported VAS levels of stress (low, medium, high) and the number of reported predisposing factors ($r(358)=0.092$, $p=0.083$), but this was not significant, which indicates that stress levels were not related solely to the number of factors reported by the participant veterans.

Following exit out of the OITM programme, veterans' average number of reported factors had fallen from 5 to 2, with a range of 1 to 16 reported factors (median = 2; mode = 2; SD = 2.38) at entry compared to a range of 1 to 12 factors at exit (median= 2, mode=2, SD=2.38) (Table 10). What was also clear was the accumulative presence of situational stressors. On entry, 2% (N=11) had reported no factors, but this had risen to 23% (N=74) by exit (see Table 10).

Factors		Veterans					
		Entry (N=503)			Exit (N=329)		
Ser	Factors	N	%	Total %	N	%	Total %
0	0	11	2	2	74	23	23
1	1	30	6	8	68	21	43
2	2	60	12	20	56	17	60
3	3	76	15	35	37	11	71
4	4	86	17	52	41	13	84
5	5	62	12	65	17	5	89
6	6	52	10	75	13	4	93
7	7	41	8	83	12	4	97
8	8	21	4	87	2	1	97
9	9	15	3	90	3	1	98
10	10	13	3	93	1	.4	99
11	11	13	3	95	4	1	99
12	12	10	2	98	1	.3	100
13	13	5	1	98	/	/	/
14	14	5	1	99	/	/	/
15	15	2	0.4	99	/	/	/
16	16	1	0.2	100	/	/	/

Table 10. Number of reported factors by veterans following OITM programme entry and exit

Participants provided further details in written comments to support their answers to best describe the factors contributing to participants accessing the OITM programme. Of these, 87 participants described physical health problems: musculoskeletal (N=57), brain injury (N=4), hearing loss (N=4), cancer (N=2), stroke (N=2), heart problems (N=2) and remaining illnesses (N=16) related to chronic health conditions. Additional information about MH problems were described by 24 grant holders, with the most common being Personality Disorder (N=10), Obsessive Compulsive Disorder (N=6), Attention Deficit Hyperactivity Disorder (N=3), Suicidal Ideation (N=2), Self-harm (N=1), Psychosis (N=1) and Social Anxiety Disorder (N=1).

Grant holders provided detail on 26 participants regarding their predisposing factors related to health following their exit from the OITM programme. These related to physical health and identified musculoskeletal pain (N=21), nerve pain (N=3) and terminal illness (N=2) as factors affecting veterans on exit from the programme.

In addition, to the credit of the RFEA, a lot of extra detail was provided regarding their interface with Project Nova including issues such as drug and alcohol dependency and clients who were under investigation for various offences. A flavour of these comments is captured in the Infographic on page 56.

Participants Comments

Westminster Centre for Research in Veterans | University of Chester

"

"Uses cocaine regularly and can spend hundreds of pounds on each session. Has around £6000 worth of debt owed to a variety of creditors and is unemployed. Struggled with transition into civilian life and not dealing with his trauma from service."

"Alcohol misuse- drinking around 16 cans of lager per day. His street has been taken over by local drug dealers who have been threatening him, Police are now involved because he made threats to kill the drug dealers."

"Bullied whilst serving. Multiple convictions for violent offences including assaulting Emergency Services and alcohol related convictions. Alcohol dependant."

"Since his divorce, he has been living in a tent until we supported him into accommodation. Alcohol dependant until 2020 and now binge drinks twice a month. Currently unemployed and in debt due to his divorce and alcohol misuse."

"Charged with domestic violence and possession of an offensive weapon. Sofa sleeping and in thousands of £ worth of debt through pay day loans."

"Currently living in a hostel due to bail conditions. Is in debt due to alcoholism."

"Alcohol dependant. Cocaine misuse. Debt of around £3000. Bereavement - lost mother recently. Extensive arrest history, mainly violent or drink related convictions"

"In around £10,000 worth of debt. Under investigation for a violent offence. Binge drinks twice a week, usually of a weekend and will drink to excess during his binges"

"Convicted of fraud and drink driving in 2011 (the reason he was discharged from the Army). Has around £2000 worth of debt and about to be evicted due to this. Addicted to Crack cocaine and cannabis."

"

"CONVICTED OF DRINK DRIVING, LOST LICENSE AND GIVEN A FINE. HAS AROUND 40K WORTH OF DEBT OWED TO A RANGE OF CREDITORS. UNTREATED PTSD AND ONGOING SUICIDAL IDEATION WITH A RECENT ATTEMPT ON TAKING HIS OWN LIFE BY OVERDOSE WHICH REQUIRED HOSPITALISATION. BINGE DRINKING OF A WEEKEND HOWEVER HE IS NOT DEPENDANT ON ALCOHOL"

Symptoms

Veterans accessing the OITM programme reported a mean of nine symptoms with a range of 1 to 17 (median = 9; mode = 11; SD = 4.49). The number of symptoms reported by veterans on entry and exit to the programme are displayed in Table 11.

Symptoms		Veterans					
		Entry (N=502)			Exit (N=315)		
Ser	Symptoms	N	%	Total %	N	%	Total %
0	0	9	2	2	101	32	32
1	1	18	4	5	52	17	49
2	2	21	4	10	40	13	61
3	3	24	5	14	33	11	72
4	4	28	6	20	17	5	77
5	5	33	7	27	16	5	82
6	6	29	6	32	8	3	85
7	7	32	6	39	12	4	89
8	8	37	7	46	6	2	91
9	9	32	6	52	7	2	93
10	10	30	6	58	6	2	95
11	11	43	9	67	4	1	96
12	12	41	8	75	3	1	97
13	13	31	6	81	3	1	98
14	14	30	6	87	3	1	99
15	15	33	7	94	1	.3	99
16	16	19	4	98	2	.6	99
17	17	12	2	100	1	.3	100

Table 11. Number of symptoms reported by participants at entry and exit

Commonly reported symptoms were anxiety (79%, N=396), low mood (78%, N=394), sleep disturbance (69%, N=345), anger (66%, N=333), feeling of hopelessness (67%, N=334), poor concentration (65%, N=327), and lack of interest (64%, N=319). Following exit from the OITM programme, veterans' average number of reported symptoms had decreased from nine to three with a range of 1-17 reported symptoms at both entry and exit. There were decreases in every criterion. See Table 12 and Figure 12.

Ser	Symptoms	Veterans			
		Entry		Exit	
		N	%	N	%
1	Anxiety	396	79	115	27
2	Low Mood	394	78	97	23
3	Sleep Disturbance	345	69	89	21
4	Feeling of Hopelessness	334	67	55	13
5	Anger	333	66	52	12
6	Poor Concentration	327	65	56	13
7	Lack of Interest	319	63	49	12
8	Loss of Confidence	303	60	48	11
9	Thoughts of Self-Harm	265	53	32	8
10	Tiredness	254	51	64	15
11	Feeling Isolated	250	50	52	12
12	Risk-Taking Behaviour	217	43	22	5
13	Alcohol Use	179	36	66	16
14	Change in Appetite	156	31	20	5
15	Physical Problems	147	30	58	14
16	Pain	142	28	47	11
17	Forgetfulness	133	27	25	6
18	Other	14	3	33	8

Table 12. Self-reported symptoms at entry and exit by participants

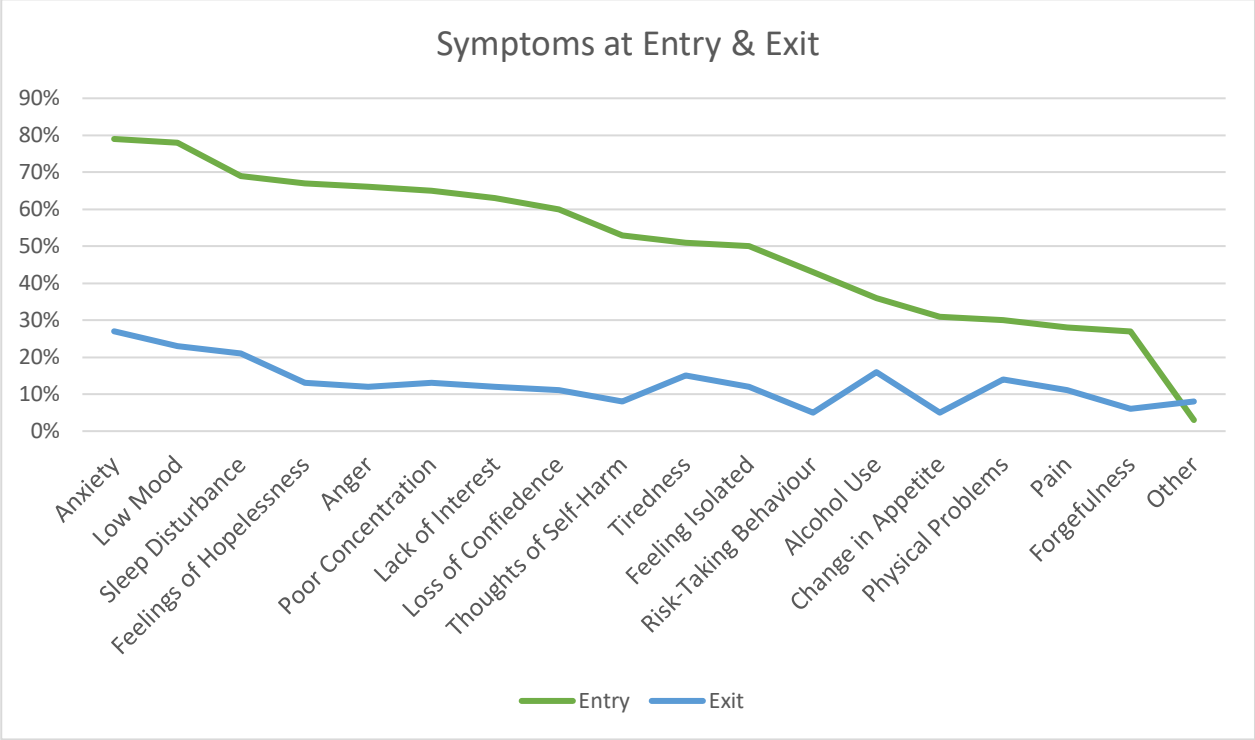


Figure 12. Self-reported symptoms at entry and exit by participants

A weak correlation was observed between age and the number of reported symptoms (r(486)=0.030, *p*=0.507), but this was not significant. A correlation between the self-reported VAS levels of stress (low, medium, high) and the number of symptoms (r (492)=0.031, *p*=0.488) was identified although again, not significant. This would indicate there to be no association between age or stress scores and number of symptoms.

Correlations were observed between the number of traumatic events experienced during service and number of reported illnesses on entry (r(450)=0.121, $p > 0.05$). Also, the number of reported factors on entry (r(450)=0.395, $p < 0.05$), and number of reported symptoms on entry (r(450)=0.439, $p < 0.05$), both of which were significant which would indicate a relationship between exposure to trauma and the number of factors, and symptoms veterans report on entry to these programmes.

On exit from the programme, there were 15 additional comments relating to PH and 18 in relation to MH. Physical health comments were related to cancer (N6), diabetes (N=2), Chronic Obstructive Pulmonary Disease (N=3), musculoskeletal (N=1), brain injury (N=1), heart (N=1) and nerve pain (N=1). MH comments were related to suicidal ideation (N=7), self-harm (N=4), psychosis (N=3), brain injury (N=1), personality disorder (N=2) and being emotionally unstable (N=1).

Support services

Veterans previous access to support

Of the 465 veterans who answered this question, 51% (N=239) reported having previously accessed support to help deal with a stressful situation. A significant negative correlation was found between the grant holders' estimated VAS stress levels and previous support access (r(447)=-0.137, $p < 0.000$), indicating that veterans who had higher stress levels were more likely to seek help.

Where veterans sought support

Of the 239 who answered this question, those seeking support had sought help from several sources, with the majority contacting a mean of two organisations, most commonly from the NHS and charities (see Figure 15). The accumulative totals being NHS 51% (N=121), charities 43% (N=13), other MH services 29% (N=70), GP 22% (N=53), 'other' 10% (N=24), veterans hub 8% (N=20); and family and friends was 8% (N=20) (see Figure 13). Differences were found between grant holders (see Table 13).

