CHAPTER 34

THE MANAGEMENT OF OPERATIONAL STRESS FOR MEMBERS OF THE NAVAL SERVICE AND ROYAL FLEET AUXILIARY (RFA)

CONTENTS

ANNEXES

CHAPTER 34

THE MANAGEMENT OF OPERATIONAL STRESS FOR MEMBERS OF THE NAVAL SERVICE AND ROYAL FLEET AUXILIARY (RFA)

3401. Introduction

In late 2007, the Second Sea Lord approved a policy to govern the management of post-operational stress for members of the Naval Service and the Royal Fleet Auxiliary. This Article details the policy and procedures for delivering Operational Stress Management (OSM) which aims to ensure that Naval Personnel returning from operations receive appropriate and coherent operational stress management, aiming for those with symptoms of operational stress to minimise impact and encouraging early return to well-being.

3402. Background

a. The Naval Service OSM policy recognises the many and various ways of serving on operations, and the increasing role that its people play in support of operations. The Naval Service has not only a military and moral imperative, but also a legal duty to protect the health, safety and welfare of all of its employees, military and civilian, from the risks arising from Operational Stress. For the Naval Service, as with the other Services, the psychological welfare of its personnel is core business and a critically important aspect of the enduring obligation to its people which must be considered before, during and after operations.

b. Operational stress is part of the continuum of occupational stress for which further guidance is contained in the Armed Forces Mental Health Plan dated 2017 and JSP 950 Part 1 Leaflet 2-7-1. MOD's operational stress management policy[1] provides the framework for the development of single Service policies on operational stress management based on six steps beginning with recruitment and ending with discharge[2]. The principles and requirement underpinning the need for an OSM policy is outlined at Annex 34A.

3403. Applicability

OSM applies to all members of the Naval Service and the Royal Fleet Auxiliary (the precise mechanics of delivery to the latter are promulgated separately by DACOS RFA Personnel). The policy recognises that, in addition to RN/RM deployment patterns, Naval personnel may also deploy on operations as Individual Augmentees (IA) or as members of Joint, Army or RAF formed units (FU). In addition, they may routinely visit operational theatres in the course of their duties whilst working with other MOD organisations or Government departments; in these instances the delivery of OSM is to be consistent with the principles and procedures outlined in this policy.

[1] The Overarching Review of Stress Management (OROSM), Phase 1 of which reported to the Service Personnel Executive Group (SPEG) (Paper 19/04 dated 29 Sep 04). Phase 2, the Training and Communication Strategy, was published 26 Apr 05 (SPEG 12/05 Overarching Review of Operational Stress Management-Phase 2).

[2] The Six Steps are: 1 - Pre-service entry beliefs and attitudes (countering negative attitudes towards mental ill health in the minds of potential recruits); 2 - In service training and promotion courses for career development (stress management education and training); 3 - Pre-deployment (preparing individuals to recognise the symptoms of stress in themselves and others, how to confront the issues they will face on operational duty and the support mechanisms available); 4 - Operational deployment; 5 - Post operational recovery; and 6 - Following Discharge from the Armed Forces.

3404. Policy Framework

a. OSM policy requires the implementation, delivery and sustainment of a 6-stage support process. The specific guidance and direction for each stage is contained in the appropriate Annex to this Chapter.

b. **Stage 1: Pre- Deployment Training.** See Annex 34B. This stage consists of appropriate briefings, the training of Trauma Risk Management Teams (TRiM Teams) (see Annex 34H) and realistic resilience training. This training takes place within the ship or unit lines and can be augmented by realistic field/training exercises.

c. **Stage 2: Operational Support.** See Annex 34C. In this stage, ships or units will utilise their TRiM Teams, Field Mental Health Teams, other Defence Medical Services and other support agencies as appropriate. Their task is to support personnel in an operational theatre to ensure that they receive commensurate levels of support.

d. **Stage 3: Decompression.** See Annex 34D. Decompression (DcN) routinely involves taking units out of an operational zone to a safe but controlled, neutral environment for a short period of time. The aim is to ease the transition from a high tempo operational situation to a barracks or domestic environment. Decompression is currently recognised as a group activity. These are people who have jointly shared common operational experiences.

(1) However, it has become recognised that a more standardised support is required for IAs. The DcN package is a very effective opportunity for personnel to take stock in a safe environment and commence dealing with the potential issues associated with returning home after a significant deployment. In short, it is an effective facilitator to normalisation.

(2) For seagoing units, DcN will take place in line with established custom and practice during the passage home from the area of operations prior to arrival in the UK. On arrival at their home port, personnel can begin winding down and rehabilitating to a normal, routine, peace-time environment.

e. **Stage 4: Normalisation.** See Annex 34E. 'Normalisation' consists of the actions to be taken on return to the home base and concludes on return from Post Operational Leave (POL) or sea-goers leave (SGL). Prior to proceeding on leave, a series of operation specific activities can be planned and executed. Activities included in this period may be varied, but can include Families Day, medal parades, Unit BBQ's and memorial services. For FUs, the responsibility for normalisation rests with the Commanding Officer and supporting chain of command. For IAs (Regular and Reservist) Career Managers, the RN Mounting Centre and Commanding Officers (donor, in-theatre and receiving) all have an important role to play.

f. **Stage 5: In-Service Support.** See Annex 34F. On return from leave, it is important that the chain of command has the opportunity to normalise and carry out any administrative/logistic tasks, including G1/N1 actions. It also permits the chain of command to carry out interviews (see Appendix 34F-2) with all unit personnel. The Regimental/Divisional Discussion (see Annex 34F Appendix 1) allows individuals to raise any issues that may have arisen during the leave period. The discussion will also touch other subjects such as returning to work, future plans and intentions etc. The 'Discussion' is not to be viewed as part of a 'screening' process but as a reasonable and sensible management action[3] for personnel returning from leave following an operational deployment.

g. **Stage 6: Aftercare.** See Annex 34G. In-Service Support deals with care for the individual for the remainder of their time in the service, whereas 'Aftercare' begins on completion of regular or Reserve Service and is primarily delivered by the NHS.

3405. Personnel Issues and Groupings

The nature and variety of the differing conditions of service coupled to the diversity of military operations render a 'one size fits all' approach impossible. Although, in principle, the same process is to be applied to all, on occasions a bespoke response may need to be applied. A group where this may be required is with Reservists. They, unlike their regular counterparts, do not return from operations to a sustained military environment in which the discussion and airing of issues is encouraged. Once they have returned to their parent unit they may not be well placed to receive support from other colleagues who may have similar experiences. Similarly, IAs may face similar challenges and encounter feelings of isolation when returning to a non-deploying unit. The methodology of how differing groups engage with OSM is detailed below.

a. **Regular Personnel**

(1) **Formed Unit on a Full Tour/Deployment**. This group represents the bulk of deployed personnel. All the elements of OSM are delivered by the normal chain of command.

(2) **Elements of a Formed Unit on a Sustained Roulement**. Groups of personnel who undertake frequent, but often shorter operational tours eg. individual flights from Naval Air Squadrons returning from Operations. These groups may receive a bespoke package from trained in-house OSM Facilitators.

(3) **Individuals in a Formed Unit not Completing a Full Tour.** Individuals who do not complete a full deployment with their ships or units (or members of headquarters or battle staffs) due to being re-assigned, or returned to UK on rotation, for career courses or compassionate leave - should be clearly identified and, once the move is confirmed, their gaining unit engaged to ensure that the wider requirements of OSM are recognised, and in particular that the Stage 4 'the Regimental/Divisional Interview' takes place. Other groups involved in this process will be the Waterfront, RM Rear Parties and in-house OSM Facilitators.

[3] IAW Health & Safety Act 1974 & Leaflet 25 to Annex D, Vol 2, JSP375

(4) **Individual Reinforcements/Augmentees.** Personnel assigned to an operational tour away from their parent unit, subsequently returning to that unit may need additional consideration by the donor and recipient unit. This could consist of going through the DcN process and they should be engaged in a Regimental/Divisional Interview' on their return from POL. Challenges for the gaining units are that the individual being new to the unit the chain of command is not well placed to make before and after deployment comparisons or recognise subsequent mood swings, different behaviour patterns etc. For people in this grouping, additional monitoring may be required.

b. **Reservist Personnel**

(1) For a variety of valid reasons, Reservist personnel have the potential to represent a greater challenge than their Regular counterparts. They can feel isolated and not feel part of the 'team'. Their civian work-mates or family members may not be interested in their experiences or feelings, and the people, with whom they shared their lives over recent months may now feel very far away.

(2) **Reservist Formed Unit.** Although not strictly relevant to the RNR or RMR, a formed unit returning following a full tour/deployment is perhaps the simplest of Reservist groups to cater for. In these instances, all factors of OSM (decompression, normalisation, 'The Regimental/Divisional Interview') are delivered by the normal chain of command. For Reservists who return with a Commando Unit, their dismounting process will normally take place at the Reserves Training & Mounting Centre (RTMC) at Chilwell, near Nottingham.

(3) **Reservist Individual Augmentees (IA).** Reservist IAs may have served in a formed unit, but for a variety of reasons have not completed a full tour. This cohort may encounter a number of emotional challenges.

(4) **Re-Assimilating into Civilian Life.** Reservists may face an additional burden to carry as they attempt to re-assimilate into the home and civilian work environment. The experience of reintegration with their employers and co-workers can be more challenging than that which may be encountered by their Regular counterparts. These could be:

(a) Considering what to say to co-workers - what level of information they can safely impart.

(b) Finding an appropriate person to speak to – who can they trust to hold confidences and provide sound advice.

(c) Coming home to no job – being rejected in their subsequent job search can intensify the emotional challenges that they have to deal with.

(5) **Returning To Former Employment.** When Reservists are de-mobilised and about to return to their former regular civilian employment, consideration should be given to providing support and advice[4] to the employer who will need to understand the potential after-effects that an operational deployment may generate within an individual. Support for employers can be supplied by the NCHQ OSM Cell who can provide booklets and/or practical advice.

c. **Other Service Personnel.** A number of other categories of returning personnel that could require special consideration are:

(1) AEROMED.

(2) Long-term compassionate cases.

(3) Disciplinary cases.

(4) Other unplanned short-notice returns to UK.

