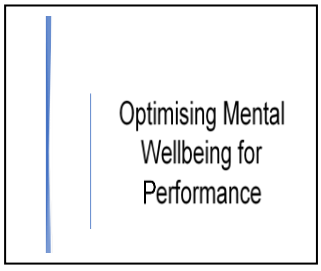
AP9012

RAF Stress Management & Resilience Policy Version 4.3



Sponsor: Section 40

Contents

The policy is broken down into chapters that deal with specific issues inside the wider stress management and resilience agenda:

AP9012 - Amendment Record

AL/Version No	Date	Text Affected	Authority
1	2008	Initial Issue	Section 40
2	2012	Complete Re-issue - Version 2	Section 40
3	May 17	Complete Re-issue - Version 3	Section 40
4	Nov 18	Start of new version. Chapter 6 – Suicide & Self Harm complete rewrite. Chapter 4 – Annex G Recall Days slight amendments.	Section 40
4.1	Nov 18	New Chapter 12 – Spiritual Resilience	Section 40
4.2	Dec 18	Revised Chapter 11 – Governance and Assurance.	Section 40
4.3	Feb 19	Slight amendment to Chapter 4, Annex D (Pre-Deployment Interview).	Section 40

Equality and Diversity Impact Assessment Statement

This policy has been equality and diversity impact assessed in accordance with

Departmental policy. This resulted in:

- Part 1 screening only completed (no direct discrimination or adverse impact identified /policy is a reflection of statutory requirements and has been cleared by a Legal Adviser).

RAF STRESS MANAGEMENT AND RESILIENCE POLICY

CHAPTER 1 – FOREWORD BY THE CHIEF OF THE AIR STAFF

INTENT

1. This policy reflects my intent to address and formalise the management of stress throughout the RAF and thereby to hone collective and individual resilience. Personnel with a healthy approach to life are critical to the optimum delivery of air power and are best placed to make decisions when they are not distracted by avoidable sources of stress and strain. Additionally, the rightful obligations placed upon us through the Moral Component of Warfare demand that we properly address the needs and welfare of our people; I view a structured, risk-based, approach to stress management as an integral part of this requirement.

BACKGROUND

2. The need to improve the Armed Forces' management of operational stress was one of the major lessons to be drawn from Op TELIC. Indeed, there is considerable evidence that pressure from excess stress impacts adversely in the workplace and, most pertinently, that military service is, by its very nature, stressful. Therein lies the link to operational effectiveness and the maintenance of offensive spirit. Within the RAF the link between deployed operations, domestic needs and the work-life balance is critical; as such, failure to manage the effects of occupational stress can manifest itself in serious behavioural and clinical symptoms such as increased alcohol misuse, drug abuse and mental ill-health.

3. Building on the evolution of the RAF Operational Stress Management and Resilience Policy in Dec 05, and the latest iteration (Chapter 4) promulgated in May 08, this policy document pulls together a holistic approach to honing resilience across the whole spectrum of RAF activities. Integral to this process has been the identification of major trends from the RAF Stress Audit in 07 which, for the first time, developed a scientific analysis of the major occupational stressors in our Service. These factors, which we all need to be conscious of, are addressed at Chapter 5. In sum, therefore, this policy covers the management of stress in the RAF throughout the duration of an individual's career. It is relevant to all RAF personnel, including Reserve Forces.

APPLICATION

4. I expect all RAF personnel to not only be aware of how to achieve and to follow this policy but also, and more importantly, for commanders at all ranks to be alert to the potential effects of stress on their people and to be able to recognise the symptoms of undue pressure. Early intervention, on a common sense basis and without prejudice to the military principles of courage, determination and discipline, can prevent the onset of chronic psychological reactions and adjustment disorders.

5. The policy itself outlines simple risk-based procedures and interventions, which need to be underpinned by strong and pro-active leadership. It does not, however, require the chain of command to become trained counsellors; instead, the policy provides a framework in which leaders at all levels can be alerted to issues that are likely to require intervention by either higher levels within the chain of

command or more specialist staffs. It also, rightly, denotes the need to include Service families in our approach.

6. The successful management of stress within the RAF will, however, require more than just the objective application of this policy. Indeed, there will need to be a degree of cultural shift in overcoming the perceived stigma of dysfunctional behavioural and mental health; this will require individuals and their commanders to be able to honestly and openly discuss issues of concern, particularly in the aftermath of a traumatic episode or following prolonged exposure to a series of stressors. To draw an analogy, the RAF anticipates that over time aircraft will experience wear and tear or be damaged. When this happens, the RAF does not pretend that it has not happened, or that is irreversible. Instead, we adopt a professional approach and take steps, through scheduled maintenance or repair, to ensure that the aircraft is airworthy. We need to take the same approach with our people and provide professional and timely assistance to those who experience adverse, yet entirely normal, reactions to stress, whether they be serving on operations or at home.

7. This policy has been developed by HQ AIR Personnel and Health policy staffs with significant inputs from across the RAF, and notably from the front line of operations, during what has been one of the most demanding periods in our recent history. I commend this policy to you as individuals, as leaders and, most importantly, as members of the RAF and look to commanders at all levels to ensure that it is fully and sensibly adopted across their areas of responsibility, leading by example.

Chief of the Air Staff
May 2008

2 INTRODUCTION

Overview

1. This Stress Management and Resilience policy affects all personnel in the RAF. It is provided to assist in the management of stress in the workplace and on operations. It does this by helping all individuals (in their position as subordinates, peers, leaders or managers) to identify the signs and symptoms of stress in themselves or others, identify what they can do for themselves and for others to manage stress, and to aid the development of resilience in the workplace or on operations. This Chapter sets the generic outline and definitions to be used in its interpretation.

Stress And [Individuals In] The RAF

2. To set the context for this RAF policy it is important to understand what is meant by stress. There are many definitions in use by different organisations and in common conversational use. Some of these will explicitly or implicitly state that stress can be positive, although what they invariably mean is that there can be benefits from the bodies 'stress reaction' which results from being under degrees of pressure rather than stress itself. The NHS states that 'Stress is the feeling of being under too much mental or emotional pressure. Pressure turns into stress when you feel unable to cope'. This leads us to the fact that all personnel need some degree of pressure or stimulation to achieve best performance but when the pressure becomes excessive, work performance and the health of individuals can be adversely affected. The RAF has therefore adopted the Health & Safety Executive definition of stress:

> "The adverse reaction an individual has to excessive pressure or other types of demands placed upon them".

3. It is natural for individuals to feel stressed at times, particularly when they feel that they cannot cope. There is no simple way of predicting what will cause harmful levels of pressure (stress) and who will be affected. Personality, experience, training, motivational factors and the support available from work colleagues, families and friends will have an impact on an individual's ability to deal with stressful situations. Moreover, stress can manifest itself as physical, behavioural, mental(cognitive) or emotional effects, or as a combination of these. These effects are normally short-lived and cause no lasting harm. When the pressures recede there is a quick return to normal. Stress is, therefore, not the same as ill-health. It is only when pressures are intense and prolonged that the effects can become more sustained and damaging, leading to psychological problems and physical ill-health, such as anxiety, depression or high blood pressure.

4. Exposure to a traumatic incident may result in individuals experiencing a stress reaction. AP 9012, Chapter 10, outlines how Trauma Risk Management (TRiM) is to be used throughout the RAF.

5. The RAF has a duty of care to protect the health, safety and welfare of all of its personnel, including the risks arising from stress. Although some factors are beyond the RAF's responsibilities or control, it is incumbent on commanders, line managers, supervisors and individuals to be aware of them, since these factors can make individuals more vulnerable to stress at work, as well as affecting performance and judgement. External pressures involved with family life, occupational stress and operational stress will at times all contribute to the risk faced by individuals. The basis of managing stress is to assess the risk and introduce appropriate control and mitigation measures. Commanders and line managers are required to identify and manage stress on operations and in the workplace and look for the signs and symptoms of stress among personnel and then take action, organisationally or individually, to help alleviate them. Individuals

are to be educated in recognising the signs of stress in themselves and others, and to know from where to seek help.[1]

6. Managing stress at the time it occurs throughout a person's RAF career represents the key principle underpinning this policy.

Dealing with Stigma

7. The stigma surrounding mental health issues such as stress and suicide is potentially pervasive in the military environment. As such, leadership must prove exemplars of good management in this field to de-stigmatise the issue of stress and mental illness. Stress treated during the early symptoms and managed correctly, whether it be cumulative or trauma related, is not lasting and in most cases does not develop into illness. Work in the Services on occupational and post operational stress has highlighted that those who suffer from stress may be reluctant to seek help due to the stigma attached to mental distress.

8. A large percentage of the Armed Forces are white males, the group which the Department of Work and Pensions cite as being most at risk of deliberate self harm and suicide. They suggest that these findings can be attributed to men being less likely to come forward for help with mental distress. Stigma against mental illness may therefore be more apparent within a predominantly male workforce such as the RAF.

9. Due to the nature of work that the Armed Forces undertake, personnel are at increased risk of occupational and operational stress. First and foremost, the organisation is required to demonstrate duty of care toward personnel and to foster a working environment which promotes both physical and mental well being. From an organisational perspective, if stigma prevents communication with, and support for, individuals experiencing mental distress, this may lead to increased absenteeism, reduced team effectiveness and retention issues. All these factors are likely to have a negative impact on operational effectiveness.

10. Stigmatised individuals experience a perceived loss of status and discrimination generating an increase in personal stress.

Applicability of the Policy

11. This policy applies to all RAF personnel, including Reservists and RAuxAF. It can also be applied to Civil Servants, contractors and members of the other Services (though not in a mandatory fashion) in order to apply good practice and to look after the needs of the whole force, rather than only elements. The overarching MOD policy is JSP 375, Part 2, Vol 1 Chapter 17 Stress in the workplace.

Actions and Responsibility

12. The policy details actions and responsibilities throughout. It is important to note that individuals as well as the chain of command have responsibilities. Unit administrative process and procedures support leadership, and the individual, in the application of this policy. It is important to note and recognise that Stress Management is a function of good leadership and management.

Lessons Identified

13. When individuals have specific and significant issues relating to stressors or risk assessment processes, these should be reported to the Air Command-led Post Event Reporting Lessons Identified (PERLI) process which feeds the Defence Lessons Identified Management System (DLIMS). Further assistance can be obtained by contacting the Air Lessons Cell Help Desk at HQ

[1]Defence Training and Education Leaflet 1.12 – Stress Management and Resilience Training.

Air Cmd on 95221 7766/7018. Individuals will be advised on any progress and will be updated on developments.

14. JPA reporting at specific points throughout this policy will enable commanders to draw on some reporting measures namely, how personnel have been trained and their management through the deployed ops process from an Operational Stress Management perspective. Where SMT is delivered as a stand-alone course, recording of the level of training achieved and date of the training is to be made on existing HR reporting systems. Where SMT is delivered as part of a broader career course, separate recording is not required.

Policy Sponsor

15. Section 40, HQ AIR is the sponsor for RAF Stress Management and Resilience policy.

16. Whilst some parts of the policy can be treated as stand-alone documents, care should be taken not to use this policy, or parts of it, in isolation. The policy aims to direct personnel and commanders to related areas and links, and for its use to be but one component of day-to-day operating procedures of the RAF. It should not dramatically influence or change what are current practices and only supplement what is generically good leadership and management throughout the organisation.

Definitions

17. Annex A contains a list of definitions as they apply to this policy. Definitions have been split into generic and military categories and many are drawn from extant policy.

Annex:

A. Stress Management and Resilience Policy Definitions.

Stress Management and Resilience Policy Definitions

Generic Definitions

Alcohol Misuse[1]

Alcohol misuse is defined as drinking alcohol, either on a single occasion or regularly, in such quantity that there is a risk to an individual, group or the overall operational effectiveness of the Services. 'Alcohol Dependence' is a psychological and/or physical addiction to alcohol.

Anxiety[2]

Anxiety is a feeling of unease, such as worry or fear, which can be mild or severe.

Depression[3]

Depression refers to a range of mental conditions characterized by persistent low mood, absence of positive affect (loss of interest and enjoyment in ordinary things and experiences), and a range of associated emotional, cognitive, physical, and behavioural symptoms. Symptoms occur on a continuum of severity, and day to day functioning is often impaired.

Pressure

The act, condition, or effect of exerting force on someone or something. This can be both physical and / or psychological.

Psychological Resilience

A commonly used concept in psychology (such as in child development, adolescent development, psychopathology, and positive psychology) to describe the positive capacity of people to cope with stress and catastrophe. It is also used to indicate a characteristic of resistance to future negative events. In this sense "resilience" corresponds to cumulative "protective factors" and is used in opposition to cumulative "risk factors". The phrase *risk and resilience* in this area of study is quite common. Commonly used terms, which are essentially synonymous within psychology are *resilience*, *psychological resilience*, *emotional resilience*, *hardiness*, and *resourcefulness*.

Resilience

In military terminology[4] resilience is defined as "the degree to which people and capabilities will be able to withstand or recover quickly from difficult conditions". Resilience can be broken down to 2 components; physical and psychological. While the physical component is easy to define the

[1] JSP 835, Chap 3 – Alcohol and Substance Misuse and Testing
[2] NHS - http://www.nhs.uk/conditions/anxiety/pages/introduction.aspx
[3] NHS - http://www.nhs.uk/Conditions/Depression/Pages/Introduction.aspx
[4] JDP 02

psychological component is somewhat harder but can be viewed as comprising mental, spiritual[5] and emotional elements. The balance of these 3 elements for different individuals will vary, and may vary for the individual over time.

Self-Harm (SH)[6]

Self-harm, sometimes called deliberate self-harm (DSH), is when somebody intentionally damages or injures their body. It is a way of coping with or expressing overwhelming emotional distress. Sometimes when people self-harm they don't intend to die but often the intention is more to punish themselves, express their distress or relieve unbearable tension. Self-harm can also be a cry for help. In addition to signifying distress it generally has a strong association with increased risk of subsequent suicide[7]. Self-harm behaviours may include:

- Cutting
- Burning
- Needle-sticking
- Over/under eating
- Banging your head
- Carving on your skin
- Severe scratching
- Punching yourself
- Biting yourself
- Self poisoning

Stress

Stress is the adverse reaction a person has to excessive pressure or other types of demands placed upon them. See also, definition of Operational Stress.

Stressor

Any event (or pressure) an individual experiences that is likely, individually or cumulatively, to induce stress. Further examples of stressors are detailed in Chapter 3 as they affect operational and occupational environments.

Suicide[8]

Suicide is the act of intentionally ending one's own life; it is sometimes a noun for one who has committed, or attempted, the act.

Suicidal Episode (Parasuicide)

Parasuicide refers to the deliberate infliction of injury on oneself or the taking of a drug overdose as an attempt at suicide which may not be intended to be successful which does not result in death (a completed suicide). A deliberate or ambivalent act of self-destruction or other life-threatening behaviour that does not result in death.

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[5] From CDG Paper 14/10 "Spiritual" is defined as religious, philosophical or political activity that enables individuals to engage with concepts that take them beyond their immediate situation. Spiritual connection to a wider conceptual environment is psychologically important (to an extent depending on the individual and at different times) to operational effectiveness; to the coping strategies of individuals and units and to their moral resilience on ops and in other situations.

[6] NHS - http://www.nhs.uk/conditions/self-injury/pages/introduction.aspx

[7] Deliberate Self-Harm Presentations to a General Hospital by Members of the UK Armed Forces, Hawton, Harriss, Casey and Simkin (University of Oxford), 2006

[8] NHS - http://www.nhs.uk/conditions/suicide/pages/introduction.aspx

Stigma

The general definition of stigma refers to “a mark of disgrace or infamy; a stain or reproach, as on one's reputation. To attach stigma to a person is to consider them flawed or inferior in some respect, sometimes to the extent that it can become difficult for others to see beyond the stigma (e.g. seeing someone with a mental illness solely in terms of their condition).

Trauma

Trauma in the context of this document is an event of such emotional intensity that it breaks through the body’s defences and floods it with an uncontrollable anxiety.

Traumatic Incident

Any event that can be considered to be outside of an individual’s usual experience and causes physical, emotional or psychological harm. (Trauma Risk Management Handbook)

Military Definitions

Commander

Commander is that individual assigned as a Commander by the Chief of the Air Staff or his delegate who has the powers of an Officer Commanding. QR 994 page 15-2, paragraph 2a, defines the Commanding Officer for disciplinary purposes.