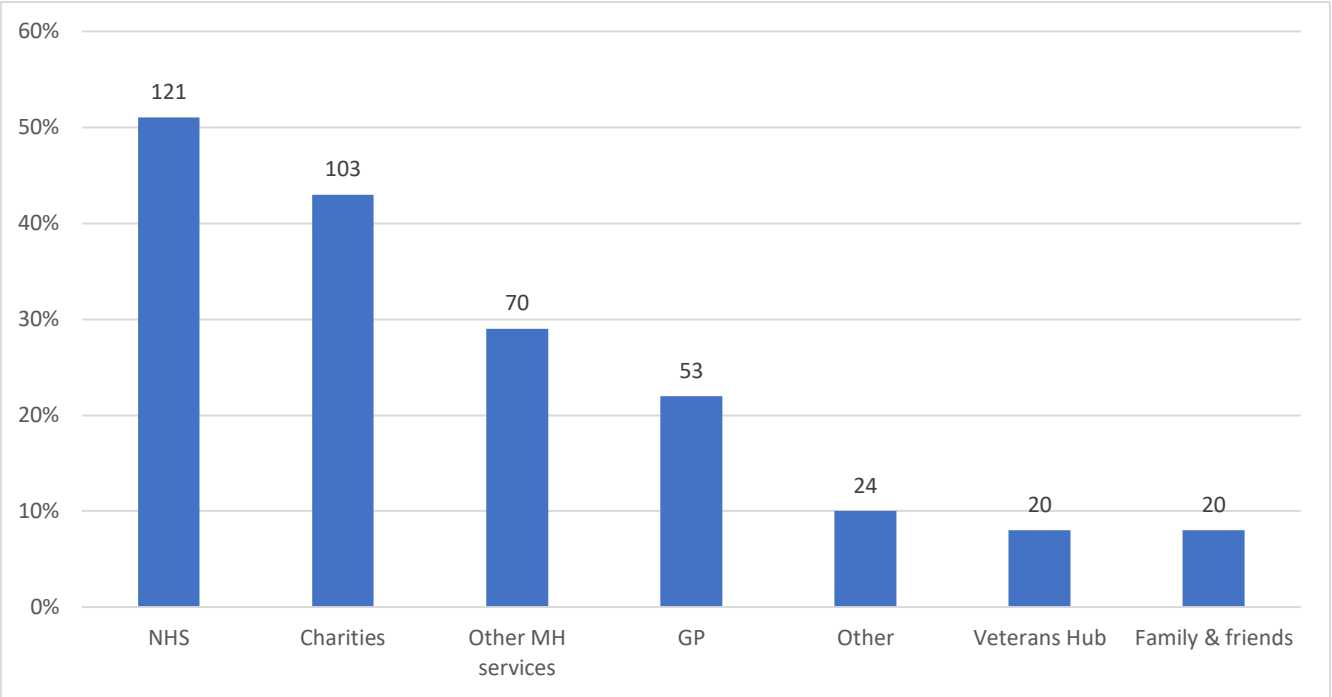


Figure 13. Services where Veterans Sought Support

Ser	Grant Holder	NHS	GP	Other MH services	Family and Friends	Veterans Hub	Charities	Regions
1	Adferiad	36 (55%)	28 (42%)	24 (36%)	14 (21%)	6 (9%)	20 (30%)	Wales
2	Inspire	42 (30%)	20 (14%)	31 (22%)	3 (2%)	10 (7%)	55 (39%)	NI
3	RFEA	5 (5%)	/	4 (4%)	/	/	7 (7%)	England
4	RMA	38 (20%)	5 (3%)	11 (6%)	3 (2%)	4 (2%)	21 (11%)	
5	**TOTAL**	121	53	70	20	20	103	

Table 13. Previously accessed support reported by grant holder

Word Cloud 2. Support services accessed by veterans

Help seeking behaviour

There were 475 participants who provided detail on their help-seeking behaviour; 49% (N=232) annotated delayed help-seeking and 51% (N=243) did not provide information that they delayed seeking help. From those, 232 answered the question concerning reasons why veterans delayed help-seeking and this was due to a mean of two factors, most commonly 'finding it hard to ask for help' at 30% (N=69) and 'being unaware of the available support' at 18% (N=41); others did not feel they needed help 17% (N=40); did not know where to go 13% (N=31); found accessing help difficult 10% (N=23); or were unaware of the one day inclusion criterion 4% (N=9); 'Other' was indicated by 8% (N=19) (see Figure 14).

A significant relationship between self-reported VAS stress scores and help-seeking was observed ($X^2(9, N=464) = 18.456$, $p < 0.05$). It shows that the greater the VAS stress score, the more likely they are to have sought help.

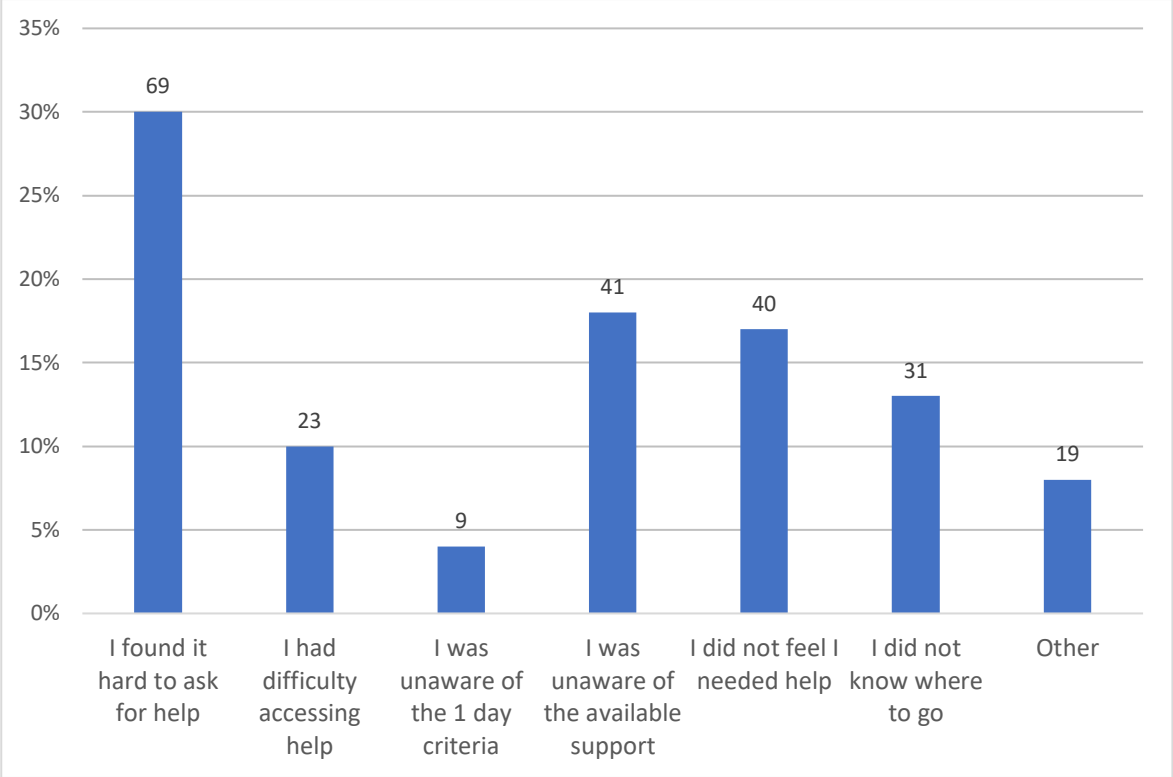


Figure 14. Delayed help-seeking

Participants (N=19) provided written comments to further explain why they delayed seeking formal help and these are highlighted in Word Cloud 3.

Word Cloud 3. Reasons for delayed help-seeking

How Veterans Accessed the OITM Programme

There were 488 veterans who indicated how they were directed into OITM projects. From the options on the survey questionnaire, the most common entry pathway into the OITM programme was by self-referral (36%, N=179), followed by charities (16%, N=80), friends (8%, N=38) and referrals which were part of the discharge process (5%, N=23), 3% (N=16) by a family member, 2% (N=11) were referred by their spouse/ partner, and 2% (N=9) by their GP. 'Other' was the overall second highest answer (27%, N=136) and this in part reflected that RFEA's 66 participants entered the service though police referrals in its Project Nova partnership. (See Figure 15).

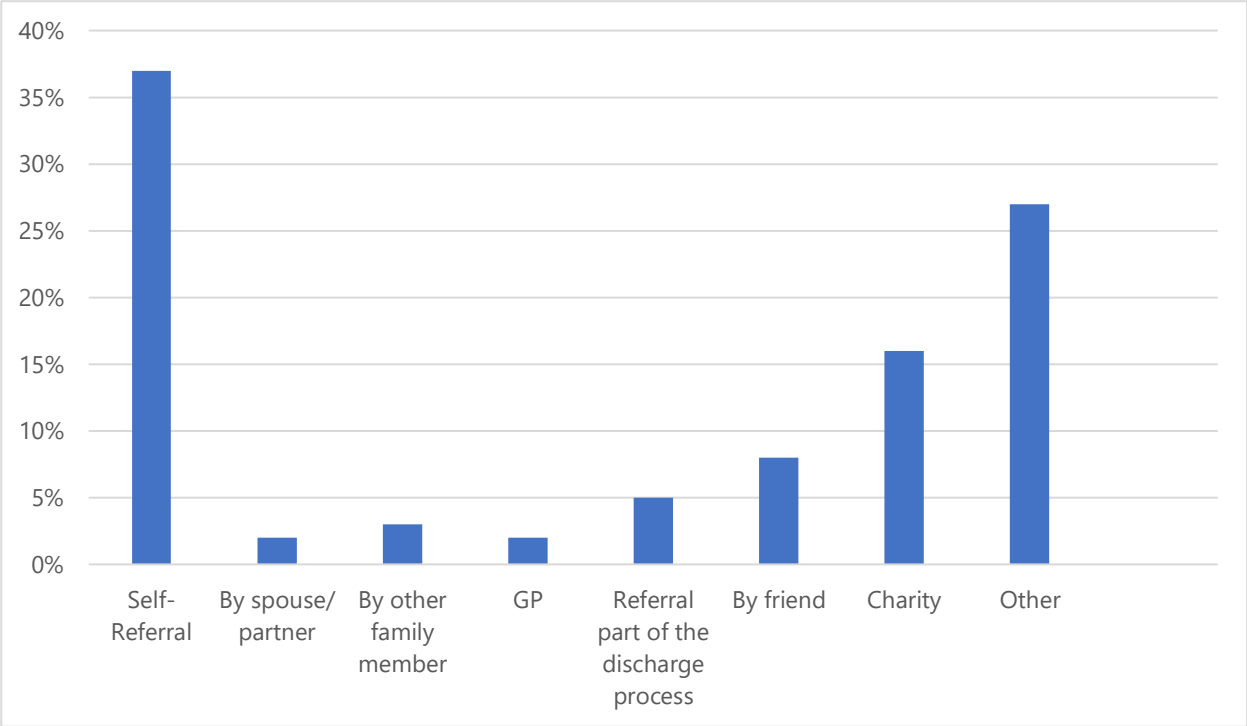


Figure 15. OITM programme entry pathways

Grant holders provided additional written comments (N=66) describing how their clients were directed into OITM projects. Of these, 41 were from RFEA's police referrals, eight were from TILS and the remainder from between one and three pathways. These are highlighted in Word Cloud 4.

Word Cloud 4. How veterans access the projects

Social Networks

Of the 471 who answered the question about social networks, 62% (N=291) of the veteran participants reported having ‘some’ people to rely on, 14% (N=68) reported ‘having people to rely on’, and 24% (N=112) reported having ‘no one’ to rely on.

Of those, 384 veterans provided detail on their engagement in social interactions and most met people ‘once or twice a month’ (31%, N=118). This was followed by meeting people ‘once or twice a week’ (28%, N=107), ‘every few months’ (20%, N=77), ‘three times a week or more’ (16%, N=62) and ‘Other’ was indicated by 5%, N=20).

Participants (N=73) offered additional comments regarding their social networks, although predominately these comments related to social isolation (N=53) (see Figure 16).