In working with the groups listed at Stage 3 - Decompression and Stage 4 - Normalisation, the protocols outlined for dealing with IAs should be followed for 'Reservists' and 'Other Service Personnel'. However, these measures are not exhaustic and consideration should be given to introducing other supporting measures for returning troops..

d. **Families.** Once an individual returns from the operational environment, close contact with the unit developed on operations may diminish or cease entirely. It is the individual's family that is likely to notice any changes and therefore vital that family members (wives, spouses, partners and parents) are engaged with the OSM process. In addition, Royal Navy forum provides a wide range of advice for families who wish to become better informed regarding potential issues that may be encountered when an individual returns from deployment.

3406. Tracking Personnel through the OSM Process

a. Annex 34F Appendix 3 is a simple proforma which can be reproduced locally for all personnel deployed on operations5. The form is designed to assist in the tracking and recording of the various stages of the OSM process. It is not designed to contain clinical information but as a management tool to verify the receipt of OSM and assist the Command in assessing the risk or likelihood of subsequent trauma. Given sufficient attention they should help ensure that those who may be considered to be at higher risk are proactively monitored and supported by their superiors.

[4] Rights and responsibilities for reservists and employers (www.link).

[4] COs of deployed formed units/sub-units are to raise records on those under their command during the latter stages of the deployment. For FUs use App3 to Annex 34F, for IAs, use App4 to Annex 34G. The RNMC will brief OSM to IAs and ensure that they engage and undertstand the regimental/Divisional process on their return to unit.

b. JPA provides a means to record basic details (date, place etc.) of key Operational Stress Management (OSM) interventions for all Service Personnel deployed on operations6. JPA is only to be used to record OSM interventions for Naval Service personnel deploying on operations for periods of three months or more. Procedures are to be established in formed units which facilitate the accurate capture, reporting to unit HR staffs and recording by them of OSM information. The RN-MC is responsible for initiating JPA OSM records for Individual Augmentees and is to conduct a check, during their attendance at the Dismounting Course, to ensure that OSM records (both JPA and the manuscript record at Annex 34G) have been compiled for returning IAs. JPA records OSM interventions for each deployment and does not permit a new OSM record to be initiated until the 'The Regimental/Divisional Interview' (see Annex 34F Appendix 1) for an 'open' deployment has been recorded and the record closed. Recording of OSM events on JPA does not negate the requirement at Para 3406 sub para a. to complete manuscript records of Operational Stress Management received.

3407. OSM Policy Summary

a. Commanding Officers, whether commanding on operations or the recipients of personnel recently returned from operations, have a vital role to play in implementing RN OSM policy; likewise the chain of command has a responsibility to ensure that the OSM needs of Commanding Officers are not overlooked. The policy and procedures have been made as straightforward and unambiguous as possible in order that OSM can be considered prior to deployment7, rather than becoming an afterthought, and the process of dealing with Naval personnel following operations becomes second nature. The key to success lies within the Divisional and Troop systems and, for the increasing number of Individual Augmentees, requires active engagement by Career Managers, RNMC and receiving Commanding Officers. Successful OSM requires the Command at all levels to be actively watchful of their people and ensure that individuals and families receive appropriate information about reactions to stress (what is normal or natural and what is not), what to do initially (peer support) and what to do if these reactions do not settle (where to seek support and how to access it).

b. OSM fulfils a crucial part of the Royal Navy's obligation as an employer in respect of health and safety but it is no substitute for good leadership which, if exercised before and during operations, will help to minimise the risk that post operational stress will affect its people. OSM is designed to ensure that members of the Naval Service and RFA undergo a coherent post operational stress package, commencing during the final phase of their deployment and extending throughout the remainder of their service and into retirement. It is mandatory that the process is followed but it is necessarily risk-based and made deliberately flexible to enable the chain of command to tailor the policy to the circumstances of individuals, the nature of the operation and the stressors to which they have been exposed.

[6] More detailed information/desk instructions are contained in the JPA Business Process Guide Move and Track – Operational Stress Management.
[7] Commanding Officers are encouraged to include details of the OSM process in the 'Returning Home' section of any ship/unit deployment guide produced ahead of an operational deployment.

3408. Support to Service Witnesses at a Coroner's Inquest

a. HM Coroners within England, Wales and Northern Ireland investigate all unnatural deaths falling within their jurisdiction. In the case of UK citizens this requirement extends to deaths that occur abroad when the deceased has been repatriated to England, Wales or Northern Ireland. This includes members of the Armed Forces regardless of whether or not the death occurred on operations. The Coroner may decide to hold a formal inquest and, depending on the circumstances of the case, will such call such witnesses as he or she sees fit. These may be expert witnesses, who can deal with the technical aspects of the death, or they can be witnesses to fact – the people who saw what happened. This latter group can find the process of giving testimony in open court a very difficult experience as it requires the witness to relive in some detail what will inevitably have been a very traumatic experience.

b. In order to support and assist these witnesses, NCHQ will provide Coroner's Witness Support Officers (CWSO) drawn from uniformed personnel employed in the Operational Stress Management (OSM) Cell. Their role is to provide support to all Naval Service witnesses before, during and after the inquest for the potential emotional and psychological effects of the experience of giving evidence. The CWSO is to ensure that the witness is fully briefed on the procedure for the hearing and the potential aftermath of the experience of giving evidence. The CWSO is to ensure that the witness is fully briefed on the procedure for the hearing and the potential aftermath of the experience of giving evidence. They will assist the NCHQ Defence Inquest Unit (DIU) in preparation for the hearing, and then attend in person to offer direct support throughout the hearing. The CWSO is not an official representative of the Service or of the Department to the court and is not to coach a witness on the content or nature of their evidence.

c. When requested by the Visiting Officer or the DIU representative, the CWSO may give support to bereaved Service families or to other witnesses. In certain circumstances, the CWSO may be augmented by members of the Divisional and Regimental Support Team.

ANNEX 34A

OSM - PRINCIPLES AND REQUIREMENT

1. Occupational Workplace Stress

The MOD definition includes the concept that stress occurs when pressures on an individual accumulate to such an extent that he or she can no longer cope. The following has been endorsed as a definition of operational stress that recognises that any pressure, challenge or threat is a potential stressor on the individual and acknowledges that all people are subject to it:

"An individual or group reaction to stressors relating to the operational context, which, if not managed, may result in impaired performance and possible effects on health."

2. OSM Policy

A policy, incorporating a framework in which OSM is to be delivered, is necessary to ensure consistency of application (formalised procedure) and raise overall awareness of operations-related stress management which, within the MOD 6 step[1] overarching stress management policy (see footnote 3), commences at the end of Stage 4 (Operational Deployment) and continues through post-operational recovery to eventual discharge from the Service. OSM policy needs to reinforce the message that:

a. Stress reactions are a natural consequence of military operations and all individuals, regardless of rank, age or gender, are susceptible; and

b. Most stress reactions are entirely normal and manageable, particularly with the correct degree of support from superiors, peers and families.

3. Command

For many Naval personnel, participation in operations does not result in significant after-effects, indeed for many it is a positive experience; however there are those for whom such experiences are detrimental due to exposure to acute traumatic pressure and resultant post-traumatic distress. Commanders at all levels must make every effort to limit the potential for those under their command suffering psychological problems as the result of operations. The onus for identifying vulnerable individuals rests with the chain of command whose familiarity with their personnel makes them best placed to identify the early signs of stress.

[1] The 6 Steps are: 1 - Pre-service entry beliefs and attitudes (countering negative attitudes towards mental ill health in the minds of potential recruits); 2 - In service training and promotion courses for career development (stress management education and training); 3 - Pre-deployment (preparing individuals to recognise the symptoms of stress in themselves and others, how to confront the issues they will face on operational duty and the support mechanisms available; 4 - Operational Deployment; 5 – Post-operational Recovery; and 6 - Following discharge from the Armed Forces.

4. Successful OSM

a. The key to successful OSM lies in awareness; the individual, families, colleagues and the chain of command all need to be alert to the signs of stress and unhealthy maladaptive symptoms, so that early intervention can lessen the risk of subsequent problems (which can include clinical disorders, disciplinary and social problems and poor work performance). OSM procedures are generic for all theatres however; the Command must have the flexibility to adapt them for the needs of any particular operation. Wherever possible, the aim is to deliver the same level of support to all personnel whilst recognising their differing circumstances and allowing for certain elements to be discretionary depending on the level and intensity of operational activity and resultant exposure to stressors. Providing Commanding Officers and all those in positions of authority over Naval personnel are given a framework of action to be taken and the necessary support, adherence should deliver effective personal support to all individuals returning from operational deployments.

b. Strong and effective leadership, good communication and training are also fundamental to the prevention and management of operational stress and this is why OSM is primarily an executive and not a medical responsibility. When implementing this policy it is vital that an expectation of symptoms of stress or disability or a culture of disability is not instilled in individuals. The briefing of individuals prior to deployment2 and on return, either individually or as part of a group, is of fundamental importance3, as is open discussion on issues arising from operational experiences and dealing with any issues arising in a timely and professional manner. Commanding Officers are to refer to or liaise with medical authorities at an early stage if there is any concern about an individual's well-being. Medical intervention is always required when symptoms are prolonged or severe doubt exists over the mental health of an individual.

c. Families, and where applicable civilian employers, must be fully engaged throughout the OSM process. The Royal Navy's corporate responsibility for the psychological welfare of its people in the lead up to, during and after any operational deployment is relatively easy to discharge and monitor in the close confines of a 24 hour operational environment but once an individual returns from operations close contact will inevitably diminish and it will often be family members who will be the first to notice changes. This can be particularly relevant when an individual returns from operations and is re-assigned to another unit to the one he or she deployed with or from.

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[2] Knowing exactly when and where they are going, what they are likely to be doing, the perceived threat level, the environmental and cultural conditions to be encountered and the measures in place to support them and their families' welfare will positively affect an individual's outlook prior to deployment.

[3] And is already established policy for Medical Staffs in accordance with Surgeon General's Policy Letter (SGPL) 03/06 issued 20 Jan 06 *"The Prevention and Management of Traumatic Stress Related Disorders in Armed Forces Personnel Deployed on Operations"*

ANNEX 34B

OSM STAGE 1 - PRE-DEPLOYMENT TRAINING

1. Training

Training is implemented when a unit or an individual is preparing for an operational deployment[1] All Pre- Operational preparation that provides realistic training (specified to the operation, likely tasks and hazards), builds cohesion and trust in the leadership, is good for stress management and resilience.