Decompression

Decompression, in military environments, is an activity that is conducted at the end of combat operations before an individual is returned to their parent unit. This usually takes place in a location away from the operational theatre and away from the parent unit – often referred to as Third Location Decompression or TLD[9]. Decompression is the physical and mental unwinding from operations and is conducted as a group activity; normally with the group that were deployed together. MOD decompression policy[10] is set by DCDS (Pers & Trg) and is implemented by PJHQ under CJO direction. Decompression activity is intended to reduce the likelihood that an individual develops damaging/poor psychological traits or behaviours following deployed operations[11] by allowing personnel a period of rest, relaxation and reflection, within a safe and controlled environment, in order to facilitate reintegration to the Home Base.

Emergency Contact (EC)

Service personnel are required to nominate whom they wish to be notified if they are killed, missing, wounded, injured or seriously ill. This person is their EC. Whilst this individual will frequently be the Next of Kin (NOK), this is not mandatory and the Service person may choose someone else, for instance if their NOK is a minor. The Service person must provide the EC’s full name, address and telephone number. They should also indicate the EC’s relationship to themselves. This is predominantly recorded on an individual’s JPA record.

[9] The parent unit (or UK) is commonly refered to as the first location, theatre the second, with a location between the two known as third location.
[10] JSP 770, Part 2, Chapter 3.
[11] “The subjective utility of early psychosocial interventions following combat deployment”, Jones N, Burdett H et al (KCMHR), 2010

Families

For the purpose of this policy, family is interpreted loosely as those persons whom the individual assigns as family or is closest to on a day-to-day basis. This could extend to uncles, partners, grandparents or children. This distinction is made, rather than using the NOK definition, for notification and benefits purposes, as individuals nominated as family will be contacted by the Community Support and Station Welfare networks during deployments.

Formed Unit (FU)

A FU is a unit that deploys in entirety or a group of individual servicemen brought together to deploy on an operation with a defined mission. The unit may consist of members of all 3 Services. This may also include **Small groups** who deploy as crews (with associated support personnel) e.g. AT or SH deployments.

High Risk Groups

Personnel who are more likely to be exposed to potential traumatic incidents e.g. Trade Group 8, (RAF Regiment, RAF Police and RAF Firefighter), Medical Personnel.

Individual Augmentee (IA)

An IA is a person who is individually deployed in support of a HQ or to provide additional support to a FU. The term is often used synonymously for Non Formed Unit (NFU) personnel.

Leader

Leader is a term interpreted in this policy as an individual who is responsible for the welfare of other personnel or holds the rank of Cpl or above**.**

Line Manager

The Line Manager is the 1st Reporting Officer for OJAR/SJAR purposes.

Moral Component of Warfare (MCOW)

MCOW is defined in JDP 0-01 British Defence Doctrine 4th Edition (Nov 11), Chapter 4 – Fighting Power. The three components of fighting power are conceptual, moral & physical. The moral component is comprised of motivation, leadership and moral cohesion.

Next of Kin (NOK)

All Service personnel are required to provide details of their NOK. If married or separated (but not divorced), this will be their spouse/civil partner. If single, a widow, widower or divorcee it will be their eldest child, a parent, sibling or other relative, or, if they have no living relatives, it may be a friend. If a Service person dies, their NOK has certain rights regarding funeral arrangements and inheritance (unless specifically excluded in a legal document such as a will). Consequently, the MoD is obliged to inform the NOK of a Service person's death or if they are missing. In the event of death it is generally the NOK who will be the focus of the support and assistance provided by the MoD[12].

[12] JSP 751 – Joint Casualty and Compassionate Policy and Procedures.

Non-Formed Unit (NFU)

Within this policy a Non-Formed Unit (NFU) person is an individual identified for a deployed position for a set period of time as part of a larger rotation plan for personnel. See also Individual Augmentee.

Normalisation

Normalisation is an adjustment period conducted at the Parent Unit (PU) location, including Post Operational Leave (POL), and is the continuation of mental unwinding and physical recovery from an operational deployment. FUs are likely to carry out a number of activities marking their return from Ops e.g. medal ceremonies. The term is synonymous with getting back into the 'normal' routine of daily life as was the case prior to the deployment, but includes also psychological and emotional adjustment as well as physical. A Post Operation Stress Management Brief is to be delivered at the 12 week period marking the end of the expected normalisation period.

Off-Loading

Off-Loading is a mechanism that gives individuals the opportunity, in a non-threatening and benign environment, to discuss an incident or experiences with command, specialists or peers. It is an opportunity for individuals to express how they are feeling about an experience or event and is generally not formally recorded.

Operation

An operation is a military action or the carrying out of a strategic, tactical, Service, training, or administrative military mission; the process of carrying on combat, including movement, supply, attack, defence and manoeuvres needed to gain the objectives of any battle or campaign.

Operational Stress

Operational stress is 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.

Parent Unit (PU)

The PU is the Service establishment from which an individual is detached; the PU is responsible for providing that individual with administrative support. The PU may change on completion of deployment, for instance if an individual is posted on return from deployed ops.

Station Welfare Casework Committee (SWCC)[13]

The Station Welfare Casework Committee (SWCC) exists to provide oversight and guidance of service and other welfare resources in support of individual Service personnel and their dependants who need, or may need, specialist welfare assistance.

Stress Management

The aim of stress management is the conservation and maintenance of the RAF's combat capability. Commanders are ultimately responsible for the operational effectiveness, health, and wellbeing of their personnel. High levels of stress can reduce the performance of personnel serving on operations and in regular duties, reducing the number of personnel available. In both

instances operational effectiveness is degraded. The simple steps outlined in this policy assist commanders in effectively managing stress.

Stress Vulnerable Individuals[14]

Stress vulnerable individuals are those who are at additional risk due to conditions that exist in their domestic or organisational situation, be they private or professional; i.e. they meet certain significant risk criteria. A list of stress vulnerable individuals' categories is at Annex D to Chapter 3.

[14] Care should be taken not to confuse this term with the term 'vulnerable adults' which is used in the Safeguarding Vulnerable Groups Act (SVGA).

3 STRESSORS AND STRESS VULNERABLE INDIVIDUALS

Overview

1. This chapter identifies common stressors in the workplace from both an organisational and domestic perspective and details indicators for the recognition of stress in individuals in order to help generate mitigating actions and procedures to reduce the impact of stress. This baseline gives commanders and individuals alike the basic understanding of how stress might manifest itself. Leaders also need to be aware of certain groups of individuals which are known to be vulnerable to stress and ensure case management is in place for these individuals.

Stress

2. All individuals need some degree of pressure or stimulation to achieve best performance, but, when the pressure becomes excessive, work performance and the health of individuals can be adversely affected. Excessive pressure in the workplace or at home can manifest itself in physical, behavioural, mental or emotional effects. The effects are normally short-lived and cause no lasting harm. When pressures recede there is a quick return to normal. Stress, therefore, is not the same as ill-health and it is only when pressures are intense or prolonged that the effects can become damaging, potentially leading to longer term mental health problems. Long-term stress has also been associated with high blood pressure, anxiety and depression. Stress as a work issue cannot therefore be dismissed and managers should acknowledge that those who cannot cope with excessive stress are neither weak nor ineffective. Unfortunately, there is no way of predicting exactly what will cause harmful levels of stress and who will be affected; as a result, individuals and line managers need to be aware of the effect stressors have on them at any one time and be able to recognise signs and symptoms within themselves, their staff, and their colleagues.

The Stress Effect

3. The fundamental sources of stress can be broken into two relatively distinct areas, organisational (work) and domestic (personal). Military service blurs these two areas, notably in terms of the work-life interface which is further complicated by the change in family dynamics resulting from operational deployments. The concept of any stress management and resilience policy is to apply moderating factors to mitigate the effects of stressors. This may be in either sphere and is best identified in organisational factors and an individual's characteristics. Whilst the RAF is responsible for mitigating stress wherever possible, and making risk assessments on the levels of stress it will tolerate, individuals can also affect their own stress levels. It is for this reason that individuals are targeted in this policy for self-awareness and care as, without their personal contribution to their own wellbeing, the organisational moderating factors will be less effective. Annex A provides a diagrammatic representative of the Stress Effect. Understanding the relationship between organisational stress and domestic stress and the organisational factors and an individual's' characteristics that can moderate the stress effect is fundamental in the management of stress and building of resilience by both commanders and individuals.

Common Occupational Stressors

4. Regardless of the specifics of an organisation or workplace, there are generic stressors, listed at Annex B, which are common occupational stressors. To fully understand these stressors as they apply to individual working environments, a workplace stress audit, as detailed in chapter 5, would need to be conducted. Annex B provides a framework identifying potential areas for attention, and would suffice in the absence of a full audit, or could be used as a checklist by management when conducting a risk assessment. Specific, though not unique to the military, is the public perception of the military and its role, keeping in mind the public includes the Service

persons' family in many cases. This stressor, which would not ordinarily occur with regular employment in the private sector, should be considered when assessing overall stress in the organisation as it can play an important role in how an individual responds organisationally and individually. For example, a negative public perception of the military and its role in particular campaigns could place stress on an individual's values and aspirations and affect workplace teams as well as domestic stress, further isolating the individual from the public.

Recognising Stress

5. There are a number of indicators which aid in the recognition of stress. The key for line managers at all levels to recognising any stress-related indicator is to put it into context which is most easily observed as changed behaviours in individuals e.g. a normally outgoing person becomes introverted. The problem with some of the indicators is that they can only be recognised by the individual or family members living with them (e.g. disturbed sleep patterns).

6. At the workplace level high levels of absenteeism, work accidents (including minor ones), low production levels, poor quality productions, frequent breakdown of equipment and difficult interpersonal relationships are frequently associated with stress[1]. Other indicators include:

- working long hours
- insufficient work
- job insecurity
- short conflicting deadlines
- qualitative and quantitative work overload
- loss of concentration
- irritability and aggression
- an increase in musculo-skeletal disorders (e.g. back ache)

7. Once stress has been recognised, whether it be by the individual, family or those in the workplace, the reporting procedure must be known, simple and without consequence. The focus must remain on addressing stressors and reducing the individual's stress levels while implementing stress management measures to build resilience. If action is not taken and no confidence in the reporting system exists, the policy cannot begin to take effect. Annex C is a list of indicators which may aid in the identification of stress. At this point it is relevant to emphasise that the detection of stress in an individual does not necessarily warrant the intervention of medical services and involving them when clinical treatment is not required simply compounds the stigma already attached to mental health and increases stress levels. Individuals who exhibit some of the indicative behaviours in Annex C are not usually suffering from mental illness and intervention by strong but empathic leadership will, in most cases, alleviate what is normally a temporary condition for the individual.

8. It is important that Line Mangers are fully aware of their limitations when addressing individual stressors and should look to signpost when required. Specialist assistance is available from the Station Welfare Casework Committee (SWCC) and early engagement with HR Staff is recommended. In addition, a number of organisations, many with Service links, are able to offer support and assistance. Chapter 9 – Resources and Related Areas, lists a range of these organisations.

[1] JSP 375 Part 2, Vol 1, Chap 17 – Stress in the Workplace.

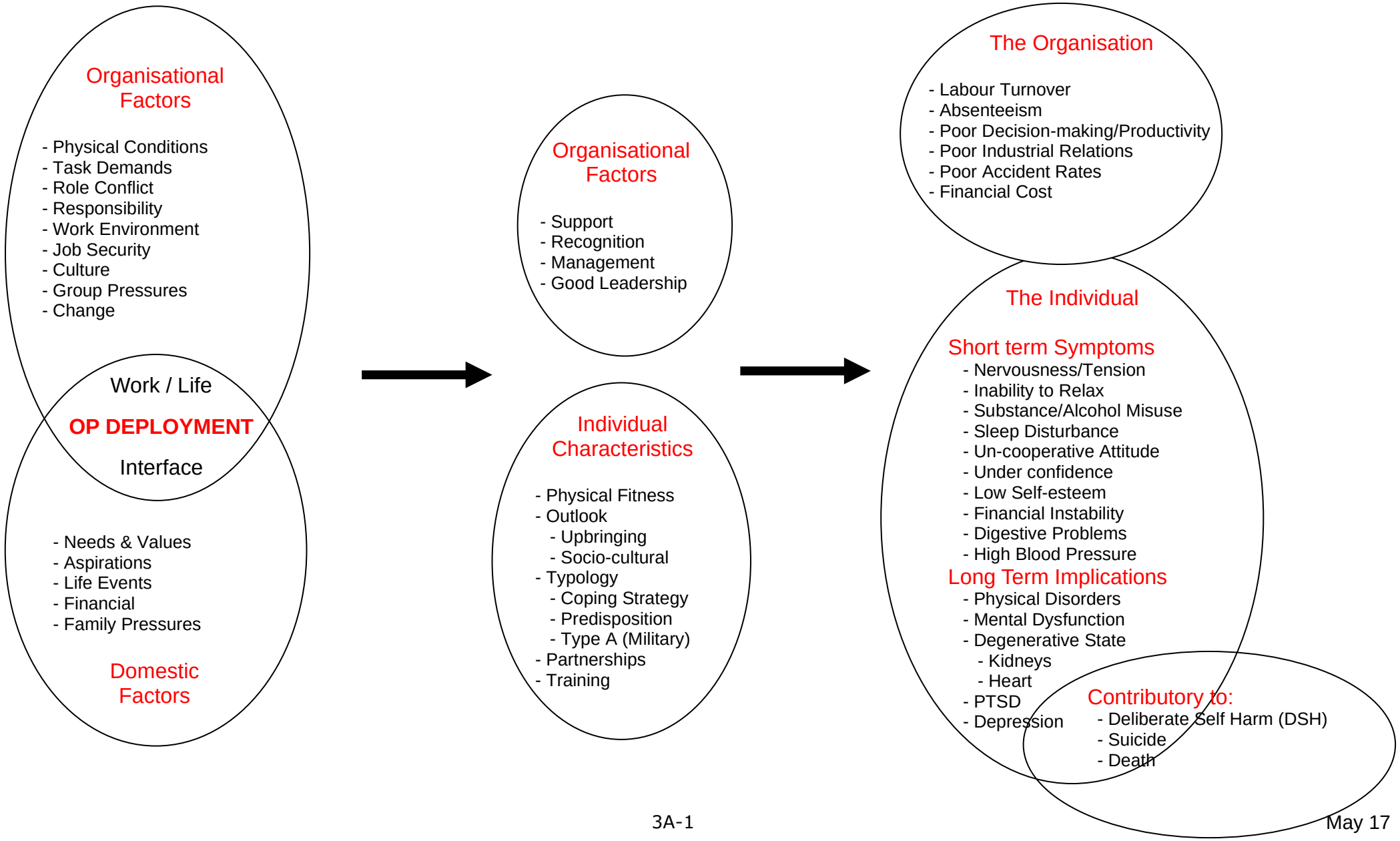
Stress Vulnerable Individuals

9. Prompt and appropriate management of and support to stress vulnerable individuals is essential in order to assist the individual concerned, or their family as needs be, and to minimise their potential for deliberate self-harm and suicide. However, it should be noted that for those individuals suffering from stress related conditions, deliberate self harm and suicide are an extreme reaction and occur rarely. Annex D is a list of individuals who should be *considered* vulnerable; however, all individuals should still be assessed for the effects of stress as individuals will all react differently.

Annexes:

A. The Stress Effect.
B. Stressors.
C. Recognising Stress in Individuals.
D. Stress Vulnerable Individuals.

THE STRESS EFFECT



STRESSORS

1. The following list of generic stressors can be applied to most workplaces then further interpreted through the use of a Stress Audit, as detailed in Chapter 5. The list is not exhaustive and is intended for guidance:

Organisational Factors

2. When considering organisational factors, management should look both up and down organisationally:

- Physical conditions.
- Task demands – workload, hours of working (too much and too little).
- Role conflict / Role ambiguity / Job design.
- Responsibility – lack of empowerment.
- Work environment.
- Job security / insecurity.
- Culture.
- Group pressures.
- Change.
- Team-working.
- Performance feedback.
- Training and development.
- Management support.
- Tools and equipment.
- Communication.
- Skill under-utilisation.
- Effort-Reward imbalance.