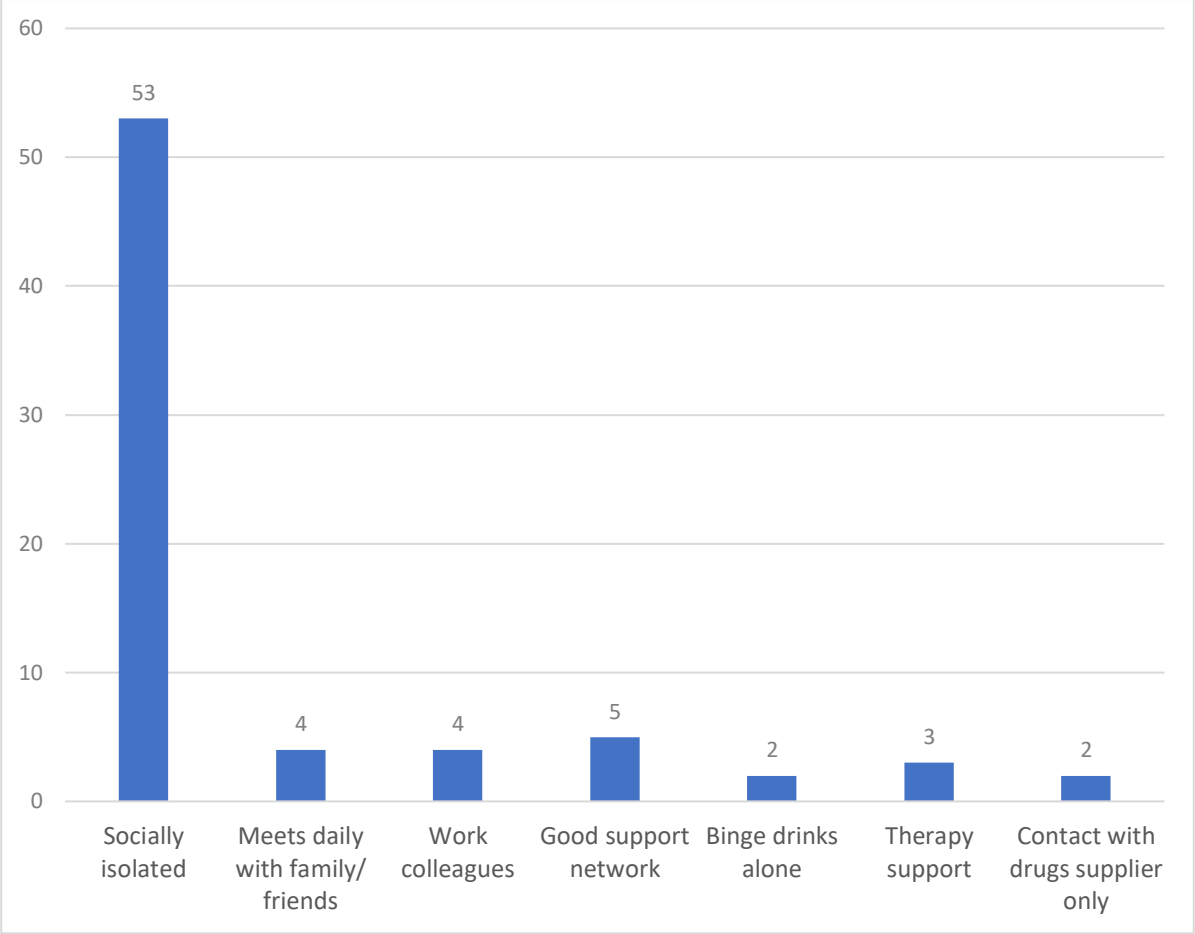
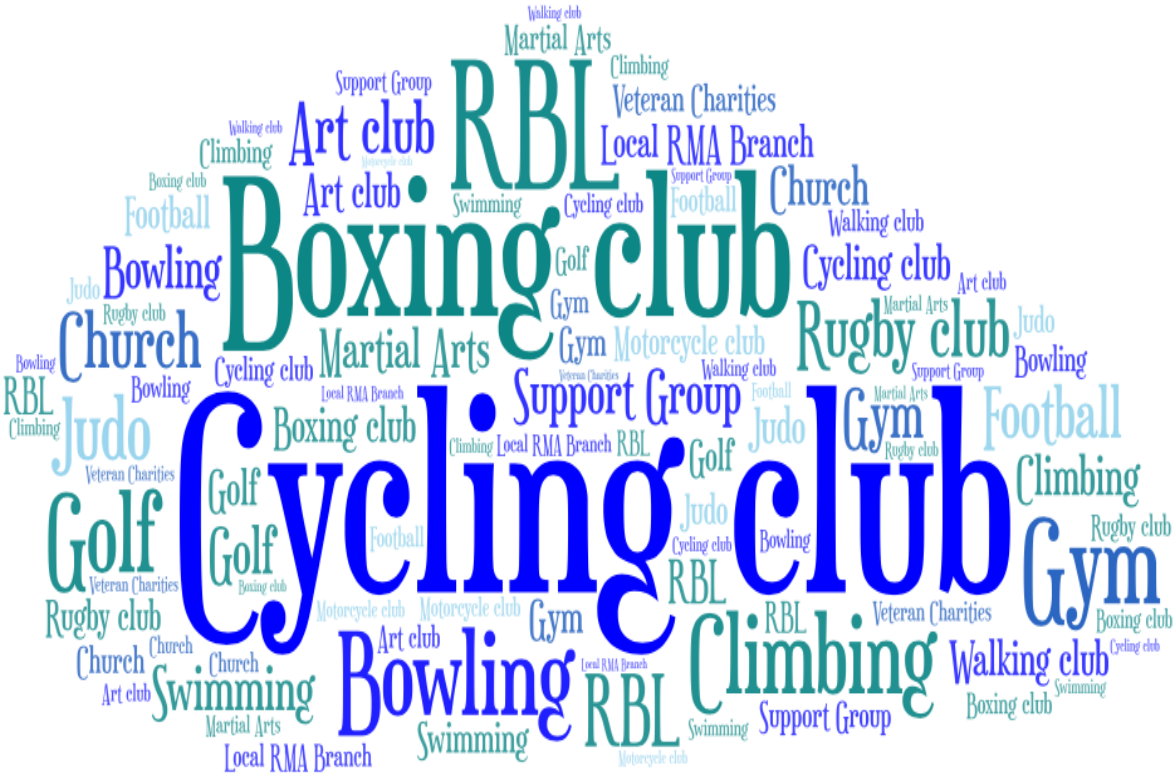


Figure 16. Social networks – additional comments

Seventy-eight percent (N=310) of the 398 who answered this question were not active members of clubs, organisations or societies. The other 22% (N=88) were active members of clubs, organisations or societies. On exit from the OITM programme, grant holders provided information for 296 clients about whether they were members of clubs or societies. Those who were active members of clubs/societies had risen to 36% (N=107) and those who were not had decreased to 64% (N=189). See Word Cloud 5.



Word Cloud 5. Various clubs, organisations or societies accessed by service users

Four-hundred and thirty-eight participants answered the question regarding how they compared themselves to people of their age and self-reported how often they participated in social activities. Veterans reporting 'much less than most' were 54% (N=236), 'less than most' were 20% (N=89), 'about the same' 16% (N=68), 'more than most' 5% (N=22), 'much more than most' 5% (N=23). On exit for the same question, 290 grant holders reported that those answering 'much less than most' were 17% (N=49), 'less than most' was 37% (N=106), 'about the same' was 36% (N=105), 'more than most' 8% (N=23) and 'much more than most' 2% (N=7).

A weak correlation was observed between age and social networks ($r(455)=0.029$, $p=0.543$) but this was not significant. Similarly, a weak but not significant correlation was found between the self-reported VAS levels of stress and social networks (r_s (465), $=0.046$, $p=0.325$).

Following the projects, improvements in their social networks were significant for 'taking part in social activities' ($X^2(20, N=265) = 34.58$, $p < 0.05$), 'active members of clubs' ($X^2(2, N=269) = 10.83$, $p < 0.05$) and 'relying on people' ($X^2(4, N=364) = 29.37$, $p < 0.05$). Improvements were also identified in the 'how often do you meet people' category although this was not significant ($X^2(20, N=270) = 29.08$, $p = 0.086$).

Employment and housing status

Employment: Many veteran participants were employed: 44% (N=221). The survey provided an option for the participants to report their annual earnings but only five did so and their responses ranged from £8,000 to £45,000 per annum with a mean of £34,000. The reported data show 39% (N=196) were unemployed, 11% (N=56) were retired, 3% (N=17) indicated 'other' as a non-specified reason, and 1% (N=3) preferred not to disclose the information.

On exit from the OITM programme, 391 participants answered the question about employment status. Unemployment had fallen to 32% (N=124), and there was an increase in employment to 48% (N=188). In addition, 12% (N=48) indicated retired and 3% (N=1) volunteering. Those who specified 'other' as a non-specified reason were 6% (N = 22), and 2% (N=8) preferred not to disclose the information (see Table 14). Significant employment differences were found between grant holders ($X^2(15) = 32.72$, $p < 0.05$).

Grant holders were also offered the option to describe their clients current employment with an open entry response, but very few provided information except for occasional further detail such as "can't work due to ill health" or " self-employed".

Housing

On entry, of the 457 respondents who reported on their housing situation, 45% (N=204) were homeowners, 37% (N=171) were living in rented accommodation, 10% (N=44) stated 'Other', 3% (N=16) were homeless, 3% (N=12) were living in residential accommodation and 2% (N=10) selected 'prefer not to say'.

On exit from the OITM projects, of the 390 veterans who answered this question, 45% (N=177) were homeowners and 39% (N=152) were living in rented accommodation. In addition, 3% (N=12) classified themselves as homeless and 3% (N=10) as living in residential accommodation.

Accommodation

On entry, of the 469 who answered this question, 43% (N=201) of veteran participants were living with their spouse/partner, followed by 36% (N=168) living alone, 13% (N=63) living with family, 3% (N=13) living with friends, 2% (N=11) in a professional house share, and 2% (N=10) indicated 'Other' and 1% (N=3) preferred not to say. On exit from the OITM programme, of the 393 responses to this question, 43% (N=182) were living with their spouse/partner, 31% (N=129) were living alone, 10% (N=41) were living with a family member, 1% (N=4) living with friends, 2% (N=1) were in a professional house share, 4% (N=16) preferred not to say and 5% (N=20) indicated 'Other'. A one-way ANOVA showed a significant difference between age and housing status ($F(3, 439)=13.87$, $p > 0.05$). Post-hoc comparison tests using the Tukey HSD test indicated significant differences across age groups (18-30, 31-50, 51-70) and housing status although there was no significant difference between age groups and the older age group (71-85). This would suggest that although differences in housing are apparent across age groups, the older veterans were more stable in terms of housing status.

Ser	Grant Holder	Entry /Exit (N)	Employment			Housing			Accommodation		
			Employed	Un-employed	Retired	Homeowner	Renting	Other	Living alone	Living with spouse/ partner	Living with family
1	Adferiad	Entry	9 (14%)	43 (66%)	11 (17%)	16 (25%)	39 (60%)	10 (15%)	33 (52%)	14 (22%)	16 (25%)
		Exit	10 (16%)	39 (63%)	11 (18%)	13 (21%)	41 (67%)	3 (5%)	35 (57%)	14 (23%)	11 (18%)
2	Inspire	Entry	50 (35%)	54 (38%)	34 (24%)	81 (59%)	46 (34%)	10 (7%)	47 (34%)	80 (58%)	9 (6%)
		Exit	40 (40%)	27 (27%)	28 (28%)	63 (64%)	28 (28%)	2 (2%)	29 (26%)	63 (57%)	6 (5%)
3	RFEA	Entry	33 (32%)	67 (64%)	5 (5%)	14 (13%)	50 (47%)	43 (40%)	46 (45%)	11 (11%)	24 (23%)
		Exit	21 (34%)	33 (54%)	2 (3%)	7 (12%)	38 (63%)	2 (3%)	31 (49%)	18 (29%)	6 (10%)
4	RMA	Entry	129 (73%)	32 (18%)	6 (3%)	93 (63%)	36 (24%)	19 (13%)	42 (26%)	96 (60%)	14 (9%)
		Exit	117 (70%)	25 (15%)	7 (4%)	94 (56%)	45 (27%)	11 (7%)	34 (18%)	87 (47%)	18 (10%)
5	**TOTAL**	**Entry**	**221 (44%)**	**196 (39%)**	**56 (11%)**	**204 (45%)**	**171 (37%)**	**82 (18%)**	**168 (36%)**	**201 (43%)**	**63 (13%)**
		Exit	**188 (48%)**	**124 (32%)**	**48 (12%)**	**177 (45%)**	**152 (39%)**	**18 (5%)**	**129 (33%)**	**182 (46%)**	**41 (10%)**

Table 14. Veterans' employment, housing and accommodation status reported by grant holders

Fifty participants provided comments surrounding housing difficulties (see Figure 17).

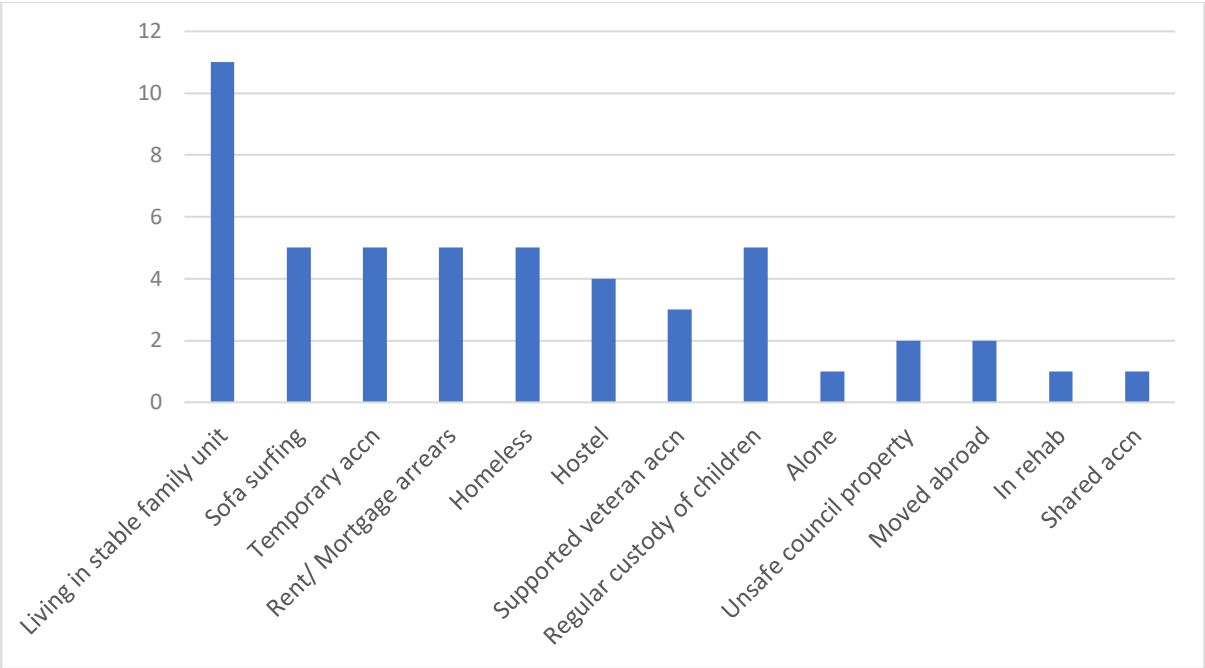


Figure 17. Participants comments on housing difficulties

Throughout the evaluation, there were no significant changes found for housing situations (t (0.293) = -0.780, p = 0.203).

Validated Psychometric Questionnaires

Psychometrics scores were only provided when that detail was being routinely gathered by the grant holders and therefore there are large amounts of what is classed as missing data in this report. The psychometric questionnaires show a sample with moderate to moderately severe depression and anxiety on programme entry. The total number of psychometrics questionnaires received at entry and exit are in Table 15, and the mean scores for the psychometric questionnaires are presented in Table 16.