2. TRiM

The current stress management tool is Trauma Risk Management (TRiM), which has been developed in UK Armed Forces and has been used over many years. Level 4 (TRiM) training can provide sub-units with a pool of TRiM practitioners and team leaders. In-house continuation training must be delivered to all members of the deploying unit by its own TRiM trained personnel, supported by the NCHQ TRiM Team. TRiM training course dates and locations can be accessed by typing 'T' for TRiM in the Royal Navy A to Z Intranet Page or by contacting Mil: 9380 28021 or Civ: 02392 573021 or email: NAVYNPS-PEOPLESPTOSMMAILBOX@mod.gov.uk

3. OSM Briefing

Prior to deployment, all personnel should receive a Pre-Deployment OSM Brief. The briefing should be delivered by a TRiM Manager or TRiM Team Leader[2].

4. Augmentees and Reservists

Care must be taken to ensure that all Individual Augmentees (IAs) and Reservists receive Pre-Deployment training and that their families receive the same levels of support. Global (RN) Individual Pre-Deployment Training is delivered by the RN Pre-Deployment Training and Mounting Centre[3].

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[1] [1] And is already established policy for Medical Staffs in accordance with JSP 950: Medical Policy - Volume 2: Clinical Policy - Chapter 7: Mental Health - Part 1 Lft 2-7-1 (v1.1 Jul 10) Mental Health and Wellbeing Briefing Before During and After Deployment.

[2] TRiM Managers are normally Executive Warrant Officers (EWO) or Regimental Sergeant Majors (RSM) who have undertaken a training course covering Management of OSM & TRiM.

[3] DIN 2017DIN07-074: Global (RN) Individual Pre-Deployment Training OS [Supersedes DIN 2016DIN07-129].

ANNEX 34C

OSM STAGE 2 - OPERATIONAL SUPPORT DURING DEPLOYMENT

1. Operational Deployment Support

a. Stage 2 of the framework is the management of stress on operations. This is primarily achieved through TRiM, supported by the Field Mental Health Teams (FMHT) and other trained members of the Defence Medical Services. TRiM Teams will have a better understanding of potential mental health issues and therefore be able to offer peer support and where necessary sign post individuals to the next tier of assistance as required. TRiM is not a therapy, but the practice of allowing individuals to talk through the incident followed by the application of tried & tested coping mechanisms, means that TRiM has therapeutic benefit. TRiM Teams are embedded within all deployed units or ships.

b. Chaplains and Padres offer another route to identifying those in need of help and should also receive additional mental health training. Families may need greater support during periods of high operational tempo. This in turn can place them at greater risk from stress related issues. In these periods, the provision of additional information for GPs, schools and other welfare providers that support Service families may be required in consultation with the Naval Families Welfare Service.

ANNEX 34D

OSM STAGE 3 - PRE-EXIT PACKAGE/DECOMPRESSION

1. Introduction

All members of the Naval Service (NS)[1] deploying on operations[2], whether part of a formed unit or as an Individual Augmentee (IA), are required to undertake OSM training and preparation in accordance with BRd 3(1) Chapter 34. On return from operations, deployed personnel may require a period of decompression or aftercare as part of the POSM process. At all stages of OSM, the OSM JPA tool is to be utilised to record all aspects of pre and post deployment briefs, support, signposting, etc. Current decompression[3] policy was based on the Op TELIC/HERRICK campaigns and, following review by PJHQ, is no longer valid. Whilst decompression remains a valid tool and a vital component of POSM, it has been assessed that there are currently no operations that expose personnel to the risk and rigour that require Third Location Decompression (TLD)[4,5]. For operations that expose personnel to the risk and rigour that may be associated with normal military activities, a 'Pre-Exit' package has been introduced to replace TLD to encourage a period of reflection and to set the conditions for normalisation.

2. Operational Aftercare

Operational aftercare consists of the vital components of the tri-Service OSM strategy. Whilst the implementation of POSM is a single Service responsibility, for operations that fall under Commander Joint Operations (CJO) command, PJHQ has responsibility for the immediate POSM activity.

3. The POSM Process

The POSM process was established in order to provide a staged support mechanism for personnel within the operational cycle[6]. Those operational deployments which are not exposed to high intensity combat engagement or significant compressing factors do not require TLD. The primary objective post deployment is to introduce a period of normalisation and to re-connect individuals with their Parent Unit and family. Delaying personnel from returning home, where there is no requirement, adversely affects morale.

4. The aim of the Pre-Exit Package

The aim of the Pre-Exit Package is to provide a level of care and enable a period of reflection for personnel on deployments which are assessed as not requiring TLD. It will be delivered in the Operational Theatre in order to assist with transition to the normalisation process provided by the Front Line Commands (FLCs).

a. The Pre-Exit Package is a fundamental part of the POSM process that complements the existing Naval Service POSM policy and procedures within BRd 3(1) Chapter 34.

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[1] The delivery of OSM to Royal Fleet Auxiliary personnel is promulgated by DACOS RFA Personnel.
[2] Operations refer to all operations for which CJO has OPCOM of the unit.
[3] De-compression was delivered, primarily, to personnel returning from land operations at Camp Bloodhound in Cyprus; this is known as Third Location Decompression (TLD).
[4] This will be kept under constant review by PJHQ.
[5] TLD does not include ship/submarine port visits.
[6] Guidelines are set out in JSP 375 P2 Vol 1 Ch 17 – Stress in the workplace.

b. Whilst the Pre-Exit package is mandated for all personnel deployed on CJO operations, it is a useful tool and should be considered by all commanders at the end of a deployment/tasking.

c. The package is designed as low level generic sign posting; it does not constitute medical or professional support. The package is to be delivered in theatre prior to any individual's departure at the end of their deployment; it is to be delivered by the Executive/J1/RNRMW by a minimum rank of OR6.

d. Although the individual delivering the brief is to be confident with the material, there is no requirement to have undertaken any additional training such as Trauma Risk Management (TRiM). In extremis, such as for small austere operations with a limited number of personnel, the package can be self-administered with PJHQ J1 approval. The full package is designed to be delivered in a maximum of 40 minutes.

5. Pre-Exit Package

The Pre-Exit Package is to be delivered in theatre within the final week prior to departure; the aim is to encourage a period of reflection. The package consists of the following:

a. **Going Home DVD - 15 mins.** The Going Home DVD explores the pressures involved with returning home and explains the POSM process, signposts mental health advice, and the additional avenues of access available to Service Personnel when they return home.

b. **Driving DVD - 5 mins**. In the Driving DVD the potential hazards of driving in UK on returning home are highlighted.

c. **Pre-Exit Brief – 20 mins.** The Pre-Exit Brief is an opportunity for the Commander or J1/Welfare Staff to discuss various aspects of returning home and mental health issues[7].

d. **Pre-Exit Hand-out.** The Pre-Exit Brief is followed up with a signposting hand-out for personnel to review and refer back to.

e. **Individual Checklist.** The individual checklist is to be signed by the individual and unit Executive (see Appendix 1 to Annex 34D).

6. Records

The individual's JPA OSM record is to be updated to show receipt of the Pre-Exit Brief[8]. Where JPA is not available, a hard copy of the checklist is to be kept until JPA can be updated. For IAs returning to their original unit, a copy of the signed checklist (Appendix 1 to Annex 34D) is to be given to the individual and presented to the unit HR Clerk/UPO on return to enable the JPA OSM record to be updated.

[7] Each commander will be issued with a slide pack and notes by PJHQ.
[8] JPA - Stage 2 - Deployment - Coming Home Brief as per the JPA Business Process Guide - Operational Stress Management (OSM).

7. Eligibility

To allow for routine visits to operational theatres, only personnel who have been deployed for more than 31 consecutive days will be required to undertake the Pre-Exit Package. Those who have deployed for less than 31 days, however, may request to conduct the package, especially if they have been exposed to a significant traumatic event.

8. Conclusion

The implementation of the Pre-Exit Package and delivery by the deployed Commander will enable effective and timely management of individuals who have been exposed to a stressful or traumatic event or who may be vulnerable to developing a stress related condition. It is critical, not only to sustain the welfare of personnel throughout deployment, but also to ensure that they receive the correct level of support and signposting through normalisation when they return home. In all circumstances, individuals who depart an operational theatre after 31 consecutive days or more will require the Pre-Exit Package. Whilst the Pre-Exit Briefing Package is mandatory for those personnel engage on PJHQ Operations as part of the OSM process, Commanders undertaking on Fleet operations/standing commitments may wish to utilise elements of the Pre-Exit Brief prior to return from deployment; an OSM JPA record will not be required in these cases. Further information regarding the Pre-Exit Package can be found on the TRiM intranet site or by contacting the team on 9380 28021/28046.

APPENDIX 1 TO ANNEX 34D

PRE-EXIT PACKAGE INDIVIDUAL CHECKLIST

Name:	
Rank:	
Service Number:	
Op Name:	
Op Location:	
Responsible Unit J1:	
Arrival Date:	
Departure Date:	
TRiM Intervention (Y/N/NA)*	
Coming Home DVD - Date:	
Driving DVD - Date:	
Pre-Exit Brief - Date:	
Pre-Exit Hand-out - Date:	

	Individual	**Chain of Command/J1 Staff (min OR6)**
Signature:		
Name:		
Rank:		

* Not mandated. It is an individual's decision to share and record a TRiM event; doing so will enable better support from the parent unit.

ANNEX 34E

OSM STAGE 4 - NORMALISATION

1. The Normalisation stage commences on return to the home base and concludes on completion of post-operational leave (POL). POL, in whatever form it is granted (POL or Sea goer's Leave (SGL) plus any Annual Leave (AL) accrued) is not to be reduced or modified in any form unless exceptions have been approved in advance by the chain of command.

2. This stage of OSM will need to be tailored for personnel serving in seagoing units, personnel returning as part of formed units from operations ashore, Individual Reinforcements and Augmentees and early or unexpected/unplanned departures from theatre. Experience suggests that virtually all personnel returning from operational deployments, along with their families, will encounter at least a little uneasiness whilst they readjust to their normal environment.