Domestic Factors

3. Whilst domestic factors in the main are more difficult to influence, awareness of an individual's domestic stressors can put in context their behaviours in the workplace where further stressors are applied. Additionally, the RAF has a distinct work-life environment where stress in the workplace more likely affects the domestic / life environment and vice versa.

- Individual needs and values.
- Individual aspirations.
- Life events – birth, death, marriage / divorce, house move (major transitions / life changes).
- Financial pressures.
- Family pressures and commitments.
- Flexibility – ability to plan.
- Work/Life Balance.
- Public image and perception.

Physical Factors

4. Physical factors can appear in both Organisational and Domestic environments

- Poor Nutrition.
- Dehydration.
- Illness & Injury.
- Poor hygiene.
- Sleep deprivation.
- Space (Privacy).
- Noise.
- Weather.
- Temperature.

RECOGNISING STRESS IN INDIVIDUALS

1. The following list of indicators may assist in the detection and recognition of stress in individuals. Individuals suffering stress would normally exhibit several indicators and context should be applied to each case. It should be noted that the categorisation of these indicators is not clear cut; what may be a behavioural issue to one person, could be an emotional indicator to another. These indicators are given for guidance purposes:

Physical

- Dry throat, muscle tension, headaches.
- Increased blood pressure.
- Inability to sleep (insomnia).
- Lack of energy or apparent listlessness.
- Change of appetite; usually a loss of appetite or abnormal eating habits at inappropriate times, indigestion, but could equally be 'comfort eating'.
- Increased reporting to medical staff with unexplained or vague physical complaints – stomach complaints / aches and pains.
- Loss of sex drive.

Emotional

- Life being 'out of control'.
- Inability to enjoy or participate in recreational or physical activity.
- Apparent lack of capacity for enjoyment.
- Sense of helplessness or hopelessness, worthlessness.
- Deteriorating relations with friends and peers.
- Inability to handle relationships and domestic upheaval, relationship breakdown.
- Concern expressed by others – family, peers or management.

Behavioural

- Changed behaviour pattern/'personality'.
- Excessive, abnormal or irrational mood swings (anger outbursts).
- Changes in alcohol / nicotine / substance use / misuse.
- Impulsive or reckless behaviour, such as binge drinking, fighting or inflicting self-harm by punching a wall, drink driving or speeding.
- Poor anger control and management, such as throwing objects or swearing/yelling at a superior, subordinate, family member or friend.
- Deteriorating work performance for no apparent reason.
- Inability to cope with day to day activities - poor functioning at work or home.
- Poor military bearing or evident and inexplicable disenchantment with the RAF.
- Disciplinary action / sporadic minor incidents (e.g. increased lateness for duty).

Mental/Cognitive

- Excessive forgetfulness.
- Apparent inability to concentrate or focus on issues at hand.
- Poor judgment.
- Seeing only the negative.

- Anxious or racing thoughts.
- Excessive worrying or daydreaming.

2. Long term stress has been associated with high blood pressure, anxiety and depression.

3. Annex H to Chapter 4 – Operational Stress Risk Indicator and Stress Indicators provides a list of indicators that are particular to those returning from operational tours.

STRESS VULNERABLE INDIVIDUALS

The following groups of individuals are classified as stress vulnerable. This list is not exhaustive and is intended to provide guidance although line management/ Chain of Command are best placed to make the assessment of an individual's vulnerability to stress Chapter 9 – Resources and Related Areas - has additional information pertinent to some of these groups.

- Young personnel of low rank – powerless/helpless.
- New members to the RAF – loneliness and isolation.
- Under Investigation – both directly (accused or complainant) or indirectly involved (witness).
- Has attempted suicide or deliberately self harmed previously.
- In debt – financial problems.
- Relationship change – marriage, divorce.
- Death/Illness - in family or close friend.
- Long-term sick / restricted.
- Those in operational readjustment period (3 months after returning from Ops).
- Families living apart (e.g. weekly commuters or those undergoing some form of marital/relationship separation for whatever reason).
- Transitions – retirement, discharge.
- Lesbian, Gay, Bi-sexual and Transgender (LGBT).
- Alcohol /Substance misuse.
- Those employed in intensively demanding roles or working regular long hours.
- Bullied/ Harassed

4 OPERATIONAL STRESS MANAGEMENT (OSM)

Overview

1. Operational stress is 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. Operational Stress is part of the continuum of occupational stress[1]. The MOD's operational stress management policy provides the framework for the development of single Service policies on operational stress management based on the 6 steps listed below. This chapter specifically develops steps 3, 4 and 5.

1. Pre-Service beliefs and attitudes.
2. In-Service training and promotion courses for career development.
3. Pre-deployment.
4. Operational deployment.
5. Post-operational recovery.
6. On-discharge from the Armed Forces.

2. Prolonged periods of stress or exposure to traumatic stressors can lead to long term clinical illness. The risk of encountering traumatic stressors could be more pronounced during operational deployments.

3. The aim of operational stress management is the conservation and maintenance of the RAF's combat capability and fighting power. Fighting power is established through the conceptual, moral and physical components of warfare. Commanders/LMs are ultimately responsible for the operational effectiveness, health, and wellbeing of their personnel which is the Moral Component of Warfare (MCOW). Stress, if not properly managed, can lead to psychological symptoms and patterns of behaviour that reduce both the performance of personnel serving on operations and also the number of personnel available for deployment. In both instances, combat capability is degraded.

Applicability of the Operational Policy

4. This mandatory policy, which includes the RAF policy on decompression and normalisation processes, applies to all RAF personnel – Regular and Reserve - who are deployed on operations, overseas or in the UK, whether as part of a formed unit (FU), a group or individually. While this policy is primarily designed for those personnel deployed on warfighting operations, the same principles are to be applied to personnel involved in operations other than war, such as peace support, or in other activities in which unpleasant experiences (such as body handling) occur.

5. Consideration should also be given to applying this policy to personnel deployed to a benign environment away from their normal place of duty and who are separated from the support of their unit, family and friends. Specifically, this covers those personnel posted into rear operational or strategic command environments, who are physically isolated from the area of operations, though work in the environment as part of their daily routine e.g. RPAS crews. Civilians under RAF command who are deploying should be managed in accordance with extant instructions[2] which include pre-deployment and post deployment procedures.

6. This policy outlines a minimum level of support to aid commanders at all levels assist in the provision of support to RAF personnel and their families recognising that there is no 'one size fits

[1] JDP 1-05 – Personnel Support for Joint Operations – Chapter 2, Section 6, Deployment welfare support.
[2] These are detailed on the People Services Channel on the Defence Intranet, under Moving Jobs, Support to Operations.

all' solution to managing operational stress. COs may enhance this policy to suit the particular needs and roles of their units and individual personnel.

Involvement of Families

7. For RAF personnel to be effective on operational deployments, it is essential that their wellbeing, and that of their families, is properly addressed. This principle is fundamental to the MCOW in maintaining motivation and addressing work-life balance. The RAF has access to various support organisations that provide community support services to personnel and their families. Further details on the 'Link with Families' are covered in Chapter 8 of this AP.

OSM Policy Framework

8. **RAF OSM Stages.** The management of operational stress within the RAF is broken into 3 stages:

a. **Stage 1**. **Pre-deployment** covers the preparation of the individual (and their family) until the individual arrives in the operational theatre.

b. **Stage 2**. **Deployment** covers the period from arrival in an operational theatre until leaving the operational theatre.

c. **Stage 3**. **Return and Post-deployment** commences on leaving the operational theatre. It begins with any PJHQ directed decompression activity and progresses to the normalisation phase when personnel return to their Parent Unit (PU), including the period of Post Operational Leave (POL). It addresses post-deployment issues in the months following the completion of the operational tour, and includes the longer term issues that may affect RAF personnel and their families up until individuals leave the Service.

9. **Actions Required.** Actions required at each stage are broken down into those required by Individuals, at Annex A, and by Commanders/LMs, at Annex B, with the latter group further sub-divided to cover the treatment of FU, NFU personnel and groups other than FUs.

10. **Principles of OSM.** The underpinning principles of this policy are that personnel deploying on operations are to be interviewed both before deployment and also on their return (for deployments of 31 continuous days or more) to the home base or gaining unit. The decompression and normalisation phases also help to address operational stress issues. In some cases, such as FU or group routine deployments from the same unit, interviews can be replaced by group briefings. The purpose of these interviews are to identify and assist in the management of any issues arising before or after the deployment that, left unresolved, may adversely affect the individuals preparation for deployment or their return home.

11. **Expectation Management.** Management of expectation is important in order to avoid resentment caused by potentially conflicting requirements. Knowing exactly when and where they are going, what they are likely to be doing, the perceived threat level, as well as environmental conditions to be encountered, will positively affect an individual's preparation and outlook. To maximise the benefits of decompression where it is mandated it must be inclusive of Tour Length. Post operational recovery, and the need to finalise post-deployment administration should also be known and understood by deploying personnel.

12. **Welfare Support.** Individuals will also have expectations with regard to welfare support whilst in theatre. Prior to deployment, they should be made aware of the arrangements set out in the Deployment Welfare Package (DWP)[3].

[3] The DWP can be viewed on the RAF Community Support Website.

13. **Reporting Requirements.** The recording of all OSM actions outlined in this Chapter is mandatory and is to be recorded by the PU on JPA using the JPA Stress Management Codes at Annex C.

14. **Reserves.** Reserve personnel are to be treated identically to Regular personnel in the category they fall into, i.e. FU, Small Group or IAs.

Stage 1 – Pre-Deployment

15. Deployments can be stressful and demands and stressors can be evident before the detachment commences. For example deployment timescales and problems or delays with administration, training and kitting can be extremely stressful. Separation from family and friends could create additional tensions, regardless of how many times an individual has deployed or whether they are deployed as part of a FU or NFU. Pre- Deployment Training (PDT) also assists with the mental preparation and adjustment for the deployment.

16. Interviewing individuals before they go on deployment – either separately or as part of a group – and on return (for deployments of 31 continuous days or more), is fundamental to the OSM framework. All personnel deploying are to be interviewed by their line managers in line with the guidance in Annex D. Section or Station administrative staffs are to carry out the required JPA actions.

Stage 2 – Deployment

17. **In-Theatre.** Responsibility for deployed personnel in theatre falls to the in-theatre chain of command; however, as most RAF personnel deployed will work within an RAF chain of Command, this part of the policy should be applied in the deployment phase.

18. **Trauma Risk Management (TRiM).** TRiM is a peer delivered, proactive human resource management tool for supporting individuals following exposure to traumatic events. Its purpose is the early identification of the signs and symptoms of stress; it is not itself a treatment for stress. Further information on TRiM can be found at Chapter 10 to this AP.

19. **Notifying Parent Units of Traumatic Incidents.** In all cases where an individual has been involved in, or on the periphery of, a traumatic incident, or exposed to tasks that are potentially distressing and outside the scope that an individual might have ordinarily expected during the deployment phase, this information must be passed back to the PU (OC PMS / OC PSF or equivalent); this should take place independently of the TRiM process if used. The onus for this reporting requirement is firmly on the deployed commander. The information is to be about the incident or tasks only and does not require a judgement on the individual's reaction to that incident. This information does not follow a set format or report, but must be marked 'Official Sensitive' and transmitted using authorised communications.

Stage 3 – Return And Post-Deployment

20. **Decompression.** MOD Decompression[4] policy directs that decompression may be mandated by PJHQ if the situation warrants it. Decompression activity is intended to ensure that all personnel deployed on operations under the Commander of Joint Operations (CJO's) operational command or within a Joint Operational Area (JOA) receive post operational stress management appropriate to their needs prior to their return to the home or gaining base. Section 40 [redacted] HQ Air assists with the co-ordination of RAF assets. Further information on decompression is detailed at Annex E and should be read in conjunction with the relevant PJHQ FRAGO.

[4] JSP 770, Part 2, Chapter 3 – Post Operational Decompression.

21. **Decompression Desired Outcome.** Decompression is designed to place individuals into a formal, structured, and most importantly, monitored environment in which to begin 'winding down' and rehabilitating to a normal, routine, peace-time environment. It allows time to begin rationalising what they have left behind in the operational setting and to think about the Service and family life to which they are about to return.

22. **Decision to Decompress**. It is mandatory for deployed commanders to consider the requirement for decompression. PJHQ will decide whether to mandate decompression for FUs and / or IAs under full command. However, since the implementation of OSM is a single Service responsibility, the Chain of Command may submit a waiver request to PJHQ through A1 Ops, HQ Air Cmd if they feel it is not warranted for the unit / individual(s) in question.

23. **On Return.** Virtually all RAF personnel returning from deployment, along with their families, will encounter varying degrees of uneasiness and challenges as they readjust. This is a normal reaction that can be expected to last for up to 12 weeks. Commanders/LMs and Welfare Agencies can have a positive influence on this process by assisting the individual and families to resolve issues that might act as long-term stressors.

24. **Post-Deployment Interview.** All personnel returning from deployment (who have been away for more than 31 continuous days (excluding Aeromed personnel) are to be interviewed by their line managers at the PU in line with the guidance in Annex F and requisite JPA action by Section or Station Administrative Staff. Providing an opportunity for individuals to discuss issues arising from operational experiences in a controlled, structured but non-threatening and empathetic environment is likely to minimise the impact of deployment on individuals. This is particularly pertinent for those who have been subject to highly traumatic experiences or close quarter combat operations[5]. Under normal circumstances, this interview will follow POL. However, in some cases an immediate post-deployment interview will be warranted. Further detail on this circumstance is covered at Annex B, paragraph 16.

a. Some personnel, particularly officers, may be assigned to a different unit post deployment and it is important that Commanders**/**LMs confirm whether an individual assigned to a new unit has received a post–deployment interview. If it hasn't then arrangements (either at the losing unit or gaining unit) must be made for this mandatory interview to be conducted. Confirmation (or otherwise) of this interview is to be confirmed/made with unit P staffs (at the current unit) at the earliest opportunity to ensure that the appropriate JPA action can be taken.

b. Particular care must also be taken to ensure that those returning from a deployment earlier than expected are not overlooked, especially if they return for hospitalisation, sickness or compassionate reasons.

25. **Behavioural Risks.** Research has shown that the period immediately following the return from operations represents a risk area for a high incidence of sexually-motivated behaviour and harassment, particularly when coupled with the ready availability of alcohol. Association with deployment and alcohol misuse indicates attention needs to be paid in ensuring sensible drinking is encouraged throughout deployments, decompression and normalisation.[6] Therefore, commanders are to brief all personnel prior, during and post operations, that they are to continue to show respect for their colleagues and that any inappropriate behaviour will be reported and appropriate disciplinary action taken by the CoC.

26. **Family Engagement.** While an individual can be easily monitored in the close confines of a 24 hour operational environment, once an individual returns to their PU close contact is diminished and monitoring becomes more difficult. This is further exacerbated when an individual joins a different unit to the one they originated from / deployed to or with. Under these circumstances, it is

[5] "The subjective utility of early psychosocial interventions following combat deployment", Jones N, Burdett H et al (KCMHR), 2010
[6] "Patterns of drinking in the UK Armed Forces", Fear N, Iversen A, Meltzer H et al (Academic Centre for Defence Mental Health, Kings College London), 2007, p9.

likely to be family members and close friends who will first notice any changes in behaviour post deployment. Therefore, it is vital that families are fully engaged as part of the operational stress management process so both the family and individuals are able to recognise signs of stress and take appropriate actions. Chapters 8 and 9 of this AP give more information on Links with Families and Resources and Related Areas to assist with awareness and support available to families.

27. **Post Op Stress Management (POSM) Brief**. All personnel returning from deployment are to receive a POSM Brief. It is to be delivered approximately 12 weeks following return from an operational theatre and is mandatory for all personnel. This brief should be delivered by a Station Recall Day or FU facilitator and incorporated in Recall Days as per Annex G, or given at a FU briefing. The POSM brief is available electronically from SMARTT 95237 ext 6621.