Ser	Psychometric questionnaire	Psychometric Questionnaires Received	
		Entry	Exit
		Veteran (N=385)	Veteran (N=147)
1	PHQ-9	99	25
2	GAD-7	99	25
3	WSAS	145	77
4	WEMWBS	127	1
5	AUDIT	25	18
6	WPAI	0	0
7	EQ-5D-5L	0	1

Table 15. Psychometrics questionnaires received at programme entry and exit

Ser	Psychometric questionnaire	Score Range	Mean Scores at Programme Entry	Mean Scores at Programme Exit
1	PHQ-9	**Depression:** 1-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-19 Moderately severe; 20-27 Severe.	17	5
2	GAD-7	**Anxiety:** 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-21 Severe.	15	5
3	WSAS	**Work and activity productivity:** 10-20 functional impairment but less severe clinical symptoms. Scores above 20 suggest moderately severe or worse psychopathology.	23	15
4	WEMWBS	**Mental Health:** Scores less than 40 are associated with a higher risk of major depression.	22	/
5	AUDIT	**Alcohol:** A score of 8 or more is associated with hazardous or harmful alcohol use.	25	28

Table 16. Psychometric mean scores across programme on entry and exit

Similarly, paired sample t-tests indicated significant differences across improvements in self-reported scores of validated psychometrics for the PHQ-9 ($t(16) = 6.38$, $p < 0.01$) and GAD-7 ($t(18) = 5.55$, $p < 0.05$), meaning significant improvements in depression and anxiety were present. However, t-tests indicated no significant differences between the WSAS ($t(3) = 0.12$, $p=0.903$) or AUDIT ($t(8) = 1.21$, $p=0.261$)). Therefore, significant differences in work/activity productivity and alcohol consumptions were not found.

Grant holders also rated participants on a Visual Analogue Scale (VAS) of 0-10 (0 being no distress and 10 being maximum distress). Based on 497 responses, the mean score was 8 (median=9, mode=9, SD= 1.61).

Exit Data including Satisfaction Rating

The total number of exit questionnaires received from all the grant holders was N=423. Of these, 70% (N=289) were planned exits and 30% (N=125) were early exits, and N=9 were missing data.

Analysis shows improvements over time between entry and exit from the programme in participants' health and well-being (Table 16). This is reflected in the number of self-reported symptoms decreasing from nine to three, and the number of self-reported factors reducing from five to two. The number of self-reported illnesses affecting the participants remained the same (N=2). See Table 17 and Figure 18.

Serial	Variable	Variable info (Score range)	Mean scores	
			Entry	Exit
1	N symptoms	The number of self-reported symptoms ticked on questionnaires (ranging from 0 = no symptoms to 18 = maximum number).	9	3
2	N factors	Number of self-reported factors/stressors ticked on questionnaires (ranging from 0 = no factors to 18 = maximum number).	5	2
4	N illnesses	The number of self-reported physical and/or mental illnesses affecting them ticked on questionnaires (ranging from 0 = no illnesses to 10 = maximum number).	2	2

Table 17. Changes between psychometric means scores at entry and exit

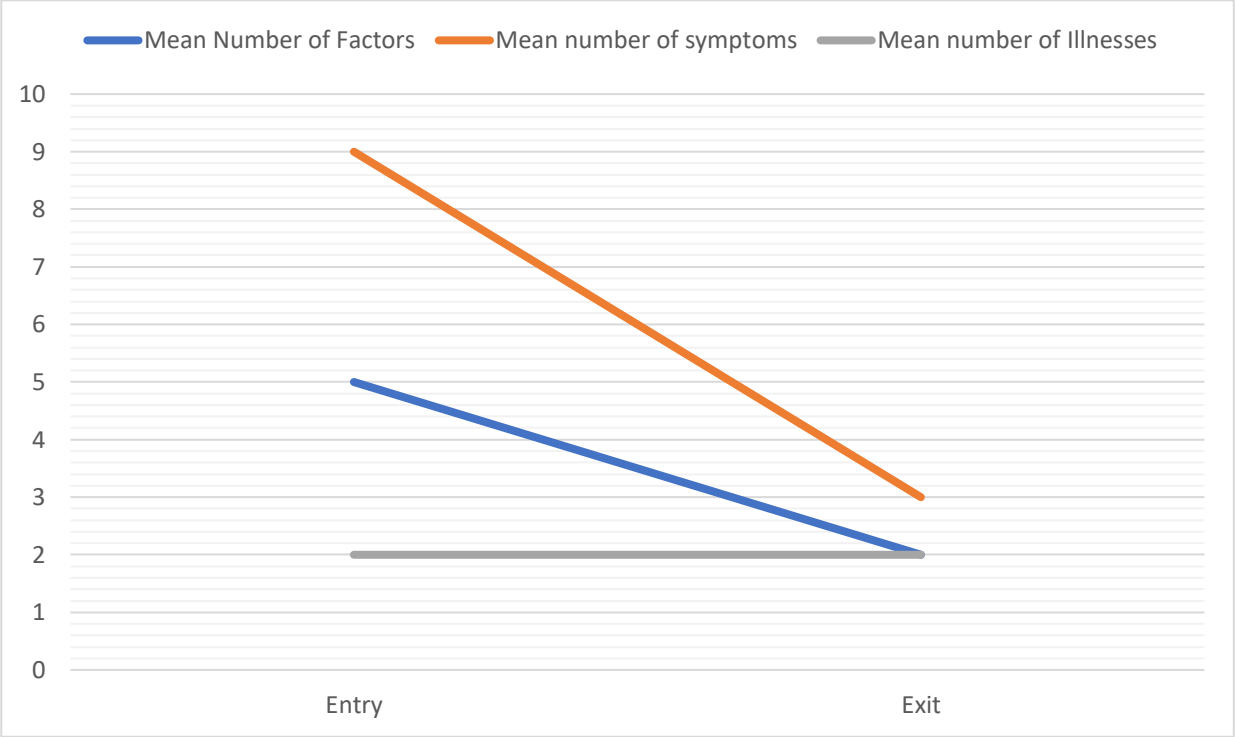


Figure 18. Illnesses, factors and symptoms at entry and exit

The exit questionnaire captured information regarding satisfaction rates. The results indicated most respondents reported high programme satisfaction (see Figure 19). Of the 389 participants who provided feedback on their overall satisfaction, their overall experience was rated on a 5-

point Likert scale ranging from ‘very poor’ to ‘very good’. More than 93% (N=364) of respondents provided a positive score of ‘very good’ and ‘good’. This consisted of 73% (N=285) providing the highest score of ‘very good’ and ‘good’ indicated by 20% (N=79). The other scores were ‘average’ by 13% (3%) indicated by participants, ‘poor’ by 2% (N=9) ‘very poor’ by 1% (N=3) (see Figure 20).

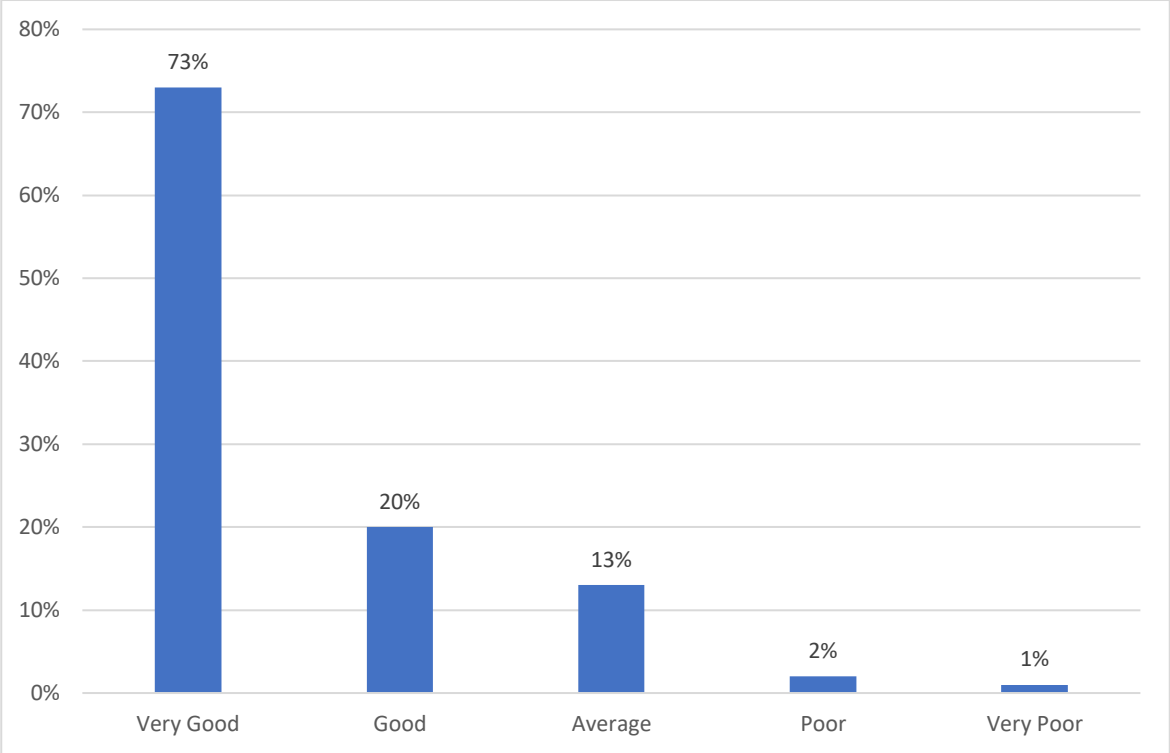


Figure 19. Participants’ satisfaction

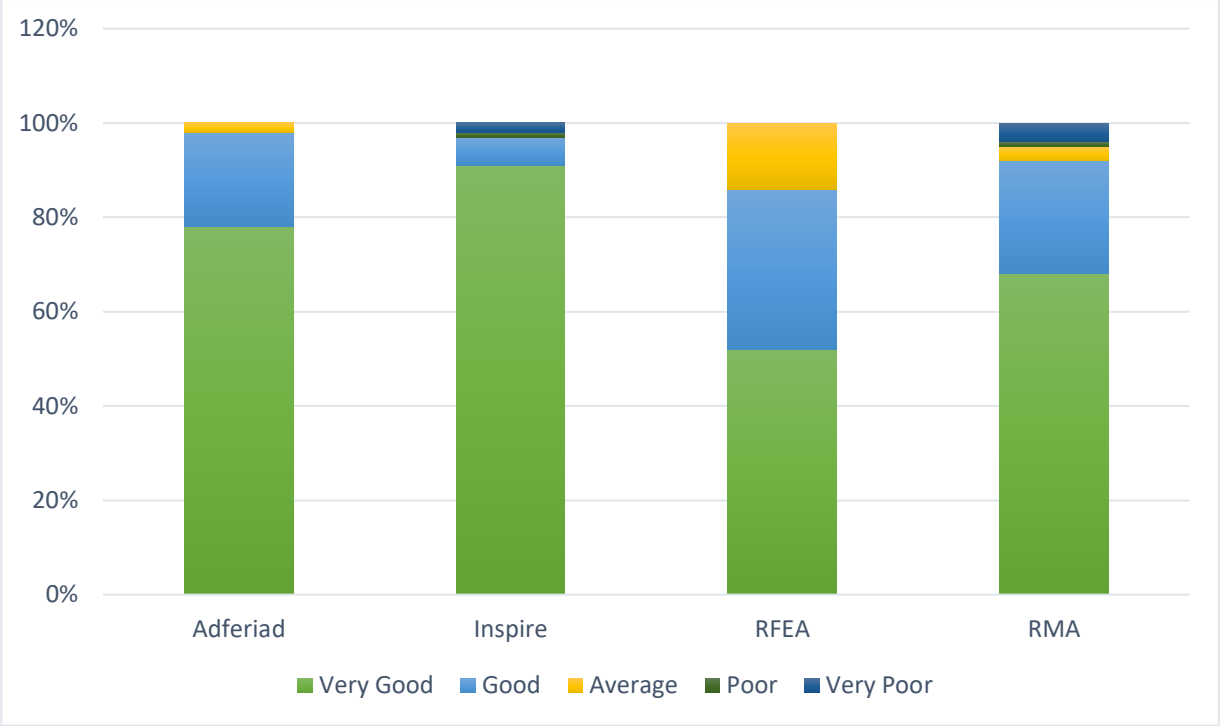


Figure 20. Satisfaction related to each grant holder

Of the 423 participants who completed an exit questionnaire, 409 answered the question about making an official complaint, 96% (N=394) were aware of how to make an official complaint, and 4% (N=15) were not. Of 347 participants who provided feedback on the programme's positive impact on their quality of life, the programmes were rated with a mean score of 9 (ranging from 0 no impact to 10 maximum impact). Of the 394 responses to the question about satisfaction with the support they received during the programme, 73% (N=289) rated the support 'very good', 'good' was rated by 20% (N=80), 'average' by 3% (N=14), 'very poor' by 2% (N=9) and 'poor' by 1 % (N=2).

Satisfaction with the information received during the programme was rated by 393 participants, 291 of whom (74%) rated the information received as 'very good', 'good' was rated by 21% (N=81), 'average' by 3% (N=10), 'poor' 1% (N=2) and 'very poor' 2% (N=9). Programme administration was rated by 389 participants, 73% (N=283) of whom rated the administration as 'very good', 'good' was indicated by 22% (N=85) 'average' by 3% (N=12), 'poor' by 2% (N=3) and 'very poor' by 2% (N=6). Programme facilities were rated by 391 participants, 68% (N=267) of whom rated the facilities as 'very good', 'good' at 26% (N=100), 'average' 4% (N=17), 'poor' 1% (N=3), and 'very poor' 1% (N=4).

Qualitative Data

Veterans were provided with the opportunity to list the top positive elements of the OITM projects as well as the top three areas for improvement, shown in the Word Cloud 6. These comments were brief and did not lend themselves to a meaningful content analysis.