3. Shore-based units returning to their home bases from operations are normally to conduct a period of 'Normalisation' prior to POL being granted[1]. The precise duration of the Normalisation period is at the CO's discretion but it must be long enough to permit non-operational activity and reintegration of all personnel. COs may extend the period following consultation with the chain of command. For personnel returning early from operations there must be a rolling normalisation programme organised by the unit rear party in order to permit individuals to undergo this stage of the OSM process.

4. Seagoing personnel are likely to have had longer to decompress and the Normalisation period will not normally require a period 'on board' in UK prior to leave being granted. Advance leave parties returning on board for duty on completion of advanced leave will, however, require special consideration to ensure their OSM needs have been met and to achieve a seamless reintegration with the ship and its routines.

5. Whenever possible, Commanding Officers are to ensure that facilities and support remain available within the ship/unit for the duration of post operational leave period.

6. All Naval Service Personnel (Regulars and Reservists) deploying as Individual Augmentees (IAs) are mandated to mount and dismount through the Royal Navy Mounting Centre (RNMC) at HMS NELSON[2]. On completion of the Dismount Course personnel proceed on POL. On returning to their Parent Unit, during their first week in work, the Regimental/Divisional Interview (Annex 34F) is to be carried out. The completed retained record Appendix 3 to Annex 34F will be returned to the RNMC for audit purposes. RNMC captures all Naval personnel returning from operational theatres to ensure that all those requiring it are tracked for both OSM JPA audit purposes and actively engage with the Dismounting process to ensure that they are not suffering from stress resulting from their deployment.

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[1] It is entirely acceptable, at the Commanding Officer's discretion, for night or weekend leave to be granted on the day of return to the UK prior to the period spent 'in barracks'. Naval Service Personnel serving as augmentees in units under Army or RAF Full Command remain under command of the CO of that unit until completion of POL and subsequent re-assignment. The CO is to determine to what extent their Naval augmentees will participate in the immediate normalisation plans for the unit.

[2] DIN 2017DIN07-074: Global (RN) Individual Pre-Deployment Training OS [Supersedes DIN 2016DIN07-129].

7. RNR and RMR personnel are mandated to return to their parent unit during their last week of mobilised service. The unit is to provide aftercare support as necessary, augmenting the briefings and guidance issued at RTMC or RNMC.

8. Individuals returning early from operations in advance of the main party, AEROMED and other personnel returning unplanned from theatre, present the greatest challenge for Stage 2. Such personnel will need to be treated on a case-by-case basis. Family support is especially important in some instances and Commanding Officers (Career Managers for personnel no longer under command) are to ensure that plans address OSM needs. For personnel admitted to hospital in UK, RCDM will ensure that the mandatory requirements of Stage 4 are met and that further support is provided.

9. Whilst in the 'Normalisation' phase, details of support agencies are provided at Appendix 1 as an aide memoire for those who may be called upon to provide support and advice (Appendix 1 to Annex 34E Support Agencies (see also BRd 3(1) Chapter 24 (Welfare) and Chapter 32 (Service Funds, Charities and Associated Organisations).

APPENDIX 1 TO ANNEX 34E

SUPPORT AGENCIES

1. If an individual finds that he or she is having difficulty in re-adjusting post operations, help is available.

2. In the first instance, serving personnel should seek the advice of a suitable superior, a unit TRiM Practitioner, Divisional Officer, Troop Commander, Medical Officer or Chaplain who will be able to offer advice and refer individuals for further treatment or professional help if necessary. Those who have been discharged from the Service will, in the first instance, need to seek the advice of their GP who will also be able to advise or refer an individual for further treatment or help.

3. The following organisations are able to offer support or advice whatever an individual's circumstances:

a. **Royal Navy Royal Marines Welfare.** Providing community and personal support to regular RN, RM personnel, RNR and RMR and their families, details of the Welfare Information Support team and contact details are available through the Royal Navy Website (https://www.royalnavy.mod.uk/welfare/find-help) or by calling Royal Navy Royal Marines Welfare on +44 (0)2392 72 87 77 (0800-1600 Mon-Thu and 0830-1600 Fri, with the exception of recognised public holidays).

Or if individuals prefer to use Social Media they may post on their Facebook page, Tweet @RNRMWelfare #RNRMW, or join the Royal Navy forum.

b. **SSAFA Forces Help.** The Soldiers, Sailors, Airmen and Families Association (SSAFA) Forcesline is a free and confidential telephone helpline and email service that provides support for serving (regulars and reserves) and ex-service men and women from the Armed Forces and for their families. As an independent charity, SSAFA is not part of the military chain of command.

SSAFA Forces Help, 19 Queen Elizabeth Street, London, SE1 2LP.

Call:	0845 1300 975
E-mail:	info@ssafa.org.uk
Website:	www.ssafa.org.uk

Forcesline can be accessed from anywhere in the world. Lines are open 0900–1730 Monday to Friday.

UK	0800 731 4880
Germany	0800 1827 395
Cyprus	800 91065
Falkland Islands	#6111
Rest of the world	+44 (0)207 463 9292

To call from Operational Theatres: use Paradigm's phone system and dial the appropriate access number then enter *201 at the PIN prompt.

c. **Samaritans.** Samaritans provides confidential non-judgemental support, 24 hours a day for people experiencing feelings of distress or despair.

Call: 116 123 (UK)
116 123 (RoI)
Email: jo@.samaritans.org

Freepost RSRB-KKBY-CYJK
PO Box 9090
STIRLING
FK8 2SA

Website: www.samaritans.org.uk

d. **Veterans UK**

Freephone (UK only): 0808 1914 2 18
Tel. (overseas): +44 1253 866 043
Email: veterans-uk@mod.uk

Website: https://www.gov.uk/government/organisations/veterans-uk

Veterans UK helpline
Veterans UK
Ministry of Defence
Norcross
Thornton Cleveleys
FY5 3WP

Normal Service 0800-1700 Monday to Friday

e. **Combat Stress (Ex-Servicemen's Mental Welfare Society).** If individuals are currently serving, or have served in the UK Armed Forces, they may call the 24-Hour Helpline to talk about mental health.

Head Office: Tyrwhitt House
Oaklawn Road
Leatherhead
Surrey
KT2 0BX

Call: 0800 138 1619
Text: 07537 404 719
E-mail: helpline@combatstress.org.uk
(Standard charges may apply for texts, check with service provider.)

f. **Veterans and Reserves' Mental Health Programme (VRMHP).** The VRMHP (link www) provides mental health assessments for Veterans and Reservists who have concerns about their mental health as a result of Service. The criteria for joining the programme are as follows:

(1) Reservists who have operationally deployed since 1 Jan 03.

or

(2) Available to those who have deployed since 1982 and who suffer mental health challenges as a result of operational deployment, the programme offers a comprehensive mental health assessment by a Consultant Psychiatrist with accompanying guidance on care and treatment for the Veteran's NHS GP and/or local NHS clinical team. Veterans should consult their GP in the first instance in order to be referred to the VRMHP.

In both cases treatment is offered to individuals whose mental health is assessed to have suffered primarily as a result of their operational service.

Freephone helpline: 0800 0326258

Email: dphce-dcmhcol-vrmhp@mod.uk

g. **NHS Transition, Intervention and Liaison (TIL) Veterans Mental Health Service.** NHS TIL Service is a new service for Armed Forces personnel approaching discharge as well as for veterans. The service will help to recognise some of the early signs associated with mental health difficulties and will provide access to a number of interventions, therapeutic treatments for complex problems and psychological trauma and prevent the patient reaching crisis point. It will also help tackle some of the most common mental health and substance misuse problems such as alcoholism, anxiety and depression and join up services across the board, working with local authorities and charities so that the whole of a person's needs and their families are looked after.

For veterans: If individuals are experiencing mental health difficulties, these services can provide a range of treatment and support regardless of when they leave the Armed Forces. This includes recognising the early signs of mental health problems and providing access to early treatment and support, as well as therapeutic treatment for complex mental health difficulties and psychological trauma. Patients are also provided with help, where appropriate, with employment, reduction in alcohol consumption, housing and social support.

Access:

Individuals must be resident in England

Have served in UK Armed Forces for a full day

Be registered with a GP practice in England or be willing to register with one

Be able to provide military service number or other form of acceptable proof of eligibility

h. **NCHQ Operational Stress Team.** The NCHQ Operational Stress Team primarily provides TRiM training for the Naval Service. In addition, the team can supply pre and post Deployment briefings and a wide range of general trauma advice. It also supplies support for Naval Service families and witnesses attending HM Coroners Courts.

Contact Details:

Group Mailbox: NAVYNPS-PEOPLESPTOSMMAILBOX@mod.gov.uk

NAVY NPS-PEOPLESPT Operational Stress Management (TRiM)
HMS TEMERAIRE
Room 140, Burnaby Road
PORTSMOUTH
PO1 2HB

Mil: 9380 28021
Civ: 02392 573021

ANNEX 34F

OSM STAGE 5 - IN-SERVICE SUPPORT

1. The In Service Support stage of OSM underpins psychological resilience and the ability to retain individuals at combat readiness. In-Service Support refers to the period of time after the return from post-operational leave rather than the initial weeks following return from operations. The chain of command is responsible for In-Service Support that continues until the individual (whether Regular or Reserve) retires; it may therefore continue for decades. During their remaining service, there remains a military and moral imperative to protect the health of Naval Personnel. Future service is likely to include further operational deployments and In-Service Support may therefore be concurrent with subsequent post-deployment Decompression or Normalisation.

2. Following the return of individuals from post operational leave, but no later than 12 weeks after the actual return from operations, COs are to ensure that personnel are interviewed by their Divisional Officer, Troop Commander or immediate superior. Commanding Officers (for formed units) and Career Managers (for IAs) are to ensure that where personnel are re-assigned within 12 weeks of returning from operations, a hot handover is conducted with the receiving unit to ensure the interview requirement is met. Guidelines and suggested topics for the post-deployment discussion are at Annex 34F Appendix 1 (Guidelines) and Annex 34F Appendix 2 (Topics). The fact that the discussion has been conducted is to be recorded on the OSM Record (Annex 34F Appendix 3).