28. **'Off-Loading' Opportunities.** Where personnel, either as individuals or as a group, have been repeatedly exposed to unpleasant experiences as part of the duties of their post, commanders should consider 'off-loading'[7] sessions facilitated by Padres or Medical Staff; for NFU personnel, the end of tour interview at their parent unit could be considered an 'off-loading' opportunity. Additionally, the Recall Day presents another 'off-loading' opportunity. For FUs and small groups, commanders could use a variety of resources which best suit these personnel. As individuals in groups or FUs will feel differently about the same or similar experiences, care should be taken to address individuals' needs as required, rather than on the group or unit 'norm'. Off Loading' is not mandatory RAF policy and is to be used at Commanders' discretion.

29. **Adventure Training (AT) Activities.** AT activities for small groups and groups of FU personnel have proven useful for dealing with the management of operational stress post deployment. The benefits of such activity are not only through physical activity but also through the opportunity to discuss issues with colleagues in a non-threatening and non-judgemental setting. Commanders should assess the needs of their personnel and make suitable AT opportunities available. AT activities selected should give opportunities for group discussions and 'off-loading' and should be supplemented with local Health (CPN or SMO) or Chaplaincy resources as appropriate. This may be as simple as having these specialists deliver refresher training on post operational stress, or grief and anger management in the lead up to the activity, or being involved in the activity so they are available throughout to meet the individual or groups welfare requirements.

30. **Follow-Up and Longer Term Management.** Commanders will need to establish how their unit procedures can be developed to capture personnel who may present effects and adverse reactions months after they return from deployment. Commanders and managers should seek advice from the SMO and Welfare Committee in these cases. The individual or group should be kept under line management review through follow up interviews and given regular opportunities, without undue pressure, to discuss any ongoing risk factors (as defined within Annex I).

a. Follow up LM interviews 4-6 month after deployment is good management practice. This could be achieved through one on one interviews or a group briefing session. The purpose is to identify if an individual/s or group have completed the normalisation process, regardless as to whether they had issues in their return interview or not.

b. It is critical that the individual or group are not re-traumatised and any follow-up interview / briefing should focus on the now and future without reference to historical events. If the individual or group presents significant areas of Risk or Stress Indicators IAW Annex I, they should be referred to SMO, Padre or welfare support available.

c. All interview records should be kept on the individual's unit personal file and destroyed once the individual is posted or after a period of six months. If the individual is posted within the six month period after the post-deployment interview or significant areas of risk have

[7] Refer to Off-Loading definition at Chapter 2.

been identified, interview records are to be forwarded to the gaining unit for longer term management.

31. **High Risk Personnel Groups.** Returning personnel who do not work in a regular RAF unit or stn are at risk as they may lack the regular support mechanisms of the RAF and its military environment. Generically, at high risk are:

a. Those returning from a deployment earlier than expected, especially if they return for hospitalisation, sickness or compassionate reasons.

b. Those who do not return to the same unit they were assigned from to the deployed environment i.e., are assigned whilst on deployment. The management of personnel assigned to new units on return from operations has already been detailed throughout this policy and, provided the policy procedures are applied, this risk should be mitigated through good communication between gaining and losing unit and the in theatre commander / unit.

c. Those who are assigned to a Joint environment where the RAF Command chain is administrative only.

d. Reserve personnel who do not return to military employment.

e. Regular RAF personnel whose assignment is within civilian employment or remotely.

32. **Reserves.** The management of Reserve personnel in the longer term presents some unique challenges that can only be overcome through contact by the Reserve Unit and inclusion of Reserve personnel in all Station follow up activity and events, including Station Recall Days and AT activities. There are policies and procedures which have been developed in support of reserves deploying on operations, including their ongoing aftercare.[8]

33. **RAF personnel Serving at Non-RAF Organisations**. RAF administrative commanders of personnel who are assigned to a Joint or civilian environment are required to fulfil the requirements detailed for commanders in this policy. It is expected that a Joint unit will assist in the stress management requirements; however, the responsibility to ensure this policy is applied remains incumbent on the RAF administrative commander.

Annexes:

A. OSM Deployment Actions Required of The Individual.
B. OSM Deployment Actions Required of The Commander.
C. JPA Operational Stress Management Codes.
D. Guidance to Line Managers for Pre-deployment Interviews.
E. Decompression.
F. Guidance to Line Managers for Post Deployment Interviews.
G. Recall Days.
H. OSM Exposure to Risk.
I. Operational Stress Risk Indicators and Stress Indicators.

[8] 2008DIN01-42 – Civilian Operational Deployment assessment – Post-operational Psychological Support (CODA-POPS); JSP950, Volume 2, Chapter 7, Leaflet 2-7-2 – Provision and Management of Defence Mental Health Services.

OSM DEPLOYMENT ACTIONS REQUIRED OF THE INDIVIDUAL

1. Individuals are to complete the actions detailed at Appendix 1 for the 3 stages of deployment.

Stage 1 –Pre-Deployment

2. Individuals who are deploying have responsibility for ensuring that they, and their family, are prepared before the deployment commences.

Stage 2 – Deployment

3. Individuals may be required to complete an in-theatre arrivals package.

Stage 3 – Return And Post-Deployment Required

4. Individuals are to be aware that if deemed appropriate, immediate decompression activity will follow their deployment, prior to their return to the UK. Individuals are also to be cognisant that once arriving in the UK, there will usually be a requirement for some post-deployment administration. This may involve, for example, the return of weapon or kit to the PU before commencing POL.

5. Individuals should understand that they may be required to return to their PU prior to the commencement of POL as well as the need for, and rationale behind, the post-deployment interview.

   a. Individuals should be aware that abnormal, extreme or traumatic events experienced on deployment can lead to adverse, but entirely normal, adjustment reactions. Assistance is available from the chain of command, Padre, SMO, Practice Nurse or Soldiers', Sailors', Airmen and Families Association (SSAFA).

6. A number of other organisations, many with Service links, are able to offer support and assistance. Chapter 9 - Resources and Related areas, lists a range of these organisations. Individuals are advised to seek help early, before problems escalate into possible illness, further complicating lifestyles and affecting performance in the work environment.

Appendix:

1. OSM Actions Required of Individuals Deploying on Operations.

OSM ACTIONS REQUIRED OF INDIVIDUALS DEPLOYING ON OPERATIONS

1. **Stage 1: Pre-deployment.** Individuals who are deploying have responsibility for ensuring that they, and their family, are prepared before the deployment commences.

a. Access the *Deployment Toolkit* on either the RAF Intranet or the Internet.

b. Read *The Demands of Deployment* booklet. Take a copy home for family members to read.

c. There may be difficulties with some aspects of administration, kitting and training. This may be frustrating, but deal with issues as they arise and ask questions if unsure about anything. Seek assistance from the chain of command if required.

d. Talk to family members about the deployment; establish what level of support they would like and report this back to your chain of command. If family or other problems are evident let someone know. Seek assistance from the chain of command, Station HR staffs, Padre, or the Soldiers', Sailors', Airmen and Families Association (SSAFA).

e. Seek advice from personnel who have experienced a similar deployment before. If possible contact the person you are replacing in theatre.

f. Eat healthily and exercise regularly. Undertake acclimatisation training as directed.

g. Think about returning home and the adjustments that may be required.

h. Read the *Return and Reunion* booklet. Take a copy home for family members to read.

i. Ensure that a unit ‘Single Point of Contact’ (SPOC) is nominated and that family members are included on the welfare and community support correspondence list from the unit. You will be asked by your unit to nominate which family members you would like contacted during your deployment. You may nominate multiple contacts if required e.g. spouse / partner and parents.

j. Comply with any pre-deployment medical and dental requirements, for example inoculations or dental check ups.

k. Attend all required pre-deployment briefings and training, including Individual Pre-deployment Training (IPDT).

l. Attend pre-deployment interview with Line Manager. Many of the points above will be discussed at this interview.

2. **Stage 2: Deployment**

a. Complete in-theatre arrivals process and/or RSOI as necessary.

b. Shortly before return, think about returning home and the adjustments that may be required.

3. **Stage 3: Return and Post Deployment.** Individuals should understand that they may be required to return to their PU prior to the commencement of POL as well as the need for, and rationale behind, the post-deployment interview.

a. In theatre, attend in-theatre return interview, complete decompression period or post-operational recovery program if deemed appropriate.

b. Conduct all post-deployment kit returns and admin, including leave application, required before proceeding on POL.

c. Re-read *Return and Reunion* booklet.

d. Attend unit post-deployment interview / briefing.

e. Attend Recall Day at approximately 12 weeks after ending the deployment.

f. Comply with any post-deployment medical and dental requirements.

g. Seek out assistance early. Individuals should be aware that abnormal, extreme or traumatic events experienced on deployment can lead to adverse, but entirely normal, adjustment reactions. Assistance is available from the chain of command, Padre, SMO, Practice Nurse or SSAFA-FH. Moreover, a number of other organisations, many with Service links, are able to offer support and assistance. Chapter 9 - Resources and Related areas, lists a range of these organisations. Individuals are advised to seek help early, before problems escalate into possible illness, further complicating lifestyles and affecting performance in the work environment.

4. Be honest with yourself; some form of re-adjustment is entirely to be expected. Be alert to the potential for you to experience any of the following:

a. Disturbed sleep patterns.

b. Unwarranted irritability and anger outbursts.

c. Difficulty in concentrating.

d. Hyper-vigilance.

e. Exaggerated startle response to noises or smells.

f. Detachment from other people.

g. Relationship difficulties.

h. Diminished interest in normal activities.

5. If so, you are likely to find it helpful to talk to someone about it – either your supervisor, the SMO, Padre, SSAFA or someone outside your chain of command. Whilst most of the symptoms are normal, and will pass, there is a risk that left unresolved, you could go onto develop more tensions and long term mental health issues requiring clinical intervention.

6. Some self help strategies to consider include:

a. Avoid isolating yourself – join in social activities, and try to revert back to life as normally as possible.

b. Try to discuss any incidents or experiences with family and / or friends.

c. Be aware that it takes time to adjust, and memories will not fade immediately.

d. Talk to others who were involved in the situation or who have had a similar experience.

e. Try to eat balanced, regular meals.

f. Try to avoid using alcohol or other addictive substances as a support.

g. Use the RAF support mechanisms in place for those returning from deployment. This policy provides a list of agencies and contacts; ask your line manager or admin staff for a copy.

OSM DEPLOYMENT ACTIONS REQUIRED OF THE COMMANDER

1. Commanders play a significant role in the management of operational stress. The exact role laid out in this Annex depends on the nature of the individuals' deployment i.e. as part of a FU, as NFU / IA, or as part of a group other than a FU[1].

2. If problems or issues are identified pre-deployment, they should be dealt with as soon as possible, with the assistance of unit and Station HR staff if required.

Management of Deployed Personnel

3. Parent Unit (PU) commanders relinquish their responsibility for personnel to the in-theatre Commander once their personnel are deployed. Responsibilities of PU commanders to their members during Stage 2 are, therefore, limited; however, they do retain responsibility for the families of personnel deployed. Commanders should track the return of deployed personnel and any reporting conducted on the individual. On return, PU commanders regain full responsibility for the individual and become responsible for Stage 3 actions. Whenever possible, deployed personnel should report to their PU on return for post tour administration before proceeding on POL.

Personnel Assigned During Deployment Period

4. When an individual is assigned during the deployment period or on return to the UK, the losing unit must ensure the full details of the individual's deployment and the pre-deployment interview record is forwarded to the gaining unit[2]. This ensures that the gaining unit can conduct the post-deployment interview on the basis of best knowledge and thus achieve the intent of this policy. This, however, does not absolve the individual of his / her responsibility in letting the 'new' unit know that they have just returned from a deployment. In this way, should administrative action by the previous unit be delayed, then all necessary post deployment action will still be carried out in a timely fashion.

Management of Families of Deployed Personnel

5. Unit commanders are to ensure that families are able to access a designated Single Point Of Contact (SPOC) during the period they are separated from their Service member. The designated SPOC should have access to timely information on the deployment. Additionally, family briefings should be offered throughout the deployment for FU and small groups when appropriate. Management of families whilst the member is deployed will assist in re-integrating the individual into the family and in re-establishing normality after the deployment. Chapter 8 of this AP further details the Link with families.

[1] Small groups or detachments that are deployed and do not constitute a FU or NFU deployment.
[2] AP3392 Vol2 Lft 1511 Annex A.

FORMED UNITS

Stage 1 – Pre-Deployment

6. The preparation for FU deployments may differ from that undertaken in respect of NFU deployments. It is accepted that individuals deploying as part of a FU are supported by their colleagues, many of whom will be familiar to them. Units also generally have clear information on the location and role they will have in theatre and probably trained for this task together. This type of deployment can be expected to present less pressure on an individual than a NFU deployment. Commanders must not generalise as any group or individual can be adversely affected by any event.

7. Where FUs deploy, and numbers of personnel are significant or the notice to move is short, commanders are to provide pre-deployment briefings that address the issues that need to be raised as part of this policy. This will normally be addressed through the relevant IRT Module.

8. Although group briefings may be convenient, commanders should remain aware that, for some individuals, group briefings may not provide the necessary support or opportunity for raising a particular or personal concern. Any individuals known to have or suspected of having difficulties or concerns should be given a personal interview as per NFU personnel. Individuals who are posted into a FU for deployment who are not ordinarily part of that FU should be prepared as NFU personnel as well as being prepared as part of that FU.

Stage 2 – Deployment

9. FUs will conduct in-theatre arrivals and/or RSOI as necessary for the operation.

Stage 3 – Return And Post-Deployment

10. FUs will ordinarily conduct decompression activity under PJHQ direction relevant to the operation. The onus for applying to opt-out of decompression activity lies with the Formation or Unit Cdr. All such applications must be staffed to PJHQ who have the final say as to whether an opt out is approved or not. Under current PJHQ policy, the RAF are responsible for providing personnel to deliver the FU decompression programme at a designated facility, dependant on the deployed units' location. Section 40 HQ AIR assists with the co-ordination of RAF assets to the FU in support of the programme. Decompression is detailed at Annex E.

11. In a similar way to pre-deployment preparation, units can be debriefed in groups although commanders should remain aware and alert to individuals that may have different needs at this time. Personnel involved in critical incidents should be individually interviewed to give them the opportunity to discuss any residual concerns they may have on a confidential basis, in addition to unit briefs. Personnel from FU who are returned home prior to or after the re-deployment of the unit, including through aero-medical evacuation, should be handled as IA returns. All personnel returned in this manner should be interviewed on return to the PU due to the increased stressors and susceptibility to re-integration issues.

NON-FORMED UNITS / INDIVIDUAL AUGMENTEES

Stage 1 – Pre-Deployment

12. Individuals who have been nominated to deploy are to be given a pre-deployment interviewed by their line manager[3] which is to be countersigned by their Flt Cdr. The interview should take place 3 or 4 weeks before the deployment and the IA given a copy of Annex A.

[3] 'Line Manager' is as defined in Chapter 2 of this AP.

Guidance for the interview, as well as a checklist, can be found at Annex D. A record of this interview should be kept by the line manager to act as a baseline and information for the post-deployment interview. The interview record should be forwarded to the IA's new line manager for them to conduct the post-deployment interview, should the IA have a new CoC or find themselves assigned after their deployment.

Stage 2 – Deployment

13. NFU personnel / IAs will conduct in-theatre arrivals and/or RSOI as necessary for the operation.

Stage 3 – Return And Post-Deployment

14. Decompression may be mandated for NFU personnel / IAs by PJHQ. The programme will be the same format used for FUs and is detailed at Annex E.

15. Where the deployed commander (or deployed unit staff) has concerns about the wellbeing of an individual returning they should contact the PU Chf Clk or OC PSF with their concerns. The PU will then need to decide on a course of action that best supports the individual on their return. The deployed commander is to make arrangements for the individual to be received at the UK airhead by a suitable representative of the PU. The ideal representative would be familiar to the individual, remained in contact during their deployment and have an understanding of the environment the individual is returning from. The PU representative is to provide the individual with a programme of upcoming appointments and events.