Word Cloud 6. Positive elements of the programme

Grant holders reported on the different interventions that participants were engaged in. This consisted of individual MH psychotherapy (such as counselling, Eye Movement Desensitisation and Reprocessing and/or (CBT) provided to 60% (N=255), group activities to 9% (N=39), MH assessments to 28% (N=118), MH medication to 1% (N=6), and other activities delivered to 11% (N=48), which included social support to 4 and life skills coaching to 6% (N=26). Of the 218 who answered this question, 98% (N=214) rated these interventions as appropriate. Participants were also asked to make suggestions to improve the projects. Given that most veterans had either disengaged or were still in the programme only a small number of responses (N=12) were received. Those that were valid are shown in the Word Cloud 7.

Word Cloud 7. Areas for improvement

LAC and Local Councillor – First points of contact to get things moving in the right direction, held meetings and discussed a plan of action.
Tai Tarian – Housing supplier who finally offered the client a property after some hard work behind the scenes.
SSAFA – After completing an application form, I Received a grant to cover bond and 1st rent also funds for brown/white goods to furnish the property.
The Whallich – After meeting their support worker, we came to the decision to apply for a DAF grant to obtain some white goods for the kitchen which we got. Also he stated that going forward he would support the client in his property.
Trussell Trust – I obtained food parcels for the client while living in his tent.

Case Study

Army
Years of service: 4
Main Difficulties:Homelessness – Living in a tent on the mountainside for several months.
Alcohol – the client states that he drinks 1Ltr of vodka a night while in the tent.
Mental Health – the client has PTSD from his time serving in the forces. He has had some input from NHSV Wales in the past but was not in the right frame of mind to continue.
Current Issues: At the moment the client is in the process of equipping his property with furniture and white/brown goods received from a grant application that I submitted to SSAFA. There are lapses in communication between the SSAFA rep, the client and the delivery company which are causing delays in the delivery of goods.Now that the client has a place to live, he is keen to access support for his alcohol and mental health issues.As soon as the goods are in and the client is happy we will get together and see where we go referral wise.
Collaborative Services:Housing Options – I contacted housing options as soon as I found out that the client was homeless and living in a tent after the assessment. This got the client registered on the housing list and got banded in readiness to bid for properties.

Discussion

Suicide is a devasting event, that has considerable damaging consequences on families, friends and colleagues. There is often a perception that military veterans' suicides are directly correlated to the impact of serving in hostile environments. However, the factors leading to someone taking their own life are often extremely complicated and influenced by numerous situational factors and personal beliefs.

In 2021, as part of the Veterans Mental Health and Wellbeing Fund, and in recognition that more could be offered to reduce veteran suicide, the Trust allocated over £2M to eight UK projects. The OITM programme followed closely on from the Trust's TSS initiative that had produced empirical evidence that signalled reductions in depression, anxiety, alcohol misuse and improvements in wellbeing. The TSS health economics analysis had proven the programme to be cost-effective and was an important stepping stone to proactively maintaining a trend in positive health and social care interventions for veterans and their families. Other lessons learnt from TSS included a recognition of the wide range of ethical challenges that grant holders face and recognition that they need better preparation and support.

OITM consisted of multiple two-year projects that were designed to significantly reduce veteran suicide by gaining a better understanding of the issues, providing timely intervention including education and peer support to improve the wellbeing of veterans, and engage where appropriate with their families and friends. There was a clear objective to address the possible barriers to accessing health care. The rationale being that when veterans and their families are provided with the appropriate interventions within an environment that values leadership and that tackles stigma, then the factors that cause suicide can be effectively managed.

The projects were to be delivered in a coordinated and targeted way and were to concentrate on the quality of the interventions in reducing suicide rather than the number of participants. Grant holders were given the freedom to offer a number of options, from the co-production research with bereaved families offered by The Baton and the University of Northumbria, to education programmes and collaborations. The four grant holders of RMA, RFEA, Inspire and Adferiad delivered direct interventions focused on traditionally hard to reach veterans and they provided the data for this evaluation. In doing this, they worked with regional delivery partners and entry into their projects was via multiple routes including self-referrals, statutory bodies and charities.

To launch the programme, the Trust hosted an Engagement Event held at Chester Racecourse on the 14th -15th September 2021. This provided an outstanding opportunity for the grant holders to connect with the AFCFT Team and the Centre evaluators. The development of the TSS initiative was discussed together with the results. Then a series of workshops helped prepare grant holders for the challenges that lay ahead including ethical considerations. The event helped clarify issues and addressed any concerns including data collection. TSS grant holders including Adferiad, Inspire and Walking With the Wounded discussed their lived experience of the TSS initiative including client disengagement, referrals, data management, and managing and supporting clients who were fearful of exiting the programmes. Grant holders were also able to

specify how they wanted to connect and their desire for networking, webinars and building networks. The event was very positively received by all attendees.

The Centre was selected to support the grant holders and extend their independent evaluation of the TSS initiative to incorporate the new OITM projects. The OITM projects started in May and August 2021. Adferiad, RFEA and RMA concluded their participant in March 2023, and Inspire in July 2023.

Engagement and Interventions

There was extensive engagement between the Centre and the grant holders, including quarterly webinars with all seven grant holders. This presented a platform to share their work and showcase what was working well and how challenges were being addressed. Feedback from the grant holders indicated the value of shared learning and having the opportunity to learn from real time data. This information helped the projects transition from concept to delivering outputs to help vulnerable veterans. As with the TSS initiative, grant holder responses signified that the military background of the Centre's team was important and beneficial to the understanding of the challenges being faced, as was its deeper understanding of the veterans' lived experiences of the AFC. This approach was first adopted by the Trust in their TSS initiative and this further affirms the positivity of using evaluators to actively engage and assist throughout the course of the programme.

The results indicate that the four OITM grant holders that provided data for this evaluation were successful in improving the MH and wellbeing of the beneficiaries and reducing suicide. This in part was reflected in the significant reduction in the number of reported MH illnesses, situational stressors and symptoms. The psychometric questionnaire also provided clear indication of declining levels of stress, depression, anxiety and alcohol consumption and improvements in wellbeing. The grant holders' interventions also improved the beneficiaries' social networks, increased social interactions and resulted in greater involvement in other activities that would fall under the social prescribing banner. Collectively this resulted in veterans being less dependent on others.

Out of the four OITM grant holders offering therapeutic interventions, three were involved in the TSS initiative, and they offered interventions that had proved successful in the TSS initiative. These included MH assessments, psychotherapeutic MH interventions such as CBT, counselling and medication. There were group activities, social prescribing events such as Equine Therapy, peer support mentoring, life skills coaching, educational courses and practical help with housing and employment. There were notable differences regarding the support offered by different grant holders, and although some offered more than others, they all seem to have achieved levels of success.

In NI, Inspire's Every Life Matters project addressed the unique circumstances that exist for veterans in NI where there is ongoing real and/or perceived threat regarding personal security. An outcome of this being that NI veterans are reluctant to seek help from NHS statutory services. Inspire also recognised that suicidal intent is related to complex and contextualised psychosocial events and it provided a proactive, targeted and integrated approach to identify, address and

reduce suicidality and concomitant risk factors, combining prevention and intervention using a case-managed stepped-care delivery model. With 24-hour coverage including psychological and social therapies it was able to address issues including Complex PTSD, alcohol misuse and relationship difficulties. Its partners included Action Mental Health to address stigma, Brooke House to support military veterans and their families, and Andrew Rawling provided suicide alertness training, and social prescribing activities were held with Horses for People and Equine Assisted Therapy. Collaborative work with the NI Veteran Support Office and associated NI veteran support bodies provided full NI reach. Inspire also offered an aftercare service. In Wales, Adferiad set out to prevent and reduce the risk of suicide across its peer mentoring and partner organisations, building on its TSS experience in which 36% (N=79) of the participants had self-disclosed suicide risk. Adferiad partnered with Hafal and its residential MH hospitals and crisis sanctuaries to provide support to those with serious mental illness, including loneliness and isolation, and with Papyrus which targets the prevention of young suicide in people up to the age of 35.

In England, RFEA operates with 20 English police forces to deliver Project NOVA (now Op NOVA) (Forces Employment Charity (2023) to support veterans who have been arrested or are at risk of being arrested. RFEA's objective is to provide specialist suicide prevention alongside the Samaritans, which trains the RFEA staff to engage with veterans experiencing suicidal thoughts. It also developed a toolkit including guidance for veterans who are feeling suicidal and included an introduction to MH treatments. RFEA's connections extend to the NHS Liaison and Diversion, NHS England's Op COURAGE services, and they intended to forge a partnership with the National Centre for Suicide Prevention Training (2023) and the Zero Suicide Alliance (2023). Also in England, the RMA provides through-life support for serving and former RMs and their families. Its Lifting the Lid project sets out to improve knowledge and awareness to help veterans and provides employment advice, financial and benevolent support, and assistance with managing MH or dealing with substance misuse. It provides training and peer support and signposting to other services. Its aim is to prevent veterans spiralling into crisis, detect those at risk and it collaborates with other organisations such as NHS services to ensure optimum treatment. RMA trained MH practitioners to respond to the "unique challenges" of RMs and the barriers they face throughout their lifetime. The RMA collaborates with the Samaritans and MH First Aid and utilises a three-step training package provided by Zero Suicide Alliance. To share its results, the RMA hosted a Suicide Prevention Symposium focusing on education and collaboration.

Evaluation

The evaluation questionnaires were completed by the four grant holders who provided data over the whole two-year period, with the entry questionnaire taking approximately 15 minutes to complete. The exit questionnaire had fewer questions and was completed by the beneficiary as a first option or by the grant holder. No data were collected specifically for the evaluation, rather the routine data gathered during assessment was added to the study questionnaires. Data collection was the responsibility of the grant holders, with an expectation that there would be 100% (N=597) compliance with questionnaire completion, and 84% (N=503) were submitted. There was a range across grant holders from the RMA submitting 99% to the RFEA submitting

57%. At exit, grant holders, (often with the beneficiaries who were given the option to complete) returned exit questionnaires. These would always be fewer than 100% due to individuals still being on a programme or having disengaged, and 423 exit questionnaires were obtained. The grant holder often took the opportunity to add other relevant detail to support the survey responses. This often identified what was working and beneficial, although it also highlighted problematic issues and challenges.

Participants

The OITM veteran beneficiaries were predominately white British males, which was to be expected due to the composition of the veteran population. However, only 20 women (4%), accessed the programme, which is well below the 11.2% of women serving in the British Armed Forces (GOV.UK, 2022). This may indicate that men experienced severe MH issues and women did not, or that women veterans were unaware of the OITM programme; the low participation is perpetuated by low female veteran registration in Primary Healthcare (Finnegan et al., 2020; Finnegan & Randles, 2022). Also, female veterans are less likely to be deployed in front line combat areas, and many take on professional roles such as doctors and nurses. Without data, it is impossible to state exactly why women were under-represented as they do commit suicide. The evaluation reinforces the requirement to further explore initiatives to engage with female veterans, and research is needed to examine the impact of gender-related experiences during military service on female veterans help-seeking behaviour.

The mean age of the OITM service users was 45 years old. There were some differences in the mean age across grant holders. In NI the participants were on average older at 50 years of age, in contrast to Adferiad where the mean age was 47 years and RFEA and RMA where it was 43 years. For women, this mean age was comparable to the civilian population where 44-49 year olds are most at risk (ONS, 2022). This would indicate that the grant holders were reaching their target vulnerable age group. It is worth noting that the age is less than the civilian equivalent of 50-54 years. Another at-risk group are young men but many of this age group will not be veteran and because they are still serving their information is subsumed within the British Armed Forces Regulars' data. The OITM service users' ages were younger than the overall median age of UK veterans, where 60% are aged 65 years old or over (GOV.UK, 2020). Although suicide rates begin to drop in the civilian population in those aged over 70 years old, it does rise again from 85 onwards and these are a particularly vulnerable group due to failing health or other issues such as bereavement of loved ones and partners. The four grant holders had service users aged between 74 and 85 years old, so some were clearly supporting this group although not in sufficient numbers to get a clear insight into the demands on this veteran group. Further insight into this under-represented elderly veteran group will emerge from the Trust's Hospital Advocates Programme (AFCFT, 2023a).

Ethnic minorities represent 9.6% (N=14,110) of the British Armed Forces (GOV.UK, 2022) and they were under-represented. Notably only three respondents were clearly people of colour although 11 stated their religion was Muslim. Whether these Muslims were white British or people of colour was unclear. In contrast to the TSS initiative, there were differences in religion with many more of the OITM participants, 70% (N=244), stating they were atheist, whereas 58% of TSS participants classified themselves as Christian; in the OITM programme the figure

was 25%. One reason for this is that the grant holders entered the data and they may not have asked the question regarding religion. That theory was tested with grant holders during the end of study site visits but the responses were that these data were captured. Religious beliefs in faiths such as Christianity have long been held to be a protective factor that caused individuals to refrain from self-harm/suicide (Lawrence et al., 2016), but that traditional safety net may be on the wane. However, the empirical evidence on this perception is inconsistent, due in part to the dimensions of religious belief in affiliation, participation and doctrine and whether self-harm, suicide attempt or completion are affected.

Service History

Within a military context, there is a paucity of research on suicide prevalence and risk, and there is no consensus as to whether military service increases the risk of suicide, self-harm or suicidal ideation (Miller et al., 2009; Kapur et al., 2009). Veterans with combat experience (Fear et al., 2010; Osório et al., 2017), operationally linked trauma (Ashcroft, 2014), injury (Forbes et al., 2010), ESLs (Buckman et al., 2013; Bergman et al., 2016), and reservists (Harvey et al., 2012) were at higher risk of MH issues.