3. In addition to the Regimental/Divisional Discussion, there is also a mandatory requirement[1] for FUs and IAs to receive a short Power Point presentation relating to Post Operational Stress Management(POSM). The POSM Brief should be given at the 8 to 12 week point after returning from deployment. The brief should be delivered by a Mental Health Professional or a Trauma Risk Management (TRiM) Manager. In extremis, the brief can be delivered by a TRiM Practitioner. The brief can be downloaded from the RM TRiM Website[2] or copies of a CD containing both the POSM Brief plus Annex 34F (including Appendices) is available from the NCHQ OSM Cell[3].

4. For groups which deploy regularly under a sustained roulement, careful Stage 3 management will be especially crucial to maintaining unit resilience for operations. Commanding Officers will need to determine how their unit's procedures are developed to achieve this intent. Funding from the Fleet Re-balancing Lives[4] initiative may be made available, on request, to support units with any group-centred initiatives aimed specifically at those who deploy frequently to operational theatres.

5. Individuals who have experienced a traumatic event whilst deployed are at most risk of adjustment difficulty; it follows that these personnel, and those considered to be a longer-term risk, should be kept under strict line management review, further follow-up interviews and specialist advice being sought from medical staff as necessary. On referral for treatment, the medical pathway and system of medical categorisation will track those suffering from psychological ill health.

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[1] The requirement to give this brief is stipulated by the Surgeon General and endorsed by NCHQ
[2] The Presentation comes in a power point format and is accompanied by amplifying notes
[3] Copies of the CD can be obtained by contacting Ms Kirstin Knowlson-Clarke on 9380 28021. In addition, she can supply details of relevant unit TRiM Leaders/Practitioners
[4] RNTM01-029/17 Rebalancing Lives – RBL.

APPENDIX 1 TO ANNEX 34F

THE CONDUCT OF THE REGIMENTAL/DIVISIONAL DISCUSSION

1. Aim of the Discussion

The purpose of the Post-Deployment Discussion is to identify and assist in the management of any issues arising from an individual's deployment on operations that, if left unresolved, could adversely affect his or her welfare, wellbeing and functionality. Appendix 2 to Annex 34F provides a suggested format for the discussion. The discussion also serves to:

a. Welcome the individual back and acknowledge their contribution to operations.

b. Gain information regarding their deployment and the nature of their work. [1]

c. Ensure that the individual is aware of the Post-Deployment support mechanisms in place for them.

d. Ensure the individual knows of any new developments in their regular work environment to help their transition back into their core role.

e. Review and, where no concern arises, complete the OSM Record (Appendix 3)

f. You may wish, if appropriate to discuss their aspirations for their future in the Naval Service.

2. Your Role as the Conducting Officer

You are there to provide an important link in the OSM Process.[2] Your background within the Armed Forces, your life experience and, where applicable, former knowledge of the individual will assist you to provide mentoring advice and signpost them to additional support should it be required.

3. Points to Note

It is important that:

a. The discussion is not to screen individuals, but is designed to encourage open and frank communication and discussion.

b. Whilst attendance at the discussion is mandatory, the sharing of personal information is not.

c. If on conclusion of the discussion, the individual has indicated that they are encountering some troubling episodes or if, in the course of the interview, they inform you of changes in their normal behaviour, you should encourage them to make contact with the medical services.

[1] Only relevant where the individual has been reassigned to a new unit prior to the discussion taking place or Conducting Officer did not deploy with the individual.
[2] Command can keep track of individuals requiring OSM stages to be completed via the Unit HR or EWO OBIEE Dashboards

4. Format for the Discussion

a. Stress the confidential nature of the discussion.. The Conducting Officer should reassure the individual that anything they say will be treated with sensitivity and discretion. Should the individual disclose information that gives rise to concern for his or her safety, or that of others then the Conducting Officer may need to break the confidence; should this be necessary the Conducting Officer is to explain the reasons before doing so.

b. Explain that the discussion is not a part of the performance appraisal process.

c. Discuss the nature of their deployment and ask if anything unexpected or stressful occurred. (Conducting Officers should exercise careful judgement and caution when considering whether to include, and in what detail they wish to discuss any potentially stress inducing activities nor the degree of risk and rigour experienced by the individual while on operations.) Point out that extreme or traumatic events experienced on deployment can lead to adverse, but entirely normal reactions. If an individual is encountering difficulties, reassure them that support is available and assist them in accessing the additional assistance that may be required. Sources of aid could come from the immediate chain of command, the unit TRiM Team, the Chaplain or Regimental/Ships Medical Officer. In addition, a number of other organisations, many with Service links, are able to offer independent support and advice (see Appendix 1 to Annex 34E).

d. Conduct the discussion as detailed at Appendix 2 to Annex 34F. The discussion should be conducted in such a way as to encourage an exchange of views. The discussion is structured to examine a number of distinct areas where normal functionality can be impaired as a result of exposure during a lengthy deployment. These are topics that you may wish to discuss, but they are not exhaustive:

Topic A: The Tour: How was their tour? Did they feel prepared for it? Were there any unexpected aspects? How did their family do whilst the Unit was on tour?

Topic B: Homecoming: How was you homecoming? Were there any difficulties or unexpected aspects about it?

Topic C: Adjustment at home/back to work: How is life at the moment? How is your wellbeing and health? How is the family? Any difficulties adjusting? Making plans for the future?

Topic D: Do they recall the OSM briefings that they have received pre and post deployment and are they aware of the amount of support that is currently available to them?

5. Discussion Records

Appendix 2 to Annex 34F is purely a guide to the conduct of the discussion. To encourage a free and frank discussion, the individual is to be given the Appendix on completion of the interview. They should retain the form so that they can refer to it from time to time. They may also wish to discuss with a partner, spouse or trusted friend to give their views on his or her responses to the topics. This will allow personnel to better gauge whether any behavioural changes have occurred in the weeks and months following the discussion. The only form that has to be retained by the chain of command in Appendix 3 to Annex 34F. They should be held centrally within the unit as part of the OSM audit trail and reflect the 4 stage entries on the JPA OSM which require completion.

APPENDIX 2 TO ANNEX 34F

THE REGIMENTAL/DIVISIONAL TOPIC DISCUSSION SHEET

(Return to UK/Barracks/Shoreside Duties)

(To be handed to the individual when complete)

Name:	
Discussion Date:	
Discussion Conducted by:	
Contact Tel Number:	

Topic	**Home, Social and Work Life**
A.	The Tour: How was their tour? Did they feel prepared for it? Were there any unexpected aspects? How did their family do whilst the Unit was on tour?
Comments	
B.	Homecoming: How was their homecoming? Were there any difficulties/unexpected aspects about it?
Comments	
C.	Adjustment at home/back to work: How is their life at the moment? How is their well-being and health? How is the family? Any difficulties adjusting? Making plans for the future?
Comments	
D.	Do they recall the OSM briefings that they have received pre & post deployment and are they aware of the amount of support that is currently available to them?
Comments	

(Continued Overleaf)

Notes:

1. Keep the completed Form safe and review it again in 3 and 6 months time. Look at the topics discussed and see if any of your responses have changed or altered.

2. When carrying out the comparison, it may be useful to do this accompanied by your spouse, partner or a trusted close friend. It may be that they are better placed to observe changes in you that you may have missed.

3. If at some future point you start to encounter difficulties related to your Deployment, contact a Unit TRiM Practitioner, the Welfare Dept or the Sick Bay and seek assistance.

Conducting Officer's Signature .....

APPENDIX 3 TO ANNEX 34F

RETAINED RECORD OF THE REGIMENTAL/DIVISIONAL DISCUSSION

(ALL DEPLOYED PERSONNEL OFFICIAL LIMITED STAFF WHEN COMPLETE)
(Form to be raised prior to an Operational Deployment by the RNPDTC or CoC on behalf of the individual)

Personal Details		
Name:	Rank:	Service Number:
Details of Operation		
Name of Op:	Start/Arrival Date[1]:	Completion/Departure Date[2]:
Unit:	Donor Unit[3]:	Receiving Unit[4]:
Duties held:	Details of in-theatre activity[5]:	
Confirmation Signature[6]: Name: Rank: Appointment: Date:		
Stage 2 - Deployment - Pre-Exit Brief/Decompression		
Pre-Exit Brief/Decompression Undertaken: Yes ☐ No[7] ☐	Location where conducted[8]:	Dates (from/to):
Confirmation Signature[9]: Name: Rank: Appointment: Date:		
Stage 3 - Post Deployment - Dismount/Recall/Normalisation		
Location:	Date(s)[10]:	Unit:
	Leave granted (dates):	
Confirmation Signature: Name: Rank: Appointment: Date:		

(Continued)

1 For maritime deployments, insert date of sailing from UK.
2 For maritime deployments, insert date of returning to UK.
3 If loaned or an augmentee from another unit.
4 If being re-assigned to another unit or returning to donor unit immediately on return from ops or on return from post-operational leave.
5 Summary of the operational environment and any potentially stress inducing activity undertaken/exposure to risk and rigour.
6 Divisional Officer/Troop Commander for Ratings/Other Ranks; immediate superior for Officers.
7 If "No" reason is to be stated.
8 Pre-Exit Brief/Decompression are an activity, targeted primarily at formed units and individuals who will undertake programmed Decompression (only if available) and specifically directed to by the Chain of Command. If Decompression conducted at sea on return passage to UK insert "On passage UK".
9 Immediate Superior or Officer/SNCO with assigned responsibility. Divisional Officer/Troop Commander for Ratings/Other Ranks; immediate superior for Officers.
10 Insert date of returning to Base Port/TAS/Home Base or period spent 'in barracks' if leave not granted immediately on return.

Stage 4 - In-Service Support - Return to Work - Interview		
Regimental/Divisional Discussion (to be conducted post leave after returning from deployment).	Date conducted:	Unit:
Confirmation Signature: Name: Rank: Appointment: Date:		
Stage 6 - Civilian Aftercare (if applicable)		
Notes (use additional paper where required)		

Notes:

1. Completion of this record (or the JPA OSM Account) is mandatory and is both the Chain of Command and the Individual's responsibility. It is to be raised locally for each operational deployment, and should be completed in full before a new record can be opened.

2. Hard copies are held within the parenting units or kept by the individual augmentee until the final Stage of the process is completed. A confirmation signature is obtained after each stage. Completed records are to be forwarded to the UPO for entry onto JPA.

3. Succeeding Divisional Officers/Troop Commanders are to review this record (hard copy or JPA) as part of the joining interview process to ensure continuity of divisional care and any other support which may be on-going or considered necessary.