16. Commanders are to ensure that a named individual within the chain of command makes initial contact with IAs (other than those returning through the procedures listed in the previous paragraph) on their return to the UK. Contact should be made before they proceed on POL, to acknowledge their safe return and confirm there are no immediate issues that need attention. Once the individual has returned from POL and when their Insert Slip has been received, the post-deployment interview should be conducted by line management; at the latest, this should take place no later than 12 weeks after the return from deployment. The notes made during the pre-deployment interview should be referred to, as well as any reporting from theatre. Guidance on the post-deployment interview, as well as a checklist, is attached as Annex F, noting the requirement for commanders/LMs to clarify/confirm that an individual who has been assigned to a new unit, post deployment, has/will receive their mandatory post-deployment interview on arrival at their new unit Interviewers should ensure that a record of the post deployment interview is kept for a period of at least 6 months. Records may be kept longer if the interviewer sees a requirement, consistent with the Data Protection Act, to do so. This is in addition to reporting requirements detailed at paragraph 16 of Chapter 4.

17. All IAs are to be administered as detailed at Annex F regardless as to whether they are returning to the unit they deployed from or have been posted into a new unit. As detailed at paragraph 3 of this Annex, the losing unit has a responsibility to forward on details of the individuals' deployment and the pre-deployment interview record. If not received, the gaining unit (LMs and P staffs) should actively seek the relevant documentation from the IAs pre-deployment unit prior and the Individuals arrival on their new unit.

GROUPS OTHER THAN FORMED UNITS

Stage 1 – Pre-Deployment

18. When small groups or detachments are deployed and do not constitute a FU or NFU deployment, a management plan for these individuals should be developed by the PU and should be based on the principles of this policy. This is particularly relevant in units where multiple short

duration deployments are part of the standard deployment routine. This policy will not dictate a minimum or maximum group size, or the duration of deployment (other than to state that only those personnel who deploy for 31 continuous days or more require a pre/post deployed Ops interview), but rather leaves this to the discretion of commanders. Examples of these groups are single AT crews flying in and out of operational theatres, FJ aircrew rotations, TSW, TMW, TCW, and SH detachment operations, communication teams operating independently and aeromedical teams (including aircrew). Short duration tours such as repatriations and those missions associated with airlift aircraft, including SH and specialist repair teams should all be considered in this grouping.

19. The experiences regularly occurring as part of these deployments will also guide the commander and individual as to what preparation is required. This group is susceptible to the cumulative effects of Operational Stress rather than a single critical incident. Similarly, detachment members may be subjected to different stressors whilst part of the same mission. An example is SH rear crew dealing with a CASEVAC patient or the extraction of troops, compared to the 'front end' aircrew operating the aircraft. The needs will be primarily determined through communication with the group through the group leader and the detachment commander. An interview in accordance with Annex D could also be given to individuals to assist with this process and Annex I used to help determine who might be at risk.

Stage 2 – Deployment

20. The nature of the RAF small group detachment and its operational experience in conjunction with the direction of PJHQ will dictate if the group is to be considered a FU or as IAs. Once decided, they should be treated iaw the paragraphs above.

Stage 3 – Return And Post-Deployment

21. Personnel in small groups can be managed as per the FU or IA procedures. Their management will be dependant on the individuals' needs but also on the basis of what the group experienced on their deployment, regardless as to the period of time deployed. Detachment commanders are best placed to make this determination.

JPA OPERATIONAL STRESS MANAGEMENT CODES

A review of the JPA Operational Stress Management codes used by the RAF took place in May 16 to make them applicable for all Services and the new codes come into effect from 1 Aug 16. Old codes will remain valid for 12 months to allow in-train OSM to be completed. The new codes are listed below and cover the main items of RAF OSM policy although do not align with the RAF's chronological order of events. This does not prevent them from being used to manage the OSM record on JPA. .

Stage 1 - Pre-deployment

Pre-Deployment RAF Interview
Pre-Deployment Briefing

Stage 2 – Deployment

Decompression
Coming Home Briefing

Stage 3 – Post deployment

Dismounting Course
RAF Station Recall Day
Normalisation

Stage 4 – Return to work

Post-Deployment Interview

GUIDANCE TO LINE MANAGERS FOR PRE-DEPLOYMENT INTERVIEWS

Objective of the interview

1. The purpose of the pre-deployment interview is to identify and assist in the management of any issues that, if left unresolved, may adversely affect the individual's or group's preparation for deployment. This should not be delegated to line managers below JNCO status. The Commander is still responsible for ensuring that the interview has taken place and counter signs the relevant paperwork The interview is to be used to:

a. Give the individual a copy of Annex A outlining their required actions pre and post deployment as a checklist.

b. Ensure the individual has access to the A1 Ops SharePoint site as well as the Serving families link on the RAF website.

c. Ensure that the individual is appropriately trained and equipped for their deployment and if required, to assist the individual in accessing training and / or equipment.

d. Ensure that the individual complies with any pre-deployment medical and dental requirements.

e. Ensure that the individual is aware of, and attends, any required pre-deployment briefings.

f. Ensure that the individual is aware of their position / role / location / environment at their deployment location. If possible, have contact details of current incumbent in theatre that the individual is replacing.

g. Assist the individual in finding personnel who have experienced a similar deployment.

h. Ensure that the nominated Single Point Of Contact (SPOC) for the individual's family has been assigned and the level of contact they require is confirmed and agreed.

i. Discuss any concerns with the individual, and any family considerations to be aware of.

j. Review current allowances and pay issues. Ensure the requisite procedure for cessation / commencement of allowances is known by the individual *prior* to deployment e.g. location allowances, SLA charges.

k. Ensure the individual is briefed on the return process, including decompression, before commencing Post Operational Leave (POL).

2. If applicable, discuss the *likely* arrangements for the administration of POL following the deployment. JSP 760 Chapter 3 provides guidance. Supervisors should note that while there will be circumstances that require POL to be postponed or curtailed, such instances must be considered as exceptional.

Your role

3. Your responsibility is to ensure that the individual is fully prepared for their deployment, and to point them in the direction of further support if required. Should any information come to light which suggests that the individual should not deploy, then you should seek advice from the CoC and unit or station administrative staffs.

Points to note

4. The objective of the interview is NOT merely to check that the individual has been issued with their equipment and knows where they are going. It is designed to ensure that the individual is physically and mentally prepared to deploy.

5. The interview itself is **mandatory**; sharing of personal information is NOT.

6. Notes should be taken, a *suggested* checklist is attached, and a record kept. These notes should be referred back to at post-deployment interview[1].

7. All pre-deployment interviews must be recorded on JPA in accordance with Annex C of this chapter.

Application timescale criteria

8. All individuals who are deploying in excess of 31 continuous days are **mandated** to receive a pre-deployment interview by their respective line management.

9. Any personnel who do not qualify for a pre-deployment interview but are regularly deploying for short term tasking's and accumulating many days away over a period of months, i.e. Aircrew; then this should be monitored closely by line management.

10. If a formed unit is deploying for a period in excess of 31 days, then group briefings may take place. However, all personnel must be given the opportunity to raise any issues individually if required.

Format for the discussion

11. Check the following has been covered:

    a. Pre-deployment training is complete, is underway, or has been arranged.

    b. Arrangements are in place for kitting, and weapon issue if appropriate.

    c. The individual knows what they will be doing on deployment.

    d. The individual knows when they will be going.

12. Discuss any concerns the individual has regarding their deployment. Amplify confidentiality again at this point. Areas they may be concerned about include:

    a. The purpose of the operation.

    b. Ethical considerations with regard to the operation.

[2] Please note that the individual has the right to see any information held on them. Refer to the Data Protection Act (1995). You may wish to give the interviewee a copy of the notes.

c. Threat levels in theatre.

d. What will happen to their present work whilst they are on deployment.

e. Support arrangements for their family whilst they are deployed. Note in this case 'family' is not limited by RAF definition, but rather as nominated by the member. Members should be reminded that their 'welfare' allocated family and RAF defined family for conditions of service purposes may be different, but the welfare nomination will not over-ride the recorded NOK. Additionally, multiple welfare family contacts may be listed e.g. spouse / partner and parent.

f. What will happen on their return from deployment, and then later, following POL.

13. When describing the family support mechanisms in place, ask if they are going through any 'life events' which are causing them concerns before deployment, for example, the imminent birth of a child, a wedding, a divorce, a recent or expected death in the family. They may need guidance in addressing these issues prior to deployment. Support mechanisms include:

a. Yourself, and others in the chain of command.

b. The Padre, SMO, Practice Nurse or SSAFA-FH.

c. The agencies listed in Chapter 9, 'Resources & Related Areas'.

14. Discuss finding someone who has been on deployment in the same location, and suggest areas they might like to discuss with that person:

a. Additional equipment to take.

b. The current climate on operation.

c. The kind of work they will be involved in, and any additional preparation they could do.

d. Communication in theatre, to set expectations for how often they will be able to contact their friends / family.

e. Other contacts to speak with before deploying.

15. Remind them that it is normal to suffer from mild to moderate stress whilst in an unfamiliar environment.

Refer to the attached checklist and make notes. Ensure a record is kept. For further assistance, contact your unit or Station administrative staffs.

PRE-DEPLOYMENT INTERVIEW CHECKLIST

Rank, name and number of individual being interviewed:			
Unit:		Date:	
Deploying to & date deploying:			

Resources: Does the individual have access to the A1 Ops SharePoint site and the Serving Families link on the RAF website?

Pre-deployment training and preparation: Has the individual been appropriately trained and fully equipped for their deployment, or is this being addressed? Any outstanding pre-deployment medical and dental requirements and when are they going to be completed? Are there pre-deployment briefs that the individual needs to attend?

Position on deployment: Is the individual aware of their position and role on the deployment, and do they have an understanding of the deployed location environment? Have they contacted the person they are replacing or as a minimum someone with recent experience in the same location?
Unit SPOC: Has a unit point of contact been nominated to keep in touch with the individual's family during the deployment? Who is it?
Family: Are there any concerns with the individual, or any family considerations to be aware of? Are family members aware of the support mechanisms available? What level of support do they want? Do they know who to contact at the unit if needs be? Is JPA NOK and will information up to date and correct?

Other issues: Does the individual understand the return process at the end of the deployment? Do they understand the likely arrangements for the administration of POL or other leave following the deployment? Is the individual likely to be posted to a new unit on return? Have they reviewed current pay & allowances for what they are entitled to or no longer entitled to?

	Interviewer		Interviewee
Signature:			
Rank and name:			
Distribution:			

DECOMPRESSION

Introduction

1. This Annex details the policy and procedures for the decompression of RAF personnel.

2. Decompression, in a military context, is an activity that is ideally conducted in a secure environment, in a third location, at the end of combat operations, and before an individual's return to their PU. Decompression is the physical and mental unwinding from operations and is conducted as a group activity. Where possible, groups that deployed and operated together will decompress together. For IAs, again where possible, they will be grouped together and de-conflicted with FU's, this is within PJHQ responsibilities and conducted under CJO direction. The aim of decompression activity is to reduce an individuals potential for maladaptive psychological adjustment[1].

3. Consideration of the need for decompression is a mandatory activity, determined by PJHQ for each operation.

Intent

4. The intent of decompression is to give individuals the opportunity to experience the immediate physical release of stress which affords the body time to re-align. Decompression should start aid the mental release and adjustment which ordinarily takes a further 1-3 months in the normalisation phase once individuals are back from deployment.

5. Decompression aims to achieve a number of distinct effects:

   a. Congratulate personnel on their achievements.

   b. Explain to those concerned what they have undergone and put it into context.

   c. Allow personnel to consider the adjustment to the different and contrasting environment of domestic life from stressful situations in theatre.

   d. To manage expectations and highlight the signs, symptoms and remedial courses of action available for those who may experience operational stress.

   e. Allow immediate physical release of stress.

   f. Commence mental release of stress.

PJHQ Responsibility

6. Although Decompression is conducted whilst forces are still under command of the CJO and as such is a PJHQ sponsored activity, this policy document provides further detail for RAF decompression programmes.

Planning Decompression

[1] "The subjective utility of early psychosocial interventions following combat deployment", Jones N, Burdett H et al (KCMHR), 2010

7. Decompression activities are usually co-ordinated and directed by PJHQ to meet the needs of the operation and the differing experiences of units, individuals and theatres off operation.

8. The decompression programme is to be constructed by a dedicated staff (usually drawn from the rear element of the unit deployed and their PU) in consultation with the HQ NCC (or equivalent) that would be expected to be called upon to find resources from within theatre where possible. Extra-theatre resources must be identified to PJHQ at the earliest opportunity. A suggested programme is at Appendix 1.

9. Early planning is key to ensuring an adequate decompression package is made available to deployed units and IAs. The following framework for deployed commanders and supporting agencies is generic for all theatres but has the flexibility to be adapted to the needs of a particular operation. It is to be implemented by deployed commanders in accordance with specific instructions from PJHQ / HQ National Contingent Command (or equivalent) on an operation-by-operation basis.

10. PJHQ decides on the location of the decompression package; for long standing operations, decompression 'sites' Section 26 [redacted] will normally be allocated. To achieve the desired effects of decompression, the conditions of the facility must be equal to, and preferably superior to, those in which personnel have lived in theatre. It is important to ensure that personal administration and communication facilities are available and personnel decompressing should be, where possible, collocated. A recce of the proposed site is advantageous.

11. FU decompression must involve <u>all</u> returning unit personnel e.g such as attached and Reserve Forces.

Considerations for Commanders of Decompressing FU / IAs

12. During decompression, the CoC should identify those most likely to be vulnerable to stress related conditions based on knowledge of their personnel and the operational activity carried out. Personnel who are assessed as at risk during decompression and deemed unsuitable to proceed on POL are to be referred to the receiving PU for immediate follow-on action.

13. Commanders also need to assess the requirement for individuals departing theatre earlier or later than the main body. These personnel should undergo decompression as per IAs. In medical and compassionate cases, decompression should not delay return.

14. Normally decompression facilities will be owned and occupied by others, and therefore, restrictions may apply to its availability and on the conduct of personnel undergoing decompression. Consideration should be given to policing the behaviour of FU personnel during decompression to ensure location rules are adhered to.

Reporting Requirements

15. All completed decompression is to be recorded on JPA as *Decompression* by the unit conducting the decompression programme.

Appendix:

1. Suggested Programme for Decompression.

SUGGESTED PROGRAMME FOR DECOMPRESSION

1. **Arrival** (Conducted at airhead):

    a. Liaison Officer to meet personnel at airhead.

    b. Transport to accommodation.

    c. De-kit: relieve of weapons, body armour and all surplus kit.

        (1) All personnel participating should have been made aware of this process before arriving so surplus kit can be separated from that needed for decompression and returned to the UK.

        (2) De-kitting may occur at decompression facility if not possible at the arrival airhead.

2. **Reception** (Conducted at decompression facility):

    a. Welcome Brief by unit commander or decompression facility commander – should not be delegated if possible.

        (1) Explain process and purpose of decompression.

        (2) Introduce staff running decompression programme.

    b. Admin brief.

        (1) Accommodation allocation.

        (2) Consideration should be given to the need for an imprest to enable individuals to draw funds.

        (3) A laundry service should not be necessary but should be considered.

        (4) Detail amenities and facilities at decompression camp.

        (5) Local rules and emergency / out of hours contacts.

    c. Programme detailed – including opportunities for personal admin.

3. **Physical Activity** (‘Off-loading’ opportunity):

    a. Organised AT or PT / sport, mandatory activity.

    b. Relaxation opportunities.

4. **Social Activity** (‘Off-loading’ opportunity):

a. Therapeutic use of alcohol – limited amount and distribution.

b. BBQ / Buffet meal.

c. Opportunities to access welfare facilities.

d. Provision of entertainment should be considered, e.g. CSE show.

5. Decompression Briefs:

a. 'Going Home' Brief.

b. Operational Stress Management brief (including handouts).

c. Driving Risk brief.

d. Opportunity for individual interviews with specialist.

6. **Departure** (Conducted at decompression facility):

a. Admin brief including departure transport details.

b. An opportunity should be made for everyone to say their goodbyes, informally and formally. A serviceperson leaving theatre feeling that they have been part of a 'job well done' will minimise significantly long term problems.

c. Closing comments from commander. This is the commanders opportunity formally to thank all personnel, including those within or attached to a unit.

NOTE: Individuals should not be bored during decompression and facilities should be made available to them for use to avoid this becoming an issue; counter to this, the decompression programme should not be completely full leaving no time for relaxation, reflection and personal administration.