However, factors that are associated with risk of suicide in veterans include being a young male veteran (under 28 years), discharging as an ESL (within four years of enlistment), being an older (over 40 years) female veteran, or having depression or alcohol problems (Bergman et al., 2022; Harden & Murphy, 2018; Rodway et al., 2022). The literature also suggests that veterans who experienced adverse life events before enlisting or who have difficulties adjusting to civilian life may be at higher risk (Rozanov & Carli, 2012). These issues can be exacerbated as veterans were poor at seeking help, often not pursuing support until they were in crisis (Randles & Finnegan, 2022).

In the OITM programme, the majority of service users were Private soldiers or equivalent on leaving the Armed Forces, with an average service of 12 years. ESLs were uncommon with only 2% having served less than one year and 6% less than four years. The majority, 53%, had also served in the British Army although this finding was due to the high number of Royal Marines participating. These veterans were supported by the RMA, and in the other three grant holder projects the number of Army participants ranged from 77% in Wales to 92% in NI.

The vast majority (97%) had completed regular service which would indicate that reservists were not being attracted into the programme or that they were less likely to meet the inclusion criteria. However, as many risk factors are situational stressors, age related, or aligned to MH issues such as depression or alcohol misuse, then more reservists would have been expected. Considering reservists were utilised extensively during recent operations in Afghanistan and Iraq, the reason why they have not been engaged needs further exploration.

Seventy-six percent had completed OTs with a mean of two each, ranging from 1 to 11 deployments, most commonly in Afghanistan and NI, both at 37% each. Also, 77% had been exposed to a traumatic event during service with an average of two each, with the upper limit being five traumas. Over 50% of the written comments included incidents associated with exposure to a death and others to conflict, contact situations followed by personal attacks and incidents that can increase the likelihood of MH issues such as PTSD.

Correlations confirmed a relationship between service-linked trauma and those who had completed an OT. Also significant correlations were observed between the number of traumatic events experienced during service and the number of reported situational factors and number of reported symptoms on entry, the indication is that it is the life stressors that are causing the veteran participants to seek help.

The OITM interventions provided a personalised care plan with a combination of social prescribing activities and peer support, and delivered trauma focused CBT intervention when required. There was also support for alcohol misuse, and there is strong evidence that in combination these interventions do reduce suicide. The High Intensity Service interventions in the English Op COURAGE programme have a similar portfolio of interventions and there is emerging evidence that this is also being effective (Finnegan et al., 2023a). The findings, which will be highlighted below, indicate that the participants had notable improvements in their overall MH and wellbeing, although that impact would have been better measured if the participants had completed all the questionnaires, and with a longitudinal study to establish improvements over time.

Physical and Mental Health

Most veterans were discharged for non-medical reasons such as reaching the end of their contract (32%) and PVR (25%). That same figure of 25% were medically discharged due to a combination of physical and MH issues and at entry to the OITM programme a significant majority of the OITM participants (83%) reported long-standing physical or MH illness. Aligned with national estimates (Gov.UK, 2019), veterans mostly self-reported physical injuries such as musculoskeletal injuries at (25%).

The overall rate of MH the British Armed Forces was broadly comparable to that seen in the UK general population (MOD, 2020). Primary healthcare research has indicated that veterans MH determinants as recorded on the patients' medical records revealed depression (18%), alcohol misuse (17%), anxiety (15%) and PTSD (3%) (Finnegan and Randles, 2022). In the OITM programme the participants self-reported MH illnesses including depression (55%), anxiety (53%) and PTSD (51%), which indicates that the grant holders were targeting the right population although these figures are likely to be higher due to individual attestation. All of these conditions notably decreased during the programme.

A means of assessing the effectiveness of the OITM programme was to measure changes over its period of operation, that is, between entry and exit utilising the assessment criteria and psychometric questionnaire. These questionnaires were limited to those used by the grant holders in any clinical assessment and were not introduced specifically to collect data for the evaluation, therefore they are not as robust as the beneficiary completing these questionnaires themselves. They also resulted in fewer questionnaires being collected than would be expected with the scales for wellbeing at Work and social functioning N=145, wellbeing at N=127, depression and anxiety at N=99 and alcohol at N=25. These psychometric questionnaire scores at entry validated the self-reported health findings; with service-users gauged to be exhibiting

severe anxiety, moderately severe depression, the WSAS scale suggested moderately severe or worse psychopathology and the wellbeing scale also indicated probable clinical depression.

Psychometric results reaffirmed improvements against all measures at exit from the programme, although the number of submitted questionnaires was considerably lower, ranging from WEMWBS at N=1 to WSAS at N=77. The results provide further corroboration of the TSS results and other studies that have indicated that a variety of interventions and/or social prescribing activities may help to improve outcomes in veterans. These include mindfulness, yoga, sports, horticultural or archaeology activities, self-compassion or educational courses (Cabral et al., 2011; Finnegan, 2016; Stanton et al., 2014; Steen et al., 2021; Wise, 2015). They also support the initial evaluation of the Op COURAGE study which demonstrated that early peer support then social prescribing and clinical interventions can have good outcomes (Finnegan et al., 2023a). These findings therefore build on the TSS study to demonstrate the successfulness of these programmes for improving the health and wellbeing of veterans. It is also clear that the programmes successfully targeted and recruited the intended population. The AUDIT psychometric questionnaire was not widely used by the grant holders and results were only provided for 25 participants therefore the measurable levels of alcohol misuse are not available.

As highlighted in the Background section of this report, any programme that is aimed at reducing suicide must have a clear insight into the situational stressors associated with the client's lifestyle because these can cause depression, anxiety or other MH problems. The Background also reports on the effectiveness of the TSS initiative in addressing these issues. The OITM programme was targeting a similar vulnerable veteran group and from the outset the grant holders were required to identify these stressors. OITM service users entered the programme with a mean of 5 predisposing factors and these ranged from 1 to 15 factors. The most common factors being previous unresolved trauma (66%), traumatic exposure (53%), family stress (47%), operational factors (42%), relationship problems (39%), alcohol/substance misuse (37%) and isolation (32%).

Exit details showed notable reductions in all areas including previous unresolved trauma (27%), traumatic exposure (21%), family stress (19%), operational factors (10%), relationship problems (17%), alcohol/substance misuse (21%) and isolation (13%). On exit from the OITM programme, the average number of factors reported by veterans had fallen from 5 to 2, with a range of 1 to 12. What was also clear was the accumulative presence of situational stressors. On entry 2% had reported no factors but this had risen to 23% by exit from the programme. These incremental reductions would clearly make a significant improvement to the participant's wellbeing with results that demonstrate that the interventions reduced the levels of situational stressors. It may be that those who left the programme early had fewer issues resolved.

The results demonstrate significant reductions in the causative factors for veterans which is a clear indication of the success of the projects that would have reduced suicide. The OITM report reaffirms the finding from the TSS evaluation that by reducing/resolving even one situational stressor in a timely and effective manner can have a meaningful bearing on the individual and re-energise and motivate them to address other issues. Therefore, programmes that concentrate on specific issues such as accommodation and employment can have much wider benefits.

Service users also had a mean of 9 symptoms with a range of 1 to 17. Most common were anxiety (79%), low mood (87%), sleep disturbance (69%), feeling of hopelessness (67%), anger (66%), poor concentration (65%) and lack of interest (63%), symptoms concurrently linked to depression (NICE, 2015; NHS 2016; WHO, 2018). The effectiveness of the projects was again reinforced with a significant reduction in symptoms from 9 to 3, improvements that represented tangible advantages for the beneficiaries. There was no significant association between age or stress scores and number of symptoms. Further exploration and understanding of risk and protective factors are imperative to reduce relapse rates, optimise current provision, and relieve pressure on healthcare services.

The high levels of lack of interest and feeling of hopelessness would have presented the grant holders with challenges in getting their clients motivated to be involved in any activities. That they did may be due to the focus on veteran specific services and peer support workers, who provided this vulnerable group with a sense of identification with those offering the support. Many ex-service personnel look back fondly on their military careers and this identification with those offering the support may again have represented a good starting point from which to address the challenges at hand. Research has indicated that men and women experience depression in similar ways but present their distress differently (Baker, 2022; Branney and White, 2010); the low number of women in the OITM projects does not present the opportunity to assess that.

Men's symptoms often poorly correlate with the diagnostic criteria for depression, and their coping mechanisms can be displayed through anger, emotional rigidity, substance misuse or other risk-taking behaviour, and social withdrawal (Finnegan et al., 2014). These symptoms are not part of the International Classification of Diseases -10 (WHO, 2022) or the classification criteria for depression (WHO, 2018) and can undermine effective diagnosis and referrals (Finnegan et al., 2014). The high levels of anger reported in 66% of the OITM service users highlights the challenges in recognising when someone needs help rather than them simply being disruptive and acting out, and behaviours should be carefully delineated during any clinical assessment. It also reinforces the importance of initiatives such as RFEA and Walking With The Wounded's Project Nova and the support of the police in helping veterans get the assistance they need.

Help-Seeking Behaviour and Social Isolation

Fifty-one percent of the OITM beneficiaries reported having previously accessed support, and on average that support came from two organisations. Of these, the most common was from NHS facilities reported by 51%, and charities by 43%, then other MH services 29% and GPs 22%. It was not clear from the data how many of these engagements were related to a self-harm attempt or feeling suicidal, nor how many of these clients were then referred to the OITM programme. But it does reveal that some did not receive the support they required, or were discharged only for their problems to resurface. The results indicated that the greater the levels of stress, the more likely they are to have sought help, and it may be that periods of personal crisis motivates the person to seek help. That 36% self-referred to the programme clearly demonstrates how important this means of accessing support is. Charities referred 16% but GPs

just 2%. It may be that GPs are unaware of the services available and refer to more mainstream support such as Op COURAGE in England.

Forty-nine percent of service users delayed seeking help and did so for an average of two reasons. Of these, 30% of the veterans found it hard to ask for help, 18% were unaware of the assistance available and 17% did not know where to go. Improving knowledge and access to primary healthcare and veteran specific services together with continued investment in destigmatising MH are required to improve access to the appropriate services. Only 4% were unaware of the one day military inclusion criterion which is a significant improvement on research into this area (Finnegan et al., 2018; Finnegan & Randles, 2023) and this may not be reflective of the veteran population as a whole. The average age of the OITM participants is lower than the population average (ONS, 2022) and elderly veterans may still be unaware of the support that is available.

Isolation and lack of social engagement can have a significant negative impact on those who are contemplating suicide. In the OITM programme, 14% had people who they could always rely on, 62% had someone who they could occasionally rely on, but 24% had no-one to rely on. Most commonly the service users were meeting people once or twice a month although a fifth of the respondents were only meeting others every few months. On entry, 54% of the veteran participants indicated that they participated much less in social activities than other people of their age and another 20% reported less participation than most. There was a marked improvement during the programme and the exit questionnaires revealed that it was now 17% who participated much less in social activities. The results did not indicate any significant differences due to age, which suggests that a variety of social engagement opportunities can meet individual requirements. On entry to the OITM programme, 78% of the service users were not members of recreational clubs and organisations and 22% were. Clearly, membership of clubs reduces social isolation, and the programme either directly connected the beneficiaries to clubs or motivated them to join. This was exhibited in the exit data with club membership rising by a sizable 14%. Many of the activities had a physical exertion component which may have enhanced their mood and made them feel better in themselves.

Overall, the OITM projects saw a significant improvement in veterans social networking, with increases in social activities, being active members of clubs and having people to rely on. There was also evidence of veterans meeting people more often. These findings are another indicator of the success of the projects, and signified that grant holders had an understanding of their clients military, health and social profile. Therefore, after an appropriate assessment they had the information to produce a personalised care plan that included ways of reducing social isolation. How this progresses over time was not identified in this programme, but the hope would be for long-term engagement, motivation and lasting benefits.

Employment and Housing

Data from the 2021 Census (England and Wales) was released in June 2023 regarding household and family composition, communal dwelling and prisons (ONS, 2023). The percentage of communal establishment residents in care homes was higher among veterans (73.28%) than non-veterans (32.95%), but after adjustment it was lower (73.28% and 76.56%, respectively).

The OITM study did not directly capture information on "communal dwelling" which would include veterans living in care homes where their presence would be expected to be high due to the age profile of the veteran population. It does however reaffirm that projects to improve the health and wellbeing of elderly veterans and their families living in care homes is required

Thirty-nine percent of OITM participants entering the programme were unemployed and 11% were retired, compared to 44% in employment. Although the age range is different, the MOD estimates that 79% of working-age veterans were employed in 2019, and only 3% were unemployed (Gov.UK, 2019). Thus there is marked difference, and stable well paid employment is very important to MH and wellbeing.

In the OITM participants, those employed were earning on average £34k per year but grant holders only shared detail on the earnings of five people. Why so few provided this information is unclear, but a likely reason is that it was not part of the entry assessment and grant holders did not feel the need to ask. They did provide some narration regarding employment and these included "can't work due to ill health" or "self-employed". Following exit from the OITM programme, unemployment had fallen markedly by 7% to overall unemployment of 32% (N=124). This was consistent across all grant holders. It was countered by a 4% increase in employment to 48% (N=188), this figure in part attributable to some people moving into retirement and some working in the voluntary sector. The projects have done well to reduce unemployment because financial issues can be a significant factor in self-harming behaviour. However, 32% of veterans still being unemployed provides an identifiable area for development in future grants.