ANNEX 34G

OSM STAGE 6 - AFTERCARE

1. At OSM Stage 6 (Aftercare) (ie. discharge/retirement from the Service), formal responsibility for medical care passes from MOD to the National Health Service. Defence Medical Services are responsible for overseeing the transition to civilian mental health care of Service Personnel exiting whilst still receiving clinical treatment. Mental Health Social Workers in departments of community mental health will provide follow-up contact with such individuals for 12 months post discharge to ensure a smooth transition.

2. Reservists demobilised since Jan 03 are entitled to continue receiving mental health care from MOD under the terms of the Reserves Mental Health Programme[1]. The programme is open to all current or former members of the UK Volunteer and Regular Reserves who have been demobilized since 1 Jan 03 following deployment overseas and who believe that their deployment as a Reservist may have affected their mental health. Any Reservist who believes they are eligible should approach their GP who will refer them to the programme; in some cases Reservists can approach the programme direct. If eligible, they will be offered a mental health assessment. The assessment will be carried out by members of the Defence Medical Services. If they have a mental health condition related to their deployed Reserve service, they will be offered out-patient treatment at one of MOD's 15 Departments of Community Mental Health around the UK. See Appendix 1 to Annex 34E.

3. The Defence Business Services - Veterans Agency (DBSV) acts as a single point of contact to provide advice for serving military personnel, ex-service personnel and their dependants. The DBSV is responsible for the War Pensions Scheme and Armed Forces Compensation Scheme. These schemes provide compensation to personnel for illness that arises as a result of service prior to 6 Apr 05 and on/after 6 Apr 05 respectively. Outside the NHS, the charity Combat Stress provides specialist advice and in-patient and out-patient mental health care for veterans. See Appendix 1 to Annex 34E.

4. NHS TIL Service is a new service for Armed Forces personnel approaching discharge as well as for veterans. The service will help to recognise some of the early signs associated with mental health difficulties and will provide access to a number of interventions, therapeutic treatments for complex problems and psychological trauma and prevent patient reaching crisis point. It will also help tackle some of the most common mental health and substance misuse problems such as alcoholism, anxiety and depression and join up services across the board, working with local authorities and charities so that the whole of a person's needs and their families are looked after. See Appendix 1 to Annex 34E.

[1] www.gov.uk/guidance/support-for-war-veterans#the-veterans-and-reserves-mental-health-programme.

5. Following publication of Dr Murrison's report entitled 'Fighting Fit' in October 2010, as well as in-Service recommendations (improving mental health assessment at routine medicals, providing access to mental healthcare for 6 months after discharge, studying the efficacy of post operational screening for mental health conditions and an on-line support service), the following are under development for veterans:

Veteran's Information Service - contact will be made to every veteran 12 months after leaving the Service to offer support.

Veteran's 24 hour Support Line - to be run by Combat Stress.

Veteran's Outreach Service - 30 FT equivalent mental health professionals to be resourced to meet needs specific to veterans within NHS mental health trusts.

An on-line support service for veterans.

ANNEX 34H

TRAUMA RISK MANAGEMENT (TRiM)

Note. *Extract from the introduction to the project protocol for the (RN) controlled trial to determine the efficacy of TRiM:*

"Exposure to traumatic events can lead to the development of psychological distress, lowered morale and organisational difficulty (Hoge et al, 2002; Greenberg et al, 2003). It is utopian to believe that traumatic stress can ever be eliminated from any military organisation. Assuming that the Armed Forces continue their primary function of war fighting, then personnel will be exposed to trauma and stress. Some of those exposed will develop psychological distress as a result. Even if this can be reduced by training and so on, no one can argue that it could ever be eliminated. On the other hand we also know that whilst this cannot be prevented, it can be better managed".

1. Introduction

a. A certain degree of pressure and psychological stress is inseparable factor in military operations. Faced with these factors we all have the potential to respond in differing ways. In addition to what we are immediately facing, there could be other external issue that can hamper our ability to cope. It is therefore important to ensure that robust mechanisms are put in place to manage the adverse effects of excessive pressure and psychological stress. Such mechanisms can diminish the effects of stress and deter them from becoming a long-term threat to an individual's health and, ultimately, their ability to operate effectively. The 6 Stages of the Naval Service's Operational Stress Management (OSM) Policy (incorporating TRiM within Stage 2 'Operational Support - see Annex 34C) provides such a mechanism.

b. Traumatic events[1] can have the potential to generate post-traumatic stress symptoms. The symptoms can include depressive episodes, anger, poor sleep patterns and risky driving. These conditions are not uncommon and, if left unchecked, can lead to poor functioning, difficulties with relationships, excessive drinking and discipline issues. In the most extreme cases, certain individuals can go on to suffer from full blown Post Traumatic Stress Disorder (PTSD). Research evidence has shown that delays in seeking help in dealing with trauma issues can often arise as a result of perceived stigma. There remains a wider stigma associated with mental health issues in both the general and service populations. This stigma can act as a barrier to individuals seeking appropriate help[2]. TRiM is designed to reduce the barriers and actively encourages sufferers to seek appropriate assistance.

[1] A traumatic event is any event that can be considered to be outside of an individual's experience and has the potential to cause physical, emotional or psychological harm.
[2] The Murrison Report (dated 21 Jul 10) made recommendations based on a number of propositions, one of which was that stigma deterred servicemen from engaging with conventional mental health provisions.

2. TRiM Delivery

TRiM is a proactive, peer group delivered, human resource management initiative for supporting individuals following exposure to traumatic events. The wider view of the TRiM protocol is detailed in the TRiM CONOPS at Appendix 1 to Annex 34H. There are three main work strands to the TRiM protocol which are:

a. **Education.** 'Pre-incident Awareness Training' with the primary emphasis being placed on operations. This is where the probability of a traumatic incident is more likely.

b. **Individual/Group Risk Assessment.** Following a traumatic incident, individual or group risk assessments to determine how much stress an individual has assimilated (the Risk Assessment process is amplified at Para 3 below).

c. **Mentoring.** Practitioners are required to provide mentoring support for individuals for a period of 6 months post incident. The TRiM Practitioner is trained to recognise the signs and symptoms of stress and give mentoring advice to individuals on coping strategies and how to better manage their issues. The request for mentoring support is generally instigated by the individual and the TRiM Practitioner will respond in an empathetic and supportive manner.

3. Risk Assessment

a. One of its primary tasks is the early identification of the signs and symptoms of stress. Having peers within a unit who have some skills in risk assessment potentially allows for an initial approach without fear of the stigma of medical/psychiatric referral. This is achieved by allowing individuals to talk through the issues surrounding an incident and by doing this, allow them to process their thoughts. This end state is achieved through the medium of the 'TRiM Risk Assessment. The two-fold aim of the Risk Assessment is as previously stated, to allow healthy processing of their thoughts and secondly; to assess how much stress the individual has assimilated as a result of the incident. Individuals are seen either as singletons or in small groups3. Under the guidance of TRiM Practitioner, the individual is encouraged to tell their story in a frank and honest way and discuss any attendant issues that may emanate. It is structured along the lines of what was happening '**Before**' the event, what was happening 'During' the event, what was happening '**After**' the event. This type of intervention is known as the BDA Model. It is not a treatment or a therapy; however the 'talking' or 'processing' element of the intervention has recognised therapeutic advantages[4]. People engaged with the process are seen on two occasions; the first occasion is three days after the incident and the second occasion is one month or 31 days after the incident. During the course of the two interviews or assessment, the Practitioner will check their progress against ten extremely well researched and evaluated trauma risk factors. This will assist the Practitioner in assessing current stress levels. If stress levels are high or if issues are not being resolved, the TRiM Practitioner may encourage the individual to engage with the Medical Services or some other appropriate agency.

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[3] The TRiM Groups are never more than 8 people. Groups are always conducted by two TRiM Practitioners

[4] The TRiM Protocol is fully compliant with the National Institute for Health & Clinical Excellence (NICE) guidelines for the delivery of post trauma support, London 2005.

b. TRiM Teams are embedded within all units, squadrons and platforms of the Naval Service. This policy ensures that in the aftermath of a traumatic event, the services of the Team are readily available to the chain of command. Additional support for units/platforms following a traumatic event is available from the NCHQ OSM Team.

c. All members of the Team are highly experienced TRiM Practitioners and can provide advice, on-site direction and practical support, post event. In working hours the NCHQ OSM Team may be contacted on Mil: 9380 28021 or Civ: 02392 573021, out of hours contact TRiM Duty Mobile on 07733 155884.

4. Training Courses

There are now a number of TRIM Training Courses at varying levels available for members of the Naval Service. However, for the training to be effective and for the successful Practitioners to be credible, the protocol must be delivered by competent and well motivated personnel. The selection of potential TRiM Practitioners should be carried out using the prescribed selection criteria (see Appendix 3). Governed by CONOPS (see Appendix 1) and a strict 'TRiM Code of Practice' (see Appendix 4), TRiM complements existing support mechanisms[5] and aids the identification of those experiencing of post traumatic symptoms. The TRiM Protocol is a human resource initiative, however, the Project maintains and supports close links with the Naval Community Mental Health Services.

5. Stress and Resilience Training Policy

A Defence-wide Stress and Resilience Training Management (SRMT) policy[6] has been developed by Chief of Defence People[7] in consultation with the three services. The policy sets out the training requirements and it is organised at four distinct levels:

a. **Level One.** Level One training includes basic stress training for all personnel newly enlisted or who have recently joined the Armed Forces (for the Naval Service this includes new entrants at HMS RALEIGH, CTCRM & BRNC Dartmouth). The training is aimed at ensuring that they recognise stress in themselves and others. The training puts emphasis on how to seek appropriate support should the need arise.

b. **Level Two.** Level Two training is required for those who manage others to ensure that they are able to recognise signs of pressure and stress in themselves and their subordinates (for the Naval Service this includes leadership courses, Divisional Officers Courses etc).

c. **Level Three.** Level Three trains those with responsibility for managing stress at an organisational level in order to maintain operational and/or business effectiveness (for the Naval Service this may include CO and/or XO Desig Courses).

d. **Level Four.** Level Four training is targeted at non-medical personnel in posts with specific stress management responsibilities. The personnel that may require this training are those that require additional stress training to enable them to carry out their duties in their key post or to address specific risks (for the Naval Service this will include TRiM training).