GUIDANCE TO LINE MANAGERS FOR POST-DEPLOYMENT INTERVIEWS

Objective of the interview

1. The purpose of the post-deployment interview is to identify and assist in the management of any issues that, if left unresolved, could adversely affect the individual's return home. It is intended to:

a. Welcome the individual into, or back to the section / department / team and acknowledge their contribution.

b. Ensure that the individual is aware of all the post-operational support mechanisms in place and has access to the *Deployment Toolkit* and the *Return and Reunion* booklet via the RAF Community website on either the RAF Intranet or the Internet.

c. Ensure that all equipment, for example weapon and kit, has been returned.

d. Ensure the individual complies with any post-deployment medical and dental requirements.

e. Ensure the individual knows of any developments in their regular work environment, to help prepare them for the transition back into their core role.

f. Gain information regarding their deployment, the nature of their work, any situations or events which they may have found particularly uncomfortable and to ask how they can use their experiences positively in their core role.

g. The pre-deployment interview should be used to compare the individual against and could help in ascertaining if the individual is experiencing, or is at risk of developing, any adverse effects due to their time on deployment or as a result of returning home.

Your role

2. You are there to help an individual work out if they need any particular support and to ensure that they can obtain this. Should any information come to light which suggests that the individual could require further help, then you should refer them to the appropriate support.

Points to note

3. The interview is NOT an investigation. It is intended to encourage communication. Whilst the interview itself is mandatory and, ideally, should take place in the first 2 weeks of returning to work, (including those service personnel who return early from a deployment). The interview must be within 12 weeks of the return from deployment, the sharing of personal information by the individual is NOT mandatory.

4. Post Deployed Ops interviews are to take place for personnel who have deployed for 31 (continual) days or more.

5. Notes should be taken[1] – a *suggested* checklist is attached – and a record kept for at least six months. The individual should have been interviewed before going on deployment; refer to the notes taken during that interview.

a. Before the interview ensure you have access to the pre-deployment interview notes, as per Annex D. This should provide an outline of the operational stress management history and is particularly relevant when interviewing personnel posted in after deployment. You should also have access to any notification of particular incidents reported by the deployed commander if applicable.

Format for the discussion

6. A suggested format for the discussion is as follows**:**

a. It is recommended you seek feedback from their supervisor in theatre. The supervisor will be able to flag up any potential issues due to the nature of the deployed environment or experiences on deployment. Look for the record of stress management activities/interventions to date.

b. Thank the individual for their participation in the deployment.

c. Cover logistical points such as the return of weapons and kit.

d. Ensure the individual knows of any developments in the section / department / team, and is prepared to assist in the transition back into their core role or into the new unit.

e. Discuss the nature of their deployment and ask if anything unexpected or stressful occurred. The intent is to understand an outline of circumstances that may impact on the individual so that support can be provided rather than probe deeply to obtain specifics. Point out that extreme or traumatic events experienced on deployment can lead to adverse, but entirely normal reactions. Assistance is available from the chain of command, Padre, SMO, Practice Nurse or SSAFA-FH. Moreover, a number of other organisations, many with Service links, are able to offer support and assistance, see Chapter 9.

f. Ask how they might use their experiences positively in their core role.

g. Discuss the reaction of the individual's family to their deployment and return. Are there any persistent issues, particularly those that did not exist prior to deployment?

h. During the interview, it may become apparent that the individual's experiences on deployment place them at 'risk' for a potential severe adjustment period and associated disorders. A list of these possible 'risk factors'[2] is at Annex I. Have a copy of the Annex at hand when conducting the interview and discuss this openly.

i. Schedule Station Recall Day.

7. If the individual reports any of these risk factors, you should recommend that they seek advice from support agencies such as the SMO, Padre, Practice Nurse, or SSAFA. There are a number of things the individual can do to help themselves, and the list below can be tailored for relevance:

[1] Individual have the right to see any information held on them. Refer to the Data Protection Act (1995). You may wish to give the interviewee a copy of the notes.
[2] These risk factors are based on Trauma Risk Management (TRiM) a risk management intervention programme developed by the Royal Marines.

a. Avoid isolating yourself – join in social activities, and try to revert back to life as normally as possible.

b. Try to discuss the incident or experience with family and / or friends.

c, Be aware that it takes time to adjust, and memories will not fade immediately.

d. Talk to others who were involved in the situation or who have had a similar experience. This opportunity should arise at the Station Recall Day.

e. Try to eat balanced, regular meals.

f. Try to avoid using alcohol as a support; aside from its potentially addictive properties, it is not conducive to a good night's sleep.

g. Advise the individual of the support mechanisms in place for those returning from deployment. Chapter 9 provides further details.

Follow-Up Interviews

8. If the individual reports any of the risk factors mentioned at para 6, or appears to have difficulties during normalisation, then a follow up interview should be conducted up to 6 months after the deployment. It is critical that the focus of follow-up interviews is on the present and the future; refocusing back to the operation has the potential to re-traumatise the individual. Thus, the format of the follow-up discussion needs to be tailored accordingly.

9. It is imperative that the interview should signpost welfare organisations available on station and/or within the individual's grasp.

Refer to the attached checklist and make notes. Ensure record is kept. For further support, contact your unit or Station administrative staffs

POST-DEPLOYMENT INTERVIEW CHECKLIST

Rank, name and number of individual being interviewed:			
Unit:		Date:	
Deployed to, dates deployed & returned:			

Resources: Does the individual have access to the Deployment Toolkit on either the RAF Intranet or the Internet, in particular the *Demands of Deployment* and the *Return and Reunion* booklets?

Post-deployment requirements: Was any operation-specific equipment or kit issued? Has it all been returned, or is this is being addressed? Are there any post-deployment medical and dental requirements. When is the next Station Recall Day the individual can attend? Has the individual received their NSAR and if so, has a copy been passed to the Appraisals clk?

Family: Are there any concerns with the individual, or any family considerations to be aware of? Are family members aware of the support mechanisms available? What level of support do they want? Do they know who to contact at the unit if needs be? Are there any issues with the family, old or new?

Risk Assessment: Was the individual exposed to any high intensity operations, death, serious injury or involved in unpleasant tasks? (e.g. recovery of body parts / bodies). How many times has the individual been deployed on recent operations?

Other issues: Refer to Annex H - Risk Indicators, as refresher : Are there other issues that need to be addressed?

	Interviewer		Interviewee
Signature:			
Rank and name:			
Distribution:			

Note: Any significant issues which arise in this interview should be referred, with the individuals concurrence, to OC PMS or equivalent for action.

RECALL DAYS

1. Recall Days[1] are aimed at NFU Personnel / IAs; FUs are expected to have their own normalisation programmes. The intent of the Recall Day, in addition to being the opportunity to give the mandatory POSM brief[2], is to give the individual the opportunity to reflect on their deployment, clear up any ongoing issues that may linger as a result of their deployment and provide a networking opportunity to develop a support group. Issues may range from administrative to clinical and, as such, the programme should be constructed in such a way that all aspects are covered and individuals have the opportunity for interview with an agent outside their line management. Attendance is to be recorded on JPA operational stress management using the code 'RAF Station Recall Day'.

2. The qualifying period for a Recall Day is set at 31 days in line with qualification for decompression. Attendance at a Recall Day, (be they Station or Medical) is mandatory and should take place at approximately the 12 week point from the end of the individuals' deployment to meet the requirements of the POSM brief. While this may not always be practicable, compliance is expected to be as close as possible.

3. Individuals should attend the entire programme. Families would not be expected to attend this particular event which should be focussed on the individuals and remain in the military context.

4. Establishments and stations that have small numbers of NFU personnel returning may wish to consider 'regionalising' Recall Days to not only share resources, but also ensure personnel are not delaying in attending a recall day.

Station Recall Days

5. Stations and Establishments are to conduct regular Recall Days for personnel who have recently returned from operations. The regularity and specific content of these days beyond that mandated is at the Stn Cdr's discretion. Additionally, Reserve Force personnel including the Reserve Sqn Cdr should be advised of the Recall Day schedule. Ideally, Reserve personnel should attend a Recall Day along the same timeline as regular personnel, on a Reserve training day wherever possible. Appendix 1 is a suggested activity list for a Station Recall Day.

Medical Recall Days

6. RAF Medical Services (RAF MS) personnel will frequently deploy as non-formed unit (NFU) personnel. In certain operational theatres they come into close contact with severely injured casualties more frequently than any other deployed RAF employment group, putting them at greater risk of post-operational stress related illness. Because their daily exposure to extreme trauma differs from the experience of other deployed NFU personnel it is necessary to make special arrangements, so that COS Health can discharge his duty of care to healthcare personnel who have provided such vital support in the most difficult of circumstances.

7. Debriefing requirements after exposure to trauma can best be served in a group who have shared the intensity and type of experience. Therefore, COS Health has arranged regular Medical Recall Days for RAF MS personnel tailored to the needs of this group. In addition to providing

[1] Station Recall Days may be referred to with different terms as deemed appropriate by Stn Cdrs, such as dismounting days or operational recovery days; the intent of the day remains extant.
[2] Units are to use the POSM brief available from the RAF SMARTT. The brief has psychological approval and is not to be altered.

appropriate debriefing and ‘Off-loading’ opportunities, the Medical Recall Days enable the collection of Lessons Identified to support continual improvement in service provision and support of deploying personnel.

8. Attendance at Medical Recall Days is mandatory for RAF MS personnel deployed to high intensity operational theatres and units are to ensure that all necessary support is provided. RAFMS personnel who have attended the RAF MS Recall Day are not required to attend a Station Recall Day.

9. It is recognised that some senior clinicians may qualify for decompression and therefore a Recall Day, albeit they are on a shorter deployment period. In recognition of their position an exemption from attendance at a Recall Day may be applied for from COS Health, who will maintain an auditable record, provided they meet the relevant criteria below.

a. Individuals are independent practitioners working in a Role 3 Medical Treatment Facility.

b. Individuals have not experienced events outside their clinical workplace which may place them at risk of Post Operational Stress.

c. Individuals were undertaking the same tasks they would normally complete in the UK.

10. Trade Group 5 personnel (Medical and Dental Servicing Section Technicians) who have deployed to high intensity operational theatres in support of the RAF MS will also have been exposed to severely injured casualties on a frequent basis. They therefore have the same debriefing requirements as RAF MS personnel and as such are mandated to attend the RAF MS Recall Day in lieu of a Station Recall Day.

Appendix:

1. Suggested Station Recall Day Activity Plan.

SUGGESTED STATION RECALL DAY ACTIVITY PLAN

Stn Cdr Introduction:

- This should include recognition of the tasks completed by the participants and cover the intent of the day.
- Whilst it is appreciated the Stn Cdr will not always be available for the entire programme or all recall days, the Stn Cdr should introduce the programme whenever possible, emphasising the importance of not only the individuals' contributions on ops but also the programme and the normalisation phase of stress management.

Networking Opportunity Through Socialising:

- Morning and afternoon teas.
- Informal BBQ / Buffet lunch.
- Also have in attendance: Padre, OC BSW, Stn WO, SSAFA staff, Community LO as deemed appropriate.

Post Operational Stress Management Brief (Mandatory):

- SMARTT Post Deployment Stress Brief.

Re-issue of Operational Stress publications to individuals:

- MOD 24-hour, 365 days Mental Health Helpline (0800 323 4444).
- SSAFA Support Helpline (0800 731 4880).
- 'Coming Home' booklet for families.
- 'Return & Reunion' booklet.
- RAF Benevolent Fund Mental Wellbeing Support. (including details of free relationship support available with RELATE

Opportunity to finalise outstanding admin issues including kitting, pay and leave.

Opportunity to talk to someone outside of unit chain of command if requested, could include Stn WO, Administrator, Padre, CPN or SMO. This could occur at the recall day or an appointment made in the future.

Adventure Training (AT) Event

The AT activity selected should be of a simple nature that is inclusive and provides participants an 'off-loading' opportunity. Refer to Chapter 4, paragraph 30. Personnel should be able to network and talk amongst themselves whilst participating,

OR

Sports Event

The sports activity selected should be of a simple nature that is inclusive and provides participants an ‘off loading’ opportunity. Most low impact team sports like softball, hockey or soccer would be appropriate. Personnel should be able to network and talk amongst themselves whilst participating.

Conclusion

The programme should be formally drawn to a close with the entire group together, ideally by the Stn Cdr or his delegate.

- Thank them for their participation.
- Reinforce to participants that some re-adjustment period is normal.
- Signpost where to go for further assistance.
- Encourage further networking with people at the recall day and on the stn.

OPERATIONAL STRESS MANAGEMENT EXPOSURE TO RISK

Introduction

1. This annex should be used as a management tool to assist the individual's Line Manager (LM), both on Operations and at the Parent Unit, to monitor personnel who may be suffering from the accumulative effect of repeated exposure to high pressure events during an operational tour. It is designed to compliment the OSM Policy defined in Chapter 4 and the use of TRiM in Chapter 10.

2. Although not mandatory, it is considered good practise for personnel who are categorised as being part of a High Risk Group to record repeated exposure to such events on an Exposure to Risk Register (ERR) at Appendix 1. By recording each event the individual will be able to capture each significant event and in turn, help the LM manage the risk for their personnel.

Guidance for Completion

3. The Excel Workbook is designed for one individual over an 18 week period.

a. The main sheet is the end of tour summary.

b. The weekly sheets are simply a weekly summary of exposures.

c. The incident sheet is to be completed for each notified exposure. It does not require specific detail, but must indicate the type of exposure. Examples are provided within the document.

d. Each individual should complete the ERR after each event. This ensures completion whilst events are fresh in the mind.

e. At the end of tour, the ERR is to be retained by the individual. This may then be produced on return to the Parent Unit to help facilitate and support the discussion during the Post Deployment Interview with the LM.

f. The LM should encourage the individual to engage with others who may have experienced the same or similar events and signpost, if required, to the relevant support agencies as detailed in Chapter 9 Resources and Related Areas.

g. It is the Individuals responsibility to retain their ERR/s for future discussion or referral.

OPERATIONAL STRESS RISK INDICATORS AND STRESS INDICATORS

POTENTIAL RISK INDICATORS

- High Intensity of Operations.
- Unpleasant role (e.g. body part recovery).
- Individuals who were working outside their normal military role whilst deployed.
- Involvement in previous trauma.
- Death of Colleague (particularly if seen).
- Threat of injury or death to self.
- Error resulting in death or serious injury.
- High frequency of deployments.
- Consistent bombardment when deployed.
- All not well at home.
- Involuntary isolation.
- Personnel with previous mental health difficulties.

POTENTIAL STRESS INDICATORS

- Life being ‘out of control’.
- Blaming others for involvement in traumatic event.
- Displaying shame in own performance.
- Constant dwelling on an episode.
- Inability to cope with day to day activities - poor functioning at work or home.
- Changed behaviour pattern / ’personality’.
- Personnel who have little social support.
- Inability to handle relationships and domestic upheaval.
- Irrational behaviour (anger outbursts).
- Disturbed sleeping patterns.
- Alcohol / Substance / Nicotine misuse or increased use.
- Concern expressed by others.
- Increased reporting to medical staff with unexplained or vague physical complaints – stomach complaints/aches and pains.
- Disciplinary action / sporadic minor incidents e.g. increased lateness for duty.
- An individual who, in their post deployment interview, reports to have difficulties or:
- Felt out of control at the time.
- Felt their luck would not hold out and that they would not ‘get out of there’.
- Unable to understand why they were placed in that situation / why the decision was made.
- Wishes to leave / PVR from the service immediately on return.

5 OCCUPATIONAL STRESS MANAGEMENT

Overview

1. The MOD has a commitment to protect the health, safety and welfare of all members of HM Forces and civilian employees[1]. This commitment extends to the effects of excessive pressure or stress and, as such, Stress Management in all places of employment and includes the application of Working Time Regulations (WTR)[2]. Operational stress is covered extensively in Chapter 4 and this chapter focuses on interpreting stressors in the non-operational workplace (occupational stress), although the nature of Defence is such that there is significant overlap between operational and occupational stress with many stressors common across workplaces and for individuals as discussed in Chapter 3.

2. Stress management and resilience issues generated in the non-operational environment can often be more challenging than those generated in the operational one. Occupational stress is often cumulative and its early signs can go un-noticed. Balancing family needs and work demands must be performed concurrently, with both environments constantly changing. The unrelenting nature of this kind of stress makes it difficult to focus on resilience.