The 2021 Census (ONS, 2023) also revealed that a higher proportion of the household veteran population (74.68%) than household non-veteran population (64.54%) owned their accommodation outright or with a mortgage; after adjustments, the percentage of veterans in this category was slightly lower than for non-veterans (74.68% compared with 75.53%). Amongst OITM participants, the number of homeowners was significantly lower at 45%, with a further 37% in rented accommodation; 3% were in residential accommodation and 3% were homeless. This reaffirms that it is these situational stressors that are causing the clients' distress, and not necessarily their operational experiences. The 2021 Census data also indicated that of those classed as living in homeless accommodation such as a hostel or temporary shelter, the percentage of veterans was slightly lower than non-veterans, although not significantly so.

Older veterans reported having more stable housing status, such as homeownership or renting. The results again demonstrate that some smaller groups of veterans need specific targeting and a better understanding of their life trajectory after leaving the Armed Forces. This was a recommendation from the TSS study that is reaffirmed here. There were reports of improvements following the OITM projects but there is room for improvement and the AFCFT's (2023b) funded Reducing Veteran Homelessness Programme projects should provide many of the answers to address these issues.

Participant Feedback and Cost-Effective Analysis

At 94%, the vast majority of participants were identified as being satisfied across all projects. There were also 96% of participants who knew how to make an official complaint which was a notable increase on the 83% reported in the TSS initiative. However, as the grant holders had overall responsibility for completing the questionnaire there may be some bias. The projects were also rated at 9 out of 10 in relation to the positive impact on the participants' quality of life.

The TSS evaluation included a cost-benefits analysis highlighting incremental savings to society together with an increase in the beneficiaries' Quality Adjusted Life Years (QALYs) and evidence that the programme would improve further in cost-effectiveness. The OITM programme did not include a cost-benefits analysis but a strong case can be made for including such an analysis in larger Trust programmes.

Reflections on One is Too Many

The Trust's OITM programme provides a reservoir of further important data that build on the lessons from the TSS initiative. The results provide statutory and non-statutory organisations with clear evidence of numerous factors that influence self-harming behaviour in the veteran population and ways of addressing those issues. These findings can therefore help to develop extant interventions and inform future programmes how to best support vulnerable veterans. The programme's systematic review (Randles et al., 2023) was the first conducted concerning this veteran population and enhances the aligned TSS help-seeking behaviour systematic review (Randles & Finnegan, 2022). Combined, they provide valuable empirical evidence that can help clinicians and peer support workers to de-stigmatise MH issues. Motivating clients to engage appears to work when the available programmes offer a combination of therapeutic and social prescribing interventions inside a safe and receptive environment.

A stressor in one family member impacts on all the family and reinforces the wider requirement for programmes engaging the whole family. With such a vulnerable population, it is reassuring that they sought and received support. In many instances the family were engaged, and an objective for ongoing services and research is to determine novel ways to access family involvement. This could help circumnavigate factors influencing poor help-seeking behaviour and motivate vulnerable clients to seek help.

All survey based evaluations require high levels of data to be able to assert that the findings are valid, reliable and significant. Otherwise the commentary is more aligned to an anecdotal observation. Because grant holders were tasked with submitting completed questionnaires then the objective was to get 100% compliance. The receipt of 85% entry questionnaires therefore left considerable room for improvement. On further analysis, the response rate from RMA (99%) and Inspire (95%) were aligned to the Trust's and the Centre's expectations. That was less so with RFEA (75%) and Adferiad (57%). The results therefore are definitely aligned to the work of those with high returns and the success of the grant holders is compromised when there are less data. This strongly identifies the potential for setting performance indicators for grant holders to achieve in relation to questionnaire uptake and this should be considered in the

future. In addition, there is a strong case to be made for using a consistent data collection survey across all large grants.

The grant holders had the option to supply written comments which many utilised together with case studies that provided further insight into the challenges of their role and how these were addressed. Overall there were vast improvements to many of the beneficiaries' health and wellbeing which undoubtedly saved lives. Yet, these challenges also expose the question of what impact this level of support has on those delivering the support, many of whom have no or minimal MH training, and who cares for the carers. A recommendation is that this should be explored as a future research project and governance measures implemented to ensure the safety of those delivering the care as well as those receiving it.

The Trust's Veterans Places, Pathways and People (VPPP) programme is providing a format to help connect a complex network of services that interlock with veterans but it often struggles to engage with this vulnerable group where help-seeking behaviour is poor. Identification with a particular charity such as Royal Marines with the RMA appears to be a particularly useful way of tackling this conundrum.

The psychometric questionnaires that captured data as part of the assessment process in combination with the study's questionnaires indicate clear improvements, but evaluators still need to be mindful of relapse rates which can be expected with specific illnesses such as alcohol misuse and depression (Hendershot et al., 2011; Kuyken et al., 2016). This becomes even more important with a client group that is identified as being at high risk of self-harm and/or suicide. Therefore, further exploration and understanding of risk and protective factors are imperative in order to reduce relapse rates, optimise current provision, and relieve pressure on healthcare services. The option to now combine the data sets from TSS and OITM provides a growing body of evidence in this area. Also, a longitudinal study would have indicated progress over time.

To better understand the provision of support and care for veterans necessitates understanding the unique lifestyle and specific culture within the AFC. Overall, many of the findings reinforce the compelling case for local community hubs as demonstrated in the concept of the AFCFT's VPPP programme.

Exit Discussions

Following the end of the data submission period in August 2021, the Principal Investigator visited each of the grant holders (except for Adferiad which was online) to discuss and reflect on the OITM projects. During these meetings, grant holders summarised positive aspects of their activities and interventions, the challenges they had faced and provided recommendations for improvements. These included discussions around client disengagement, referrals, data management, and managing and supporting clients who were fearful of leaving the projects. The RFEA highlighted that participants did not like the term exit on the departure questionnaire. It did appear however that in many cases the grant holders were maintaining continuing and regular contact with their partner agencies and their clients.

Some participants did not favour online questionnaires, which suggests that clients can struggle with the technology, and many preferred paper questionnaires. A lesson learnt was the need for specific administrative support staff, including a person to help engage participants and provide assistance with completing exit questionnaires. The latter proved particularly challenging if unforeseen circumstances such as staffing and IT issues interrupted the programme and its evaluation. As with the TTS initiative, challenges surrounding client disengagement were reported, with participants being reluctant to complete exit questionnaires despite saying they would. Some service users were apprehensive of their support ending following exit questionnaire completion. Exit questionnaires were distributed, but participants were often reluctant to engage once they had improved. However, the grant holders did have the responsibility in these cases for ensuring completion of the questionnaires and submitting the required information.

Limitations

The OITM programme was designed and targeted to support veterans who had specific complex MH issues that may result in their self-harm or suicide. The outcome that only 4% of the programme's beneficiaries were women means that the results do not provide an empirical overview of gender differences. There is also a gap regarding support to the older veterans. The evaluation did not capture the views of the beneficiaries' families who would have likely provided specific insight into the background leading up to the request for help and the longer-term issues. This reinforces the wider requirement for similar programmes that involve the whole family. Veterans who disengaged from the OITM projects did not have their views captured, although grant holders provided written narrative comments to offer some insights.
The volume of exit evaluation questionnaires received did not correspond to the number of entry evaluation questionnaires received. The grant holders had overall responsibility to guarantee these submissions, however IT issues at Adferiad and staffing issues at the RFEA significantly impacted the number of completed entry and exit questionnaires to support this independent evaluation.

Despite increased awareness of veteran suicides, there is a paucity of research and the OITM background systematic review has been published in *British Medical Journal Military Health* (Randles et al., 2023). However, there remains a limitation in that there is not a better understanding of the lived experience of family members and friends who have been affected by suicide in the veteran community, and the support services available to them. The inclusion of family members and friends should be considered in future studies and the work undertaken by The Baton and the University of Northumbria as part of their overall programme should prove illuminating.

Considering that not all grant holders provided psychometric scores, it is evident that different approaches were employed to undertake initial assessments of the veterans enrolled in the OITM projects. As a result, it is difficult to draw definite assumptions and conclusions based on the low number of psychometric scores received.

Conclusion

It would be remarkable to reveal in the conclusion to this OITM report that no veteran involved in the programme had taken their own life. However, this is not the case, and to the distress of all those involved, a colleague decided that suicide was the only option available. This again highlights the incredible challenges faced in trying to support former vulnerable teammates who cannot envision a future that is worth living for. However, the OITM projects have made a positive difference. This report is a clear demonstration of treatments and interventions that have improved MH and wellbeing, which undoubtedly has saved lives.

The OITM programme's flexibility and responsiveness to referrals, aligned to multiple levels of collaborative networking and connectivity between grant holders was impressive. When combined with a suite of interventions within a personalised treatment and intervention programme, the results were overall successful in reducing the situational stressors that can lead to self-harming and suicide. With ongoing empathetic peer support the result for the majority of clients was notable improvements in MH and wellbeing. When united with the evidence from the TSS initiative, the collective findings provide vital information to help grant holders shape their current provision to maximise support to vulnerable veterans and their families.

A TSS report highlighted that the adoption of the TSS delivery model within other projects and initiatives should provide better support to veterans and family members and should be considered. This was witnessed in the OITM programme, including the adoption of a modified/shortened version of the TSS questionnaires and there is now an option to amalgamate both datasets.

The OITM programme has illustrated risk factors leading to veterans' self-harm, suicide risk and protective factors and these can now inform policymakers, healthcare professionals, and third-sector organisations of a direction of travel that has palpable benefits. The OITM findings may facilitate the development and implementation of preventative and intervention strategies to best support the MH and wellbeing of UK Armed Forces veterans in crisis.

Clearly, many of the factors causing the clients so much distress were due to their current situation rather than anything that had occurred in their military career. There were multiple examples indicating this such as the much lower level of homeowners compared to the general veteran population.

That 96% of the questionnaires were from men may reflect that men experienced severe MH issues, or that women did not want to access the service or complete the study questionnaires. Also, female veterans may have been unaware of what was available and there may be a need for better promotion of the services as a new initiative. Without data, it is impossible to identify the cause of only 4% accessing the service, and there remains a need to further explore ways to engage with female veterans and understand the impact of gender-related experiences during military service on female veterans help-seeking behaviour.

The OITM programme is therefore building a reservoir of information and can assist future research to explore the impact of these portfolio interventions over a prolonged period. A 6- to

12-month post exit data collection period within a longitudinal study presents many advantages for determining long-term benefits, as would enhanced qualitative data captured through interviews with beneficiaries, their families and staff. In addition, future evaluations should consider the utilisation of a cost-benefits analysis.

Following on from the TSS initiative, the evaluation presents very positive evidence of the success of the OITM programme. Reductions in depression, anxiety, alcohol misuse and improved health and wellbeing can only be beneficial. There are clear indications of better social interactions. There is a strong case to be made for using a consistent data collection survey across all large grants.

This report re-emphasises the importance of providing timely and skilled care within a setting in which beneficiaries feel safe. There is evidence that the grant holder's clear dedication, enthusiasm, and intelligent application of resources alongside participant engagement led to widespread accomplishments. The only caveat is that the quantity of data from grant holders varied considerably, and these conclusions are easier to confirm when the data returns are high.

The combination of the TSS and OITM data is an important bank of evidence to demonstrate success, inform other organisations and provide examples of how to improve veterans' care. These findings can inform other veterans with similar issues who are not seeking help.

The OITM programme has provided a bedrock for the grant holders to forge lasting collaborative partnerships that can be extended to working with other authorities and organisations, governmental agencies, professional bodies, charities, businesses, and appropriate networks. Most importantly it presents another example to those veterans and their families who need help and functional choices from which to obtain the support, care and intervention they require.

Recommendations

GRANT HOLDER ENGAGEMENT: In the prelude to the commencement of the OITM programme, the Trust hosted an engagement event at Chester Racecourse. This provided an outstanding opportunity for the grant holders to meet the AFCFT Team and the Centre evaluators. Equally important was the chance to interact with each other. A series of workshops were held including an ethical considerations, and this helped the grant holders prepare for the future challenges. The Centre team's military background and their insight and understanding into the lived experiences of the AFC was well received. Grant holders specified that they wanted to keep in contact throughout the programme, and the Centre hosted regular Webinars. This provided the platform for shared learning with real time data to indicate what was helping beneficiaries and identify how challenges were being tackled. **Recommendation:** large grants should incorporate similar arrangements and utilise the project evaluators' experience to actively engage with the programme and have a role in supporting grant holders.

CARING FOR THE CARER: Grant holders were responsible for providing support to vulnerable veterans, many of whom were former colleagues. The resulting occupational stress raises the question of what negative impact this level of support has on those delivering the care. In the case of peer mentors and support staff, they may have received minimal MH training for their role. **Recommendation:** give consideration to providing a standardised training package to those delivering care that is combined with mandatory governance structures. Research can also help ensure the safety of those delivering the care as well as those receiving it.

HELP-SEEKING and STIGMA: Veterans help-seeking behaviour is poor. This can result in excessive delays in addressing problems, which are often left unresolved until veterans are in crisis. A significant number found it hard to seek assistance or did not know where to go for help. In addition, more than 50% of participants had previously accessed support, many from their NHS services and charities. Improving knowledge and access to PHC and veteran specific services together with continued investment in destigmatising MH and advertising veterans services are required to improve access to the appropriate services. **Recommendation:** assessments of beneficiaries entering future programmes and the subsequent evaluations should capture details surrounding the factors that negatively impact on help-seeking behaviour. Novel support with peer mentors who provide individually personalised support, drop-in centres, Community Hubs together with engagement with the Police and Emergency Services may prove helpful in addressing stigma. Entry into programmes should continue to be though multiple routes including self-referrals, statutory bodies or charities.

UNDER-REPRESENTED and MINORITY GROUPS: With regards to recruitment into the OITM programme, groups such as women, ethnic minorities, reservists, the elderly and the LGBTQ communities were under-represented. The results demonstrate that veterans with specific characteristics need explicit targeting and a better understanding of their life trajectory after leaving the Armed Forces. **Recommendation:** programmes should include a strategy for reaching under-represented and minority groups and provide specific programmes for these groups.