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[5] Positive leadership, divisional/troop and peer group support, welfare, medical and pastoral care.
[6] JSP 822: Defence Direction and Guidance for Training and Education – Defence Training & Leaflets – 1.12 Stress Management and Resilience Training.
[7] Service Personnel Support, Health and Well-being, part of Chief of Defence People, 6th Floor, MOD Main Building. This policy has been checked and is extant as at Nov 16.

6. Documentation

All incidents involving a TRiM Intervention are to be fully documented in a Naval Service TRiM Incident Log Book. All the documentary requirements are clearly detailed in the log book and should be accurately followed. Once all TRiM activity relating to the incident has been completed, the TRiM Manager who initiated the documentation and supervised the TRiM Intervention should then return the completed paper work to the NCHQ OSM Cell.

7. Summary

The majority of Service Personnel who are exposed to traumatic events will not go on to develop long-term problems. However, we have a responsibility to meet our duty of care obligations and our legal requirements, as well as to develop a broader awareness of the issues of stress amongst the Naval Service. TRiM has proved effective in identifying the small number people who may go on to develop problems in the future. Operational factors such as geographical isolation, logistical constraints, the wide dispersal of personnel (a particular issue for land forces) and limited psychological support mean that initial management strategies (trauma triage) can initially be carried out by trained unit TRiM Practitioners rather than external mental health professionals from outside the unit. Simply put, TRiM is a tool which helps recognise when somebody is not behaving normally and suggests to the affected individual the need to seek professional medical help. It is prima facie leadership; the use of TRiM assists in formalising a function of command relating to the care of individuals and allows it to be applied more routinely. The embedding of TRiM teams and the use of TRiM, in conjunction with the wider stages of OSM, enhances considerably the knowledge and understanding of stress management within the Naval Service population. These factors taken together are, in turn, demonstrably improving leadership on both land and sea. The Commander of 12 Mechanised Brigade stated in his Op 'HERRICK' Post Operations Report that :

> *"The heavy emphasis placed by the Commander on TRiM prior to the start of the tour has undoubtedly paid off. This simple but effective method of managing the aftermath of traumatic events has meant that 12 Mech Bde units have been able to mitigate some of the harrowing effects of close quarter combat. This has undoubtedly kept soldiers in the front line. This process must now be endorsed as best practice in Defence".*

APPENDIX 1 TO ANNEX 34H

TRiM CONOPS[1]

1. Introduction

As an executive tool, TRiM policy resides with the Operational Stress Management Cell within NCHQ. However, once a TRiM capability has been established within a unit, platform or establishment, the responsibility for maintaining, exercising and deploying TRiM rests with the Commanding Officer (CO). This Appendix aims to provide the CO with guidance to assist them in their task.

2. A Traumatic Incident

In the aftermath of a traumatic event a variety of emotional effects can be placed upon us. Some effects are quickly recognised and by virtue of our training and personality we are capable of dealing with them. However, some or more discrete and their effects are more discrete and their effects are harder to recognise and predict. As a result they are more challenging to deal with and it may be appropriate to seek assistance from a TRiM Practitioner. For the purposes of these CONOPS A traumatic incident is defined as:

> *"Any event that can be considered to be outside an individual's usual experience and has the potential to cause physical, emotional or psychological harm."*

The keyword in this definition is "potential". Both during and after a traumatic incident everyone can react differently. When dealing with effected individuals, everyone will have differing needs & requirements. The TRiM should recognise this and plan its strategy accordingly. It is not a case of one size fits all.

3. Employment

As stated above, everyone will respond differently to a traumatic incident. Some may be severely traumatised whilst some may not be affected at all. However, a TRiM team should be employed as a precautionary measure in the aftermath of incidents similar to those listed below.

a. Sudden death.

b. Serious injury.

c. Disablement or disfigurement.

d. Multiple traumas.

e. Near miss (or near hit), defined as an uncontrolled event which fortunately did not physically injure the person but if it had then there was the potential for serious injury.

[1] JSP 770: Tri-Service Operational and Non-Operational Welfare Policy – Chapter policy remains extant and retained from Version 11 of JSP 770 and provided as PDFs and a revised DIN: Chapter 2 – Trauma Risk Management (TRiM) Policy (PDF). This chapter and DIN will be integrated into the new JSP 661 Defence People Health and Wellbeing, when it comes into being.

f. When survivors are encountering overwhelming distress (an example would be when engaged on disaster relief work or body handling duties).

g. Engagement with child enemy combatants.

4. Unit TRiM Teams

The TRiM team of trained personnel embedded within each Unit/Squadron/Platform are trained to recognise the symptoms of stress and give advice to individuals on simple coping strategies and how to manage them. The TRiM model is consistent with the aims of existing Stress Management Training (SMT) and conforms to the National Institute for Health and Clinical Excellence guidelines. TRiM also seeks to eradicate the stigma attached to stress and mental health by educating personnel to ensure that they:

a. Recognise that stress and trauma can affect even the toughest individual but that feelings and behavioural changes in the aftermath of traumatic events are neither unusual nor unexpected and all can be effectively treated.

b. Can identify the signs of stress and strain within themselves and their shipmates.

c. Can be made aware of simple coping strategies that exist to manage stress, including the dangers of alcohol, substance abuse and poor sleep hygiene.

d. Know when to seek additional help and understand which agency can assist them.

5. TRiM Principles of Employment

TRiM is employed with the following principles, which are consistent with the objectives of military mental health provisions:

a. **Proximity.** Support should be provided at unit level wherever possible and with engagement at all levels of command. Individuals are not compelled to attend a TRiM Risk Assessment. However, there is an expectation that they will attend in order to support others who were involved in the same incident. The TRiM Team Leader will also be required to:

(1) Continue to engage with those who initially decline to attend a TRiM Risk Assessment.

(2) Notify the Chain of Command of any individual considered to be a serious risk to themselves or others. This reporting responsibility will be with the knowledge of the individual but does not require their consent[2].

[2] The requirement to carry out this reporting responsibility is clearly explained in the 'Introduction' phase of the Risk assessment.

b. **Immediacy.** TRiM assistance should be in place in the immediate aftermath of the event. Embedded Team Leaders should provide an immediate response to the incident in the form of advising the Chain of Command and the formulation of appropriate management plans. Formal individual or group risk assessments should not be initiated until at least 3 days have elapsed. Earlier intervention is likely to produce a markedly inaccurate Risk Assessment. On some occasions, external TRiM assistance may be required if the embedded Team personnel are encountering difficulties due to the intensity of the events, the scale of the numbers involved and/or personal involvement[3].

c. **Expectation.** Personnel should be made aware after the incident that they will resume their normal duties as soon as possible.

d. **Simplicity.** The programme is simple to teach and implement. It keeps ownership of the management of stress reactions at unit level, and commanders retain responsibility for the well-being of their personnel.

6. Planning the Intervention

TRiM affords commanders a number of bespoke options when dealing with the aftermath of a traumatic event. For minor incidents they may wish to employ a local defusing strategy amongst either individuals or groups. For major incidents, particularly if they involve death, the entire TRiM team may be required in addition to medical, pastoral and welfare services (where available). TRiM helps to assess the initial impact of traumatic stress and reassures the Command that vulnerable people are being identified promptly and signposted to receive specialist support at the earliest opportunity. Within three days of a traumatic incident, the team manager, or senior stress practitioner, should have sought permission to convene a planning meeting to determine the most appropriate stress management strategy. The following personnel should attend:

a. Senior management (XO or 2 i/c).

b. Senior Stress Practitioner (TRiM Team Leader).

c. G1/N1 representative (normally the Logs Officer at sea).

d. Someone with knowledge of the incident.

e. Someone with knowledge of the individuals involved.

f. Medical Officer or Senior Medical Rating.

g. Chaplain (if borne).

[3] Embedded teams should provide an immediate response to a traumatic incident. On occasion, the scale of an event may overwhelm the TRiM team. In these circumstances the NCHQ OSM Cell can provide additional TRiM support. All members of the Team are highly experienced TRiM Practitioners and can provide advice, on-site direction and practical support, post event, if necessary and in conjunction with DCMH staff.

7. On Completion of Planning

At the conclusion of the planning phase, the following options are available to the Chain of Command and the Unit TRiM Manager:

a. **Do Nothing**. If the event is relatively minor and individuals appear to be taking the incident in their stride, a policy of 'watchful waiting' incorporating regular reviews may be sufficient.

b. **The Briefing Meeting.** An initial strategy to consider could be to conduct a 'Briefing Meeting'. This can be used to give trauma related information to vulnerable people who are aware of the incident, but their involvement is more peripheral. The Briefing Meeting can involve the whole ship's company and should be conducted within 48 hours of the incident.

c. **Individual/Group Risk Assessment**. Following an incident, assessments will be conducted at intervals of three days and one month (the one month interview takes place 28 days after the initial 3 day risk assessment. Both assessments will allow informed judgement so that early referral for treatment may be achieved.

d. **Mentoring.** The mentoring process allows individuals unrestricted access to a TRiM Practitioner. It gives them the opportunity to discuss and ventilate any issues in an empathetic and benign environment.

8. Stigma

There is a recognised reluctance amongst the wider male UK population to seek help in aftermath of a traumatic event. In the Armed Forces this can be exacerbated by a culture which emphasises robustness and resilience. Whilst these traits are admirable when engaged on operations, they can act as a barrier to seeking help at a later stage. TRiM Teams, by their awareness of the nature of reactions to traumatic events, are well placed to give support to these individuals. Within the Naval Service as a whole, we are seeing less resistance to seeking emotional support. The TRiM Teams, the Chain of Command and the other Carer Agencies should continue to work collectively to reduce the corrosive effects of stigma.

9. TRiM for Injured Personnel

There are individuals who are injured or damaged in some way and are subsequently returned to the UK. Dependent on the nature and severity of their injuries, they may spend a short period at Queen Elizabeth's Hospital, Birmingham. After initial treatment they may be sent to their family home for a period of convalescence. These individuals, due to their rapid departure from the operational theatre, are unlikely to have engaged with the TRiM process. Due to this factor we are unable assess how much stress they have assimilated, and as such, we are hampered in giving them adequate post-incident support. Faced with these and other issues, it is important that TRiM support is provided within two weeks of the injured individual arriving in the UK. The protocol covering these circumstances is contained in Appendix 2 to Annex 34H.

10. Documentation

All incidents involving the intervention of a TRiM Practitioner are to be fully documented by the TRiM Team Leader in a TRiM Incident Log Book (OFFICIAL SENSITIVE STAFF once in use). The log book records details of the incident, those directly and indirectly involved, details of decisions made at the planning meeting and those in attendance, the names of individuals invited to be risk assessed (and those who decline assistance) and the risk assessment checklist scores and action taken. Team Leaders are to keep completed Incident Log Books for a period of 3 months from the date of the incident after which they are to be sent to NAY NPS-PEOPLE SPT OSM TRiM SO2 for inspection and archiving.

11. Reporting

There is a requirement to collate data on TRiM interventions. These are required to provide evidence to its efficacy, to meet requests for statistical information and to provide effective long term support our personnel. The area of JPA used for recording TRiM interventions is the individuals 'exposure to hazard'[4] tool detailed in the JPA Operational Tracking (OPLOC) section. The inputting of TRiM Interventions into the 'exposure to hazard' of JPA is the sole responsibility of the NCHQ OSM Cell. The source document for inputting the information is the submitted Naval Service TRiM Incident Log book. The entry will not contain any of the details of the event or elements of the TRiM discussion[5]. It will solely detail the specific TRiM Risk Assessment number plus the date of the assessment.

12. Benefits of Reporting

The primary beneficiary of this policy is the individual. It allows the chain of command to support them appropriately during and post service. It also gives an audit trail to demonstrate that, at some stage previously in their service life, they have actively engaged with the TRiM process[6]. To assist the individual further, on completion of the TRiM process, they will be issued with a unique 'JPA Hazard Number'. They should retain this number and refer to it if they ever need to deal with the Service medical services or other agencies.

13. Referral/Signposting

Depending upon the outcome of the risk assessment, a TRiM Practitioner, after consultation with his TRiM Team Manager, may consider an individual to be in need of additional professional support. Identified personnel should be encouraged to contact unit medical staff who may refer individuals for specialist mental health support. The following conditions are an indicator to the TRiM practitioner that further medical support is required:

a. Prolonged and profound psychological distress indicated by high scores in the risk assessment.

b. Acute distress.

c. When post-incident issues emanating from the event are having a marked effect on the individual's duties and/or social interaction.

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[4] JPA provides a suitable functionality known as: 'Recording Exposure to Hazards' (abbreviated to 'E2H'). This was included in JPA release 8, activated in 2009. See Desk Instructions.
[5] The generic introduction given prior to conducting any TRiM Risk assessment has been amended to reflect that the assessment is now recorded on JPA.
[6] Personnel entered in on E2H are the individuals who, as a result of the Planning Meeting are invited to attend a risk assessment. If an individual subsequently declines to attend, this fact is also recorded on E2H.

14. Selection of the TRiM Team Leader and TRiM Practitioners

TRiM Practitioners are not aligned to specific posts within unit establishments. Any prospective TRiM Practitioner should be held in high regard by and hold the trust of their peers. They must be volunteers and have good life experience skills; ideally they should not have been involved in a traumatic incident or bereavement within the past year. The specific criteria for selection are at Appendix 2 to Annex 34H.

15. Continuation Training

Due to skill fade, Annual Continuation Training will be conducted by the unit, ship or establishment TRiM Team Manager (or TRiM Team Leader) to ensure that the TRiM Team remains current with best practice. This training will be audited through FOST, or the NCHQ TRiM Team.

16. The TRiM Code of Conduct

All TRiM personnel are subject to a code of conduct which clearly defines how they conduct their working practices. A copy of the code is detailed at Appendix 4 to Annex 34H.

APPENDIX 2 TO ANNEX 34H

SELECTION OF TRiM TEAM LEADERS AND TRiM PRACTITIONERS

1. Introduction

Trauma Risk Management (TRiM) is a proactive, common sense strategy which aims to mange the effects on individuals of a potentially stressful incident. The management of the traumatic aspects of the incident is peer group delivered using trained TRiM Practitioners. The effectiveness of the intervention primarily rests on the shoulders of each practitioner and their approach to the task will greatly determine the success of the final outcome.

2. The TRiM Practitioners Course

The Course will give the potential practitioner the requisite skills to carry out the prescribed task. However, careful selection is required to ensure that the personnel nominated by the ship, squadron or establishment possess the essential core skills to carry out this exacting role. The aim of this Appendix is to outline the methodology that should be followed during the selection process.

3. Selection Background

Generally, TRiM Practitioners are not aligned to specific appointments within their units. Personnel who attend TRiM training should be volunteers and should not have been involved in a traumatic incident or a significant bereavement within the previous year. The specific rank of the individual is not relevant, but in making their selection, the unit/establishment must be convinced that individual can deal with the nature of the work.

4. Selection Criteria

Volunteers should be capable of meeting the following criteria:

a. Capable of maintaining peer confidentiality.

b. Be mature and empathetic.

c. Be respected and trusted by colleagues.

d. Have good communications skills.

e. Be capable of learning about a psychosocial process.

f. Be capable of adhering to the TRiM Code of Conduct and working within established boundaries.

APPENDIX 3 TO ANNEX 34H

CODE OF PRACTICE RELATING TO TRiM PRACTITIONERS

1. Introduction

The Trauma Risk Management (TRiM) protocol is a Human Resource initiative. However, the Project maintains and supports close links with the medical services.

2. Code of Practice

a. TRiM interventions and risk assessments should only be carried out by practitioners who have undertaken an officially recognised TRiM Course and are in date.

b. All TRiM interventions should be conducted strictly in accordance with the protocols taught on the TRiM Course.

c. All TRiM Practitioners are to observe the following ethical statements:

(1) Maintain confidentiality unless indicated by law not to do so.

(2) Obtain informed consent.

(3) Avoid any re-traumatising actions to the greatest extent possible.

(4) Operate within personal levels of training, expertise, education and experience.

(5) Use the TRiM protocol in an empathetic, sensitive and respectful manner.

(6) Self monitor personal capacity to do ‘the work’.

(7) Do no harm.

(8) Promote human welfare.

(9) Be fair.

(10) Fulfil commitments to clients.

(11) Finally, take regular and ongoing actions to insure self-care and enhance the ability to deliver quality and professional services.

ANNEX 34I

TRiM EXPOSURE TO HAZARD REPORTING

1. Introduction

The Naval Service has an enduring requirement for a robust audit process for personnel who have engaged with the TRiM Process. In accordance with the JSP 770[1], we record occasions when an individual has been 'Risk Assessed' by a TRiM Practitioner. This process allows the Naval Service to meet its obligations for the provision of accountability and transparency. The recording process is fully explained to all personnel taking part in a TRiM Risk Assessment (RA). It is clearly covered in the 'Introduction' phase of the RA, specifically in the 'Confidentiality' paragraph.

2. Data Recording

The information is recorded in the 'Exposure to Hazard' (E2H) Section of JPA. Recording sensitive details on JPA may appear to run counter to the fact that a RA is a confidential process. Only NCHQ TRiM Team is responsible for the input of information relating to TRiM Incidents onto the JPA E2H. Under no circumstances should details of the incident or individual TRiM scores be recorded on JPA. Details of whether individuals were invited to be risk assessed and/or whether they declined assistance are to be recorded in the TRiM Incident Log Book, but only the offer of a TRiM intervention is to be recorded on JPA. This decision places heavy reliance on careful stewardship of TRiM Incident Log Books within units and commands, and a similarly robust mechanism is required for JPA administration.

3. Log Book

All TRiM interventions are to be fully documented in a TRiM Incident Log Book. The Log book is to record details of the incident and all personnel involved. It is to capture the details of decisions made at the planning meeting and a nominal record of those personnel who were in attendance. The names of individuals invited to be Risk Assessed, whether the offer was accepted or declined, and the subsequent risk assessment checklist scores and action(s) taken, must also be recorded. Once initiated, TRiM Log Books are not to be destroyed but must be retained and archived in accordance with standard operating procedures. When the incident is closed by the Unit[2], the completed Log Book should be forwarded to the NCHQ TRiM Team.

4. Documentation

Unit personnel who were invited to attend a Risk Assessment (including the 'Decliners') are entered onto the JPA E2H Database. Those entered into the system receive, in addition to a covering letter, the following items:

a. **A TRiM Reference Card**. The card contains information[3] that may assist the individual in the medium and longer term future (perhaps at a time when they have left the Naval Service).

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[1] JSP 770: Tri-Service Operational and Non-Operational Welfare Policy - Chapter policy remains extant and retained from Version 11 of JSP 770 and provided as PDFs and a revised DIN: Chapter 2 – Trauma Risk Management (TRiM) Policy (PDF) - This chapter and DIN will be integrated into the new JSP 661 Defence People Health and Wellbeing, when it comes into being.

[2] This normally occurs after the execution of the 1 or 3 month follow up Risk Assessment. If there are specific reasons for keeping the Log Book open, then this should be reported to the NCHQ TRiM Team. On completion, the log book should be returned to NCHQ TriM team by the 6-month point.

[3] The Trim Log Reference Number, Your TRiM JPA Reference Number, Your Name and Service Number, the TRiM Cell Contact Details.

b. A ‘Question & Answer Sheet’ which outlines 10 questions and answers, explaining how the Reference Card can be used in the future.

c. A Confirmation Receipt Form to ensure effective management of the TRiM Reference Cards.

5. Outcome

Whilst there is a requirement for the Naval Service to retain records regarding the usage of the TRiM process, the primary beneficiary of E2H policy is the individual. Whilst in the Service or perhaps when they have returned to the civilian environment, an individual may encounter post-traumatic issues. They may require additional medical or mental health assistance. If they attempt to seek help from their GP or a mental health professional, they may have problems in clearly describing the circumstances of the events that are troubling them. The production of a ‘TRiM Reference Card’ will provide a conduit to enable GPs, mental health professionals, welfare staff or Government Agencies to clarify the Veteran’s version of events. The discussion with the TRiM Team could also highlight other pertinent aspects of the incident.

6. Summary

The JPA E2H process will provide a robust audit trail to enable NCHQ to quickly validate the circumstances of a reported incident which has received a TRiM intervention. This in turn will enable our Naval Service Veterans to be assisted and receive the appropriate support during and following their tenure in the Naval Service.