3. Occupational stress is distinctly related to the workplace and surrounding environs. Thus for the RAF, it stretches over a large spectrum of employment and locations, ranging from contractor workshops to flight lines, training units to kitchens. The variation in RAF workplaces means that the development of an all-embracing occupational stress management and resilience policy is not possible. Instead, this policy is designed to provide the generic framework to be applied and adapted to local environments.

4. All personnel are responsible for the execution of this policy, whether it be in a leadership or supervisory role, as a colleague or simply as an individual with responsibility to themselves. The signs and symptoms of stress, as detailed in Chapter 3, are varied but many are easily detectable before stress becomes an illness.

5. The focus of the occupational stress policy has been informed by the results of RAF Stress Audits from successive RAF Occupational Well-being surveys (see paragraph 14 below). The Executive Summary of the most recent survey is at Annex A. It is intended that this will be conducted every 2-3 years.

Applicability of the Policy

6. This policy applies to all RAF personnel. Civilian personnel working in RAF environments are to be managed iaw the guidelines in JSP 375, Part 2, Vol 1, Chapter 17 - Stress in the workplace.

CUMULATIVE STRESS

7. The cumulative effects of stress are more likely to affect personnel in the longer term and as a result, it is the daily rigours and stressors of both life and work that need to be managed to ensure the longevity of the individual, and therefore, resilience of the RAF. Cumulative stress is more often linked to heart attacks and high blood pressure and, by its very nature and name, builds up over a period of time. The RAF has mechanisms in place, such as annual leave, community support, adventure training and sport to relieve these pressures in order to preserve a person's well-being and maintain the force resilience. The prevention of cumulative stress is supported by

[1] JSP 375 Part 2, Vol 1, Chap 17 – Stress in the Workplace.
[2] The Working Time Regulations Act 1998 (S.I. 1998/1833), specifically 2008DIN01-050, March 08.

awareness training to individuals and management in the signs and symptoms and activities and events which are stress inducing, but which would not be classified as traumatic events in their own right or be expected to draw a traumatic stress response.

Traumatic Incident Stress

8. A traumatic incident on a RAF stn or military establishment, as on operations, will need to be addressed over and above the normal routine management measures employed. The RAF recognises that incidents of this nature have the *potential* to cause acute stress reactions and distress to those involved, both in the short and long term. The consequences of traumatic incidents can be managed by timely, systemic processes that are aimed at assisting individuals in returning to normal function as quickly as possible following an incident. Traumatic incident Stress Management should be facilitated by TRiM trained personnel in conjunction with the commander and executive.

9. Chapter 10 gives details on the use of TRiM.

Occupational Policy Framework

10. This occupational policy framework is set around a simple strategy which is the identification, prevention and management of stressors (Chapter 3, Annex B) in the workplace and stress in individuals (Chapter 3, Annex C).

11. The strategy in summary is divided into three stages:

1. Identification – the conduct of risk assessments of the workplace, including procedures and positions;
2. Prevention – early intervention practice designed to mitigate identified stressors;
3. Management – the implementation of prevention measures and the ongoing management of stress as it occurs and taken at risk.

12. The RAF focus is on the prevention of illness or accident and injury and the phrase ‘prevention is better than the cure’ is a simple but useful headline. The strategy relies on good planning to mitigate stress wherever possible rather than simply managing it once it occurs.

Stage 1 - Identification

13. This stage deals with the initial identification of stressors and high stress positions or roles in the workplace. It includes an assessment of the procedures in that workplace and focuses on the following areas:

- The demands of the job.
- Control over the work.
- Support from command/manager.
- Relationships in the workplace.
- Role in the organisation.
- Change in the workplace/organisation.
- Workload and Manning.

14. Tools to assist line managers in making stress assessments are limited[3] so line managers should consider how the headline stressors detailed at Annex B to Chapter 3 of this policy could be applied to a risk assessment of the workplace. When conducting an assessment, commanders should assess the stressors one level up as well as internally.

15. **RAF Stress Audit[3]**. The local identification of stressors should be seen against the backdrop of the RAF-wide Stress Audit conducted through the periodic RAF Occupational Well-being Surveys completed in 2007, 2009, 2012 and 2015. These audits noted that whilst RAF reported strain rates were comparable with the RN, they were higher than the rates found within the UK general population on a common (16-65) age basis. The following factors were identified across the audits as having a statistically significant correlation with high reporting of mental stress levels:

- **High work load/long working hours**
- **Dissatisfaction with pre, during and post operational deployment**
- **Time away not meeting expectations**
- **Impact of Service Life on family**

The overall strain rate has dipped and then risen since 2007 with an increase of 8 points in 2015 over 2012. Although female strain rates reduced 3%, male strain rates increased by 10%. Although some of these factors can only be fully addressed at the organisational level, commanders should bear in mind that many of these issues are a function of local management and practise. These findings should thus be used as the basis for both increasing awareness of common stressors in day-to-day behaviours and also to act as a catalyst for change, thus honing corporate and individual resilience. A Summary of the latest report is at Annex A.

16. The identification of stressors in isolation does nothing to reduce stress in the workplace. Where staff have been involved in informing the stress assessment, it is important that follow up actions, whether they be preventative or mitigating measures or acceptance of the risk, need to be developed after the identification stage. Furthermore, the results of surveys and decisions relating to personnel should be communicated back down to those who are affected by the stressors. Assessments should then be revisited periodically, ideally developed into a stress management plan or integrated into other unit management plans dealing with health and safety.

Stage 2 - Prevention

17. It is accepted that many of the tasks carried out by the RAF as standard business will apply pressure to individuals. Good training and recruitment selection mitigates much of this pressure; however, there remain many preventative measures and actions available to commanders to reduce stress. All preventative management actions should be in response to an identified stressor and aim to mitigate its effect. Early intervention, through preventative measures is one of the most valuable tools in reducing stress illness and the effects of stress.

18. Good management, coupled with clear communication, in many cases significantly reduces the pressure felt at all levels. The following short list provides some examples of management actions which aid in the prevention of stress:

- Open and clear communication of tasks.
- Clear prioritisation of tasks.
- Individuals trained for job and matched to position.
- Clear articulation of the organisation's direction.

[3] In accordance with JSP 375 Part 2 Vol 1 Chap 17 Stress in the workplace, the MOD has adopted the HSE Management Standards approach and the HSE Management Standards Analysis Tool as the minimum standard for managing stress in the workplace. This can be accessed through the HSE website.
[3] RAF Occupational Well-Being Survey, 2012, HQ Air Cmd DPTS, Mar 10.

- Change management plans in place where appropriate.
- Stress Management Training.
- Individuals have direction and career development.
- Staff not overloaded or under-employed.
- Control over work where appropriate – avoid 'micro-managing' or a 'long screwdriver' approach.
- Prioritisation of personnel management polices (e.g. OJAR/SJAR on time).
- Address issues as soon as they become apparent – issues left unresolved will only worsen the effects and increase management overhead to resolve.
- Consider workplace stress audit to identify stressors.
- Feedback- both negative and positive, both formal and informal.
- Unit plan with feedback mechanism published – reporting opportunity for near miss, better practices, highlight issues, unit POC.
- Workplace free of bullying and harassment.

Stage 3 - Management

19. Preventing all occupational stress is an unreasonable expectation in an organisation such as the RAF with its large and varied workforce and working environments. However, the RAF recognises that the treatment of stress, from either a managerial or clinical perspective, may be required at points during an individual's time in the Service. As such, a number of provisions and support services have been developed and are available to individuals either directly or through the chain of command. These include flexible working arrangements, Confidential Support Line, padres, MOs and leave. Commanders can also use a number of other options to mitigate stress, particularly cumulative stress. Some examples are:

- Team Building.
- Adventurous Training.
- Professional Personal development for all.
- Physical Training – iaw RAF Fitness Strategy.
- Flexible working arrangements.
- Professional assistance – chaplain, Mental Health, suicide awareness training.
- Recognition (i.e. awards) – both formally and informally.
- Identify positions which are more likely than others to develop stress in personnel – e.g. Repatriation teams, emergency services, pinch point trade groups, and ensure they are given additional support at regular intervals.

20. **'Off-Loading'**. This is another tool available to commanders; this is particularly useful for individuals or groups who are in positions identified through the identification stage as high stress positions. Off-loading is the opportunity for personnel to release stress by discussing issues with any group they feel comfortable with and in a benign environment. This could be a professional group who may have shared experiences or colleagues from the same unit, shared ranks or with management. Personnel may feel that 'getting an issue off their chest' to management relieves stress they may be harbouring, especially if they are not normally well connected to management (e.g. in a location removed from the PU). Off-Loading can also be facilitated by professionals (e.g. SSAFA), MO, Padre or personnel officers. Many off-loading issues are resolved through the act of sharing the problem and in some regards are nothing more than a structured or forced communication. They should not be recorded, though like any confidentially clause, may be broken in exceptional circumstances if deemed essential for the immediate safety or security of individuals, or relating to a criminal offence.

21. **Stress Vulnerable Individuals.** The identification and management of stress vulnerable individuals is covered in Annex D to Chapter 3 – Stress Vulnerable Individuals.

22. **Working Time Regulations (WTR) 1998.** The WTR provide further protection of the health and safety of workers by ensuring personnel are not required to work excessive hours. The WTR were developed to set limits for a maximum working week, to ensure minimum rest and break periods, to regulate shift work, and to guarantee minimum periods of annual leave.

a. The MOD is required to comply, as far as is practicable, with the WTR 1998 and failure could amount to a breach of Health and Safety laws which in turn may result in legal action being taken against the MOD and/or a commander. Important exemptions are granted which allow the MOD and RAF some flexibility in limited circumstances when implementing the Regulations. *DIN 2015DIN01-144 Guidance on the Working Time Regulations Service Personnel* provides guidance on the implementation of the WTR within the Armed Forces and details the conditions when exemptions may be applied.

b. The Regulations apply to Great Britain and Northern Ireland and they also apply overseas if a worker works for an employer who carries on business in GB. Therefore, commanders are to apply the Regulations (including the exemptions where appropriate) on a worldwide basis. This applies to Service personnel working overseas on temporary detachment.

c. Commanders are typically required to ensure that personnel do not work more than an average of 48 hours a week over a rolling 17-week period, in the normal working environment (this averaging period may be extended in some instances to 26 weeks). WTR generically do not restrict military operating procedures and in many cases merely consolidate what has been good practice for many years.

23. **Harassment and Bullying.** If the underlying cause of stress, anxiety or depression is as a result of bullying or harassment, individuals, if unable to broach the subject with either the harasser or their line manager, should seek the advice of their local Equality and Diversity Adviser. Alternatively, individuals may contact the Confidential Support Line (Forcesline) on 0800 731 4880 or use the Forcesline e-mail service which is completely anonymous; visit www.ssafa.org.uk. More information on Harassment Complaint Procedures is contained within JSP 763 and single Service booklets.

Annex:

A. RAF Occupational Well-Being Survey (Stress Audit) 2015 –Summary.

RAF OCCUPATIONAL WELL-BEING SURVEY (STRESS AUDIT) 2015 SUMMARY

Background

1. The RAF and Health and Safety Executive (HSE) define stress as "the adverse reaction an individual has to excessive pressure or demands placed upon them". Such pressures and demands can lead to a range of negative outcomes and to that end the RAF has conducted regular studies of occupational strain (or 'stress') amongst the organisation's population since 2007. This report presents the findings from the fourth iteration of the Occupational Well-Being Survey (OW-B).

Survey content

2. The OW-B survey contains a wide range of items which may be associated with psychological strain, including: aspects of the current job; time away and deployments; working environment; amount of perceived job control; provision of resources; equality and fair treatment; and support systems. The survey also includes the General Health Questionnaire 12 (GHQ-12) which is used to identify groups of individuals with higher levels of psychological strain than is deemed appropriate for a military context. Strain rate refers to the number of individuals in a cohort who were deemed to be experiencing excessive psychological strain or pressure.

Survey administration

3. The survey was distributed to 2801 RAF Regular personnel in Jun 15. A total of 1350 useable surveys were returned, yielding a response rate of 48%.

Strain rates

4. The overall strain rate for the RAF population was 37%; an 8% increase since 2012. Female JNCOs continue to self-report the highest levels of psychological strain (44%), whilst male JOs had the lowest strain rate (26%). Despite having higher strain rates overall, female strain rates have reduced by 3% since 2012 whilst male strain rates have increased by 10%. Male SNCOs had the highest overall increase in strain rate since 2012 at 17%.

Key findings

5. Statistical analysis identified a number of factors which were significantly associated with higher strain rates. These included:

a. **Deployment**. Being prevented from deploying; being dissatisfied with deployment support; and perceiving deployment lengths and time away to be too short or too long.

b. **Job-related**. Working more than 45 hours per week; excessive work demands; high workload; Unit being under-manned; lack of resources; conflicting job demands; and inability to work flexibly.

c. **Workplace relationships**. Experiencing inappropriate behaviour at work; lack of support from colleagues; poor relationship with immediate boss; and dissatisfaction with

local-level communication.

d. **Organisational climate**. Worry regarding changes to the employment offer (such as pensions); and uncertainty regarding future career prospects in the RAF.

e. **Work-family conflict**. Dissatisfaction with the effect of Service on home/family life; lack of stability for the family; lack of support from spouse/partner/family; and feeling under pressure from one's partner/family to leave the RAF.

Conclusion

6. It is not possible to provide a causal explanation for the increase in strain rates; however the factors associated with strain provide an indication of ways in which strain may be reduced. The experience of strain is partially dependant on an individual's ability to cope with the demands placed upon them; thus the results from this study should be used to inform the stress management and resilience training which is administered to RAF personnel. Some factors may be referred to as local-level stressors (e.g. work-place relationships) which may be minimised through local-level manager training and unit-level initiatives. Other factors such as organisational climate and work-family conflict may be related to organisation-level changes and the nature of Service life. Whilst it may not be possible to prevent such issues, greater application of existing policies (e.g. the non-standard hours policy) may aid in balancing the needs of the organisation with those of the individual and their family.

AP9012, Chapter 6

Suicide and Self-Harm

Why should I read this??

'Every single life lost to suicide is one too many. The way forward is to act together and the time to act is now'.

World Health Organisation

"*When I think of the word Suicide it takes me back to that day I can only describe. Imagine the darkest colour grey on the mistiest day, everything becomes unclear and confused. Then suspended silence, everything is moving but you. There's no control, no answers, something that will never be resolved or concluded; the loss of a loved one by suicide*" – 'Paula' 2018.

Sponsor: Section 42

Contents

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Support – Care Assessment Plan (CAP)
- Medical Referral
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Part 2 Annexes:

A. Care Assessment Plan (CAP) - Example.
B. Care Assessment Plan – A guide to management and care.

1-1 Overview/Introduction

1. Suicide[1] is the act of intentionally ending one's own life; it is sometimes a noun[2] for one who has died by, or attempted, the act. A suicidal episode (or Parasuicide) refers to the deliberate infliction of injury on oneself or the taking of a drug overdose as an attempt at suicide which may not be intended to be successful which does not result in death ('a death by suicide'). The term suicidal gesture is no longer used as it is impossible to gauge the individuals' intent at the time therefore runs the risk of trivialising what is a very serious action. Self-Harm, can be defined as self-poisoning or self-injury irrespective of the apparent purpose of the act[3].

2. The causes of Suicide and Self-Harm (S&SH) can be complex and some individuals may be more susceptible to this. There are a number of factors that may increase this risk[4]. These include amongst others; gender (men are more likely to attempt suicide), a previous history of Self-Harm, psychological disorders, alcohol and/or substance abuse, recent stressful life events, and access to means.

3. Suicide, suicidal episodes and acts of Self-Harm can be extremely damaging to the operational effectiveness of a unit and certainly erode the morale and motivation underpinning the Moral Component of Warfare. Small teams, like those in the RAF, that are tight knit and operate together across the work-family interface in a close environment, are particularly susceptible.

4. Whilst not suggesting that all personnel experiencing some stressful life event may engage in Self-Harm or attempt suicide, the possibility of such behaviour occurring should not be discounted. Individuals may find themselves in vulnerable situations for a range of reasons, some of which may be beyond their control. Prompt, appropriate management of vulnerable individuals by the Chain of Command, with the assistance of clinical and welfare staffs, is essential to assist the individual concerned, and/or their family as required; thereby, reducing the potential for S&SH. The co-ordination of a response to S&SH falls to the unit welfare staffs through the Station Welfare Casework Committee (SWCC) or equivalent.

5. The aim of this Chapter is to provide a framework to support the prevention of S&SH and articulate the processes for intervention and "postvention". Part 1 of this chapter details policy and information while Part 2 provides direct guidance to assist individuals, line managers and unit welfare staff.

6. Chapter 9 contains a list of existing AP leaflets and other policy documents that, depending on the individual circumstances involved, may assist commanders if they are called upon to manage an incident involving vulnerable individuals.

7. This policy provides an approach to suicide prevention, intervention and postvention that recognises the contributions that can be made across individual, line

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[1] Refer to AP9012 Chapter 2, Annex A for full definitions of suicide.
[2] Translates from the Latin words sui and caedere – '**to kill oneself**'.
[3] Taken from NICE guidelines 2018. AP9012 Chapter 2 Annex A refers.
[4] Whilst in no way the complete list, these can be found at paragraph 9.

management and welfare staffs throughout the entire RAF. It draws on local experience, research evidence from national organisations (such as NICE and the Samaritans) and the expertise of our people, some of whom have experienced the tragedy of a suicide within their own families. This model is intended to be up to date, wide-ranging and ambitious.

1-2 Indicators, Warnings and Risk Factors

8. Many studies[5] now support the genetic link between the suicide of a family member and the heightened risk of suicidal behaviour in future generations. However, it is dependent on specific factors, which could include: a history of childhood abuse, maltreatment, exposure to trauma, psychological distress and major psychiatric disorder (this list is not exhaustive). Personality traits are partly genetic, and therefore, it is recognised that some personality types are more vulnerable to S&SH. Studies conducted recently[6] have found that the possibility of suicide in families of suicide victims could be twice as high, compared with families with no history of suicide.

9. S&SH rarely occur without some indicators and warnings from the individuals who are contemplating either act. The following risk factors, in no significant order, have been associated with suicidal behaviour and may ***potentially*** increase the possibility of S&SH behaviour[7]:

a. **History of Previous Suicide Attempts.** A previous suicide attempt[8] is widely recognised as the single most significant predictor of suicidal intent[9].

b. **History of Self Harm (SH)[10].** Some incidents of SH can be little more than a way of coping or expressing overwhelming emotional distress but more than half of people who die by suicide have a history of SH.[11] . Whilst a previous episode of SH does not necessarily mean that an individual has any intent to die by suicide, that intent may become prevalent if action is not taken to resolve those difficulties, perceived or real.

c. **Mental Health Referral or Diagnosis[12].** Serious mental illness, depression and borderline personality disorders, all of which are strongly associated with an increased risk of suicide, are clinical problems, and suspicion that an individual is so affected should result in a referral to medical

[5] /The Neurological Basis of Suicide Chapter 11 /
[6] The Neurological Basis of Suicide Chapter 11.2
[7] A review of RAF deaths by suicide carried out by HQ Air Cmd APC showed that at least 2 of these indicators had been present in all cases.
[8] /Prevalence of and Risk Factors for Lifetime Suicide Attempts in the National Comorbidity Surveyjamanetwork
[9] One out of three suicides are not the first attempt.
[10] SH is an act in which an individual, with wilful intent, causes self-injury or deliberately ingests a substance believed to be poisonous or ingests a pharmaceutical product more than a prescribed or generally recognised dosage.
[11] Taken from the NHS webpage in relation to S&SH.
[12] Evident mental health difficulties will usually be the preserve of the medical authorities, for whom clear guidelines are provided on clinical risk assessments for S&SH.

support if they are unwilling or unable to self-refer. Patients who have been hospitalised with a serious mental illness and discharged after improvement should also be considered as potentially at risk and assessed accordingly. An apparent improvement in mental state, even a clear indication from an individual that harbouring suicidal thoughts or intentions is no longer present, does not necessarily mean that the risk has passed[13].

d. **Relationship Problems.** Relationship problems, particularly the breakdown of a marriage or long-term partnership, have been clearly identified as a significant risk factor associated with S&SH.[14]

e. **Significant Loss (Death of Someone Close).** When someone close dies, intense emotions are usually experienced, particularly when the death is unexpected. The death of a partner or child can be especially stressful. Specific-longer term stressors associated with the death of a loved one include, change of routine, loss of emotional support, increased responsibility for family and financial loss[15].

f. **Loneliness and Isolation.** Young people on joining the RAF may be away from their friends and family for the first time and in some cases, will be experiencing a change in culture and conditions, as well as discipline and demands, which may be entirely alien to anything that they have experienced before. Loneliness and isolation can also be a problem on operational deployments, as there can be no 'down-time' for relaxation with little or no privacy; equally, boredom can be a problem[16].

g. **A Sense of Powerlessness, Helplessness or Hopelessness.** A sense of hopelessness, induced by despair, is a significant underlying symptom[17] of many suicides. However, it does not necessarily follow that an individual will translate that despair into a desire for death or, ultimately, into suicidal intent.

h. **Current or Pending Disciplinary[18] or Legal Action.** Investigations, particularly those conducted by the SIB or civil police, are usually drawn-out, time-consuming and stressful for the individual being investigated. This is compounded by the fact that legal outcomes may be difficult to anticipate and thus will generate anxiety.

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[13] Many suicidal people feel temporarily 'better' once they have made their decision to kill themselves and identified the means; they will then have the energy to wrap up loose ends, see others, say goodbye and generally exhibit signs of apparent improvement or resignation.
[14] Discovered sexual infidelity may exacerbate the risk.
[15] Of note, a common reaction is social withdrawal and the desire to be left alone, with important dates and anniversaries of a death making people significantly more vulnerable at that specific point in time.
[16] Those who have difficult welfare or relationship concerns back at home will be especially vulnerable, particularly if they are unable to communicate with the home base or feel unable to do something about the situation. A sense of powerlessness or hopelessness in such a situation will be very corrosive, as well as undermining the morale of those around them.
[17] Combined with a feeling of powerlessness or helplessness to make things better, and an absence of any hope or apparent escape options from an intolerable situation, some individuals will simply give up.
[18] A review of deaths by suicide over a 3-year period showed that 6 out of 9 of the individuals had pending disciplinary action.

i. **Investigations in Relation to Sex Offences[19].** Extreme care must be taken if any individual is cited as being under investigation for child pornography or sexual offences.

j. **Personnel under Investigation.** It has been identified that there is a high risk that individuals under investigation for serious offences may self-harm. This has been seen to be particularly relevant to, although not confined to, suspects in cases related to Operations ORE and FALCON (International Child Pornography Investigations). The police investigating a case, whether civil, MOD or Service, have guidelines in place regarding the prevention of suicide or SH.

k. **Substance Abuse.** Alcohol and drug abuse may be associated with distress and are often linked to a wide array of other problems that degrade effectiveness at work and personal quality of life. People undergoing stressful life events may turn to alcohol to help alleviate their distress through 'blocking out' the real world[20].

l. **Financial Problems.** Financial challenges can arise from unanticipated emergencies, fiscal mismanagement or addictions such as gambling or alcohol. Financial hardship is most commonly found in junior ranks, single parents, newly divorced / separated individuals and newlyweds; all groups of personnel who have a changed circumstance financially and / or emotionally[21].

m. **Serious Medical Problem.** Diagnosis of chronic and terminal illness carries a high risk of suicide and is an acute source of stress and need for adjustment. When an illness arises, many life activities can be disrupted which may result in a state of crisis for the individual. The individual may experience intense feelings of disorganisation, anxiety, fear and depression[22]. New responsibilities may fall to the person's partner and children, creating additional challenges for a family. Those on long term illness should be managed iaw AP 3392, Vol 5, Leaflet 125.

n. **Work Related Problems.** A sudden change in job performance and / or personal behaviour at work can signal the beginning of problems at the workplace[23]. These changes may specifically indicate depression or may be

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[19] Many individuals facing serious legal problems will worry about being disgraced and about the detrimental impact on their family and career. Whilst under investigation or facing disciplinary action, special vigilance should be maintained on those individuals with a history of depression or alcohol abuse.

[20] Significant amounts of alcohol can act as the stimulant to induce an impulsive, spontaneous and irrational desire to die by suicide. In most of these cases, the underlying intent to die by suicide was not present (although one or more risk factors was present in almost every case) but a night of heavy drinking, often culminating in an inter-personal difficulty such as an argument with a close friend or the apparent break-up of a relationship, led to an alcohol-induced corrosive and impetuous desire to die by suicide.

[21] Warning signs of financial problems include repeated use of advance pay, creditors calling for payments, repeated borrowing from friends, and being unable to buy essentials. Financial strain can cause personality changes in an individual and has been linked to depression which can impact on work performance and interpersonal relationships.

[22] Related to these issues is the potentially significant financial and career impact that the illness can have, especially if it is long term. The development of an illness can also create problems in social interaction.

[23] Commanders might note such things as tardiness, attitude problems, poor concentration, an inability to complete jobs on time, broken promises of specific achievement, and lack of participation in organised activities.

the result of other problems such as being overwhelmed by the work, under trained for the job, relationship difficulties with superiors or subordinates, or a lack of responsibility, satisfaction or recognition for their work. Physical problems affecting work performance that entail frequent doctor's appointments, and complaints such as fatigue and sleep problems may also be indications of stress.

o. **Re-adjustment from Operations.** Chapter 4 deals specifically with operational stress management and details measures as part of a Post Operational Stress Management (POSM) process. However, there may be some individuals who undergo a protracted readjustment on their return which may result in suicidal thoughts and planning to kill themselves.

p. **Transitions (Redundancy, Retirement, Discharge).** Transitioning from the military to the civilian environment can impact on an individual in many ways. It is not only a job transition, but may produce a change in lifestyle and social status. Although many personnel will look forward to this next phase of life as a new challenge, the multitude of changes that occur will inevitably lead to increased stress. The individual may feel threatened by the civilian culture, experience a loss of prestige, and be concerned about the overall transition. In cases of a sudden discharge, commanders must make reasonable efforts to assist individuals in adapting to the civilian environment. When undergoing an administrative or medical discharge, an individual will usually experience significant stress[24].

q. **LGBT+.** Research[25] has shown that episodes of LGBT+ victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behaviour by 2.5 times on average.

r. **Access to Live Arms.** In a military context, the evidence shows that personnel subject to the risk factors detailed in para 9 h-j are at a heightened risk of S&SH. Full consideration should be given to access to the issue of live arms in such cases. This risk is held by the Commanding Officer (the Stn Cdr as head of establishment and cannot be delegated to subordinate or unit commanders. The CO should be made aware of all instances when a person subject to a serious investigation is to be issued with live arms and the decision/risk is to be reviewed and recorded appropriately to the Station Welfare Register.

10. Where risk factors are present and a person discusses or talks about any of the following, even jokingly, then the increased risk of suicide **will be very real indeed.** Line Managers should ensure that they seek advice prior to potentially removing these personnel from their established support network such as

[24] Stressors may include impending unemployment, financial problems, family disappointment, and feelings of failure. In relatively rare instances, reactions to such stressors can include suicidal behaviour.
[25] *IMPACT. (2010).* Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. American Journal of Public Health. 100(12), 2426-32. A review of deaths by suicide carried out by HQ Air Cmd APC over a 3-year period showed that 4 of 9 individuals had unresolved gender/sexuality issues (i.e. part way through gender transition or not 'open' about their homosexuality).

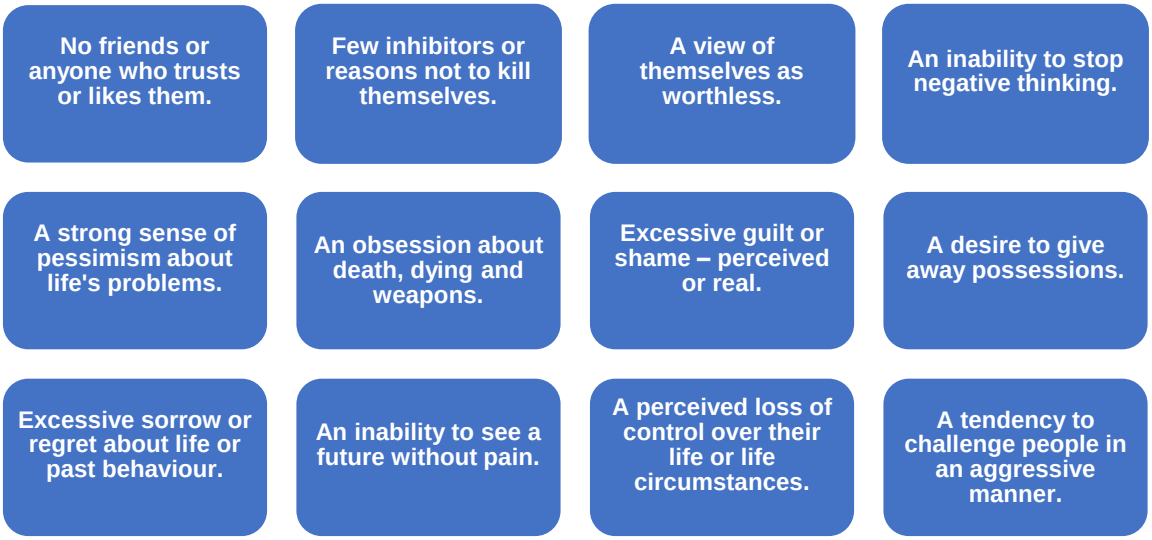
employment on critically safety duties, deployment on operations, or temporary detachment even in the UK:

11. Stress in some individuals can lead to the development of odd or unhealthy behaviour, which can be a precursor or warning sign of potentially suicidal thoughts. The people an individual sees every day are in the best position to recognise changes stemming from stress and to provide support. Any observable change in behaviour may warrant further discussion with the individual and, where appropriate, further investigation by the chain of command and / or a medical referral. Those people supporting the individual in the intervention of suicide must be comfortable approaching the RAF for support and be clear on the way to access this support. Information on S&SH awareness and intervention training courses can be found at paragraph 30b to this chapter.

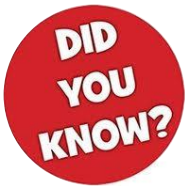
12. The ‘Potential Stress Indicators’ for Operational Stress Management listed at Chapter 4, Annex H, are similar to those listed here, and individuals who are struggling to readjust after an operational deployment could be considered as being individuals with risk factors associated with to suicide. Increased stress may be exhibited in one or more of the following behavioural changes:

- Excessive, abnormal or irrational mood swings.
- An inability to sleep (insomnia).
- An apparent inability to concentrate or focus on issues at hand.
- A lack of energy or apparent listlessness.
- Significant changes in alcohol use, particularly anti-social drinking or heavy drinking outside social occasions.
- A significant change of appetite; usually a loss of appetite or abnormal eating habits at inappropriate times.
- An inability to enjoy or participate in recreational or physical activity. An apparent lack of capacity for enjoyment.
- Poor anger control and management, such as throwing objects or swearing / yelling at a superior or subordinate.
- Impulsive or reckless behaviour, such as binge drinking, fighting or inflicting self-harm, drink driving.
- A sense of helplessness or hopelessness.
- Deteriorating relations with friends and peers.
- Deteriorating work performance for no apparent reason.
- Inexplicable disenchantment with the RAF or wish to ET.

13. The risk of S&SH is increased if any of the behavioural changes described above can be linked to a situation where a person appears to have:



14. Self-Harm is different in that the intent to kill oneself is rarely the motivation, but is rather a coping mechanism to relieve emotional pain or discomfort or occasionally is an attention-seeking act. However, an individual who has a history of Self-Harm is more likely to attempt suicide. Self-Harm must, therefore, be treated as seriously as a failed attempt at suicide with the two actions almost impossible for unit management or peers to distinguish between.



15. The following is a list of known myths and facts about suicide[26] and self-harm[27]:

Myth	Fact
People who talk about suicide do not die by suicide.	8/10 individuals communicate their intention to kill themselves before they die by suicide.
Suicide always occurs precipitously, on impulse and without warning.	Suicide can occur seemingly without warning, especially if