ASSESSMENT: On entry into the OITM programme, a majority of participants were experiencing significant predisposing stressors and they reported multiple symptoms. These symptoms should be noticeable, in particular to family members and this reinforces the need for family interventions. It is essential to identify and understand the situational factors associated with stress in the AFC such as family or relationship problems, and unemployment. Addressing even one causative factor in a timely fashion can have a significantly positive bearing on the client, and re-energise and motivate them to address other more complicated issues. **Recommendation:** contributing situational stressors should be identified in the assessment process to ensure appropriate treatment and promote successful outcomes.

INTERVENTIONS: The OITM programme mirrored the TSS initiative in offering a mixture of different intervention options including psychotherapeutic sessions, group activities, social prescribing, mentoring, educational courses, and practical help. The peer mentoring and a shared group identity also appear to have helped address poor help-seeking behaviour. In both programmes, there were notable differences regarding the support offered by different grant holders but all achieved some levels of success. The findings indicate that if veterans are provided with appropriate interventions within an environment that values leadership and that tackles stigma they can be effectively supported. **Recommendation:** future programmes should offer a mixture of interventions that suit particular beneficiaries including social prescribing activities.

EMPLOYMENT & ACCOMMODATION: Thirty-nine percent of OITM participants on entering the programme were unemployed, 11% were retired and 44% were in employment. These are much higher than the MOD estimates. The number of homeowners was also significantly lower than in the 2021 Census results, and 3% were homeless. Although there was a 7% reduction in unemployment on exit from the OITM programme there is significant room for improvement, and the results suggest that it is these situational stressors that are causing the clients' their distress, and not necessarily their operational experiences. **Recommendation:** programmes should concentrate on improving employment and accommodation and gain a better understanding of a veteran's life trajectory and identify ways to prevent/address homelessness. The evaluation should determine aspects that are important to measuring success in getting veterans and their families back into employment and improving their lifestyle.

EVALUATION: The OITM and TSS initiative shared the same question set, which provides the foundations for amalgamating the data sets. The TSS evaluation also included a cost-benefits analysis that indicated that from both a healthcare and societal cost perspective the programmes were effective at providing incremental savings to society, together with an increase in the beneficiaries' QALYs. Both programmes used psychometric questionnaires to provide evidence of improvements in areas such as anxiety and depression, and help validate that the targeted audience with complex MH issues were enlisted. However, evaluations require high levels of data to affirm that the findings are valid, reliable and significant otherwise the results may be viewed as anecdotal. **Recommendation:** utilise a consistent data set in programme evaluations to determine effectiveness over time. Data collection performance indicators aligned to financial remuneration would improve the number and quality of survey returns. Large grants would benefit from a specific economic evaluation.

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Appendix A

Systematic Review : Summary of Included Papers and Reports

Author	Type	Sample	Method	Results
Bergman et al, 2017	Quantitative	56,205 veterans and 172,741 demographically matched civilians on age, gender, and socioeconomic status.	Scottish linked health records and mortality data. Demographics provided by NHS electronic registration records. Socio-economic status determined from most recent registered postcode of residence. Deaths were included resulting from suicide, intentional Self-Harm or were undetermined.	267 suicides (0.5%) in veterans compared to 918 (0.5%) in civilians. 7.6% of deaths in veterans and 8.4% of deaths in civilians. The difference was not statistically significant. Incidence was lower in younger veterans and higher in veterans over the age of 40. ESL's not significantly increased risk but only in older age groups. Female veterans significantly higher risk of suicide than female civilians. Veteran women who died by suicide joined before 1991, 50% left after <3 years and 0% served for >11 years. Methods of suicide did not differ significantly between veterans and civilians for either gender. In both groups, males were more likely to use violent methods. A significant interaction between birth cohort, veteran status and high risk is confined to 1950-54 cohort. No evidence of association with intense operations.
Williamson et al, 2021	Quantitative	204 veterans	Self-report experiences during military service. Participants asked whether they had experienced a challenging event during military service and asked to write a description. These were then classified by 2 researchers as a moral injury, non-morally injurious trauma or mixed. Probable PTSD assessed with PCL-5, depression PHQ-9, anxiety GAD-7, alcohol AUDIT, suicidal ideation SBQ-R. Combat exposure via combat exposure scale with 17-41 score indicative of moderate - high exposure.	Served between 18 months and 42 years. 98.2% white British, 88.6% male. 33.4% were exposed to morally injurious event. 27.9% exposed to non-morally injurious trauma. 15.2% mixed event and 24.5% reported no exposure to a challenging event. Veterans who experienced morally injurious event were significantly more likely to meet case for PTSD, anxiety, and suicidal ideation.
Brewin et al, 2021	Mixed Methods	114 veterans with PTSD, 39 veterans with a physical disability	Veterans in receipt of a war pension recognising a PTSD diagnosis or physical disability due to service. On average veterans joined at 18 years old and served for 8.5 years. Major conflicts of NI, Persian Gulf, Bosnia. War-zone stress assessed with Deployment Risk and Resilience inventory. Conducted interviews.	Having a PTSD diagnosis and reporting a negative change in perception of the world is significantly related to predicting suicidal thoughts, plans or attempts. Not related to trauma exposure but rather to post-traumatic symptoms. In the interviews, perceptions of disillusionment about human nature and the rejection of civilian life were associated with suicidal thoughts, plans or attempts. Expected to be associated with negative self-views but found to be stronger in regard to alienation from civilian life.

Bergman et al, 2022	Quantitative	78,000 veterans and 253,000 demographically matched civilians on age gender, and socioeconomic status.	Data taken from the Scottish Veterans Health Study. Demographic data obtained from electronic NHS registration records were linked at an individual level to death certificates to provide information on deaths by cause, and to routine hospital admissions data and psychiatric inpatient records for information on any antecedent mental health diagnoses. Survival analysis to examine risk of suicide in veterans compared to civilians.	Over the period of follow-up, there were 388 (0.5%) suicides among veterans (6.6% of all veteran deaths), and 1531 (0.6%) suicides in civilians (7.8% of all civilian deaths). However, direct comparison is misleading because of generally shorter follow-up in the veterans. Cox proportional hazard analysis, taking account of length of follow-up, demonstrated that there was no difference in risk of suicide overall between veterans and civilians.
Kapur et al, 2008	Quantitative	Anyone who had left any of the three branches of the Armed Forces between 1st April 1996 and 31st December 2005. 233,803 individuals were included. This represented 98% of those who were discharged.	The database of those who had left the Armed Forces was linked with the database of the National Confidential Enquiry into suicide. This was compared with suicide rates of the general population.	224 individuals were found to have died by suicide after leaving the Armed Forces. Their median age was 22 years (19–29 years) and they were predominantly male (215 [96%]). Hanging or strangulation (99 cases [44%]) and self-poisoning (47 cases [21%]) were the most common methods of suicide. Deaths involving firearms occurred in only five cases (2%). The median time to death after leaving the services was 31 months (16–57 months). Although overall the rate of suicide was not greater than that in the general population, the risk of suicide in the two youngest age groups was approximately two to three times higher than in same age groups in the general population. For males aged 30–49 years the age-specific mortality ratios suggested that the risk of suicide was lower than for the same age groups in the general population.
Ministry of Defence, 2016	Quantitative	53,409 UK Armed Forces personnel that deployed to the 1990/91 Gulf Conflict. Compared with 53,143 UK Armed Forces personnel of similar age, gender, Service and rank who were in Service on 1st January 1991 but did not deploy to the Gulf.	Comparison of the mortality rates of 53,409 UK Armed Forces personnel that deployed to the 1990/91 Gulf Conflict to those of a cohort who did not deploy. The statistics also compare the mortality rates of Gulf veterans and the comparison group to rates observed in the UK general population over the same time period in order to place the mortality rates for the Gulf and comparison cohorts in context.	There was no statistically significant difference between the rates of suicide for the Gulf and age-adjusted comparison cohorts showing, across the whole time period there was no effect of deployment to Gulf 1 in terms of mortality rates for suicides. For both cohorts across the majority of the past 25 years, they had a statistically decreased risk of suicide when compared to the UK general population.

Rodway et al, 2022	Quantitative	458,048 veterans who had served as regulars and had left the British Armed Forces between 1st January 1996 and 31st December 2018.	A retrospective cohort study of personnel who left the UK Armed Forces, the main outcome was death by suicide after leaving service. The national databases of discharged British Armed Forces personnel were linked with the National database of deaths by suicide. Comparisons were made with the general population and serving personnel.	1,086 (0.2%) died by suicide after leaving. Median age at death was 32 years (26-42 years). The majority (1,046, 96%) were male. Around 19% (n=203) of the 1,086 veterans who died by suicide were aged under 25 years, 63% (n=682) were aged between 25-44 years, and 19% (n=201) were 45 years or older. The most common method of suicide was hanging or strangulation (n=672, 62%), followed by self-poisoning (n=155, 14%). Firearm deaths were rare (n=27, 2%). The risk of suicide for male veterans was similar to the risk of suicide in the age-matched general population. If anything, the SMR and 95% CIs suggested the veterans' suicide rate was very slightly (but statistically significantly) lower than the rate in the general population (SMR [95% CI] 94 [88-99]). However, the risk of suicide for the two youngest veteran age groups (16-19 and 20-24 years) was approximately two to three times higher than their counterparts in the general population. An increase in suicide risk was associated with male sex, being discharged from the UKAF between the ages of 16-34 years, being untrained on discharge, having served for less than 10 years, and receiving an administrative, disciplinary, or medical discharge.
Bergman et al, 2019	Quantitative	56,206 veterans	Retrospective, 30-year cohort study of 56,206 veterans. Examined the association of previous self-harm and suicide. Data retrieved from Scottish Health Records.	Examined data on 266 vets. Fifty (18%) had a previous history of self-harm. The median time elapsed between the first record and fatal episode was two years. The mean age of veterans ending their life with a previous history of self-harm was 45.5 years. Only 9% of veterans who died as a result of suicide aged under 30 had a previous history of self-harm. Whilst for veterans aged 50 and over at suicide, the figure was 26%.
Harden & Murphy, 2018	Quantitative	144 linked to suicidal ideation. 259 no linkage to suicidal ideation.	Cross-sectional study, data drawn from veteran's engaging in MH treatment (provided by Combat Stress). Questionnaires sent to veterans. The provided data was then linked to risk assessment extracted from clinical records.	Age and ESL are significantly associated with suicidal ideation. Veterans aged between 35 and 44, 45 and 54 were more likely to report suicidal ideation (SI). ESL was also more likely to have data related to SI. Unemployed veterans are at increased risk of SI compared to those employed, as well as the time veterans took to seek help and SI (>5 years to seek help at a decreased risk). Veterans with high pre-adversity scores are at a higher risk of SI.
Ministry of Defence, 2014	Quantitative	1,478 veteran deaths. Of those, 1,171 (79%) were the result of disease related causes and 266 (18%) were the result of external causes of injury.	Summary statistics on the causes of deaths that occurred among the UK Armed Forces veterans of the Falklands war between 14 June 1982 and 31 December 2013. Stats are based on deaths in this time period that were reported to the MOD by 1 February 2014.	As of 31st December 2013, there were 1,478 deaths among the Falklands veterans. Of these, 1,171 (79%) were the result of disease-related causes, and 266 (18%) were the result of external causes of injury. The largest group of deaths due to external causes was due to intentional Self-Harm and events of undetermined intent (suicides and open verdict deaths) with 101 deaths (7% of all deaths). Of the 101 suicide or open verdict deaths, 13 occurred in-Service. For each year between 1982 and 2013 there have been fewer than 10 deaths with a coroner confirmed suicide or open verdict. For the entire period, the risk of dying as a result of suicide for the Falklands veterans are no different to the UK general population.

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RESEARCH TEAM

PROFESSOR ALAN FINNEGAN PHD RN FRCN FRSA CF FAAN

Director of the Centre and Professor of Nursing and Military Mental Health. Alan is a Registered Nurse (Adult) and Registered Nurse (Mental Health) who served in the British Army from 1987 to 2016. Alan was the Principal Investigator involved in all aspects of the evaluation. Alan designed the evaluation methodology including the study questionnaires and interview schedule.

KATE SALEM BSC MRES MBPSS

Kate works at the Centre as a Researcher, having previously, worked for the Ministry of Defence. Kate is also undertaking her PhD which uses mixed-methods to explore mental health and help-seeking in military families. In this evaluation, Kate led on the qualitative analysis and qualitative analysis. Kate is also the wife of an Army veteran.

NATASHA GREEN BSC MSC PHD

Natasha joined the Centre in March 2021. She was awarded her PhD from Queen's University Belfast and has research experience in qualitative and quantitative methodologies. Natasha is connected to the Armed Forces Community, with both of her parents previously serving in the British Army. Natasha contributed to the analysis of the report.

LOTTIE AINSWORTH-MOORE

Lottie joined the Centre in January 2019. She is a military spouse of a currently serving Officer and has previously worked for military charities. She is working on various evaluations with the Armed Forces Covenant Fund Trust and the NHS. In this evaluation, Lottie was the Project Administrator providing grant holder support and was responsible for constructing the online questionnaires.

LAUREN WEST

Lauren works as an Administration Assistant and PA to Professor Finnegan at the Centre. Lauren assists in several military forums, including Secretary for the Cheshire Armed Forces Covenant Partnership Committee, and oversees the administration of all veteran-related projects within the Centre. In this project, Lauren contributed to the questionnaire design and administrative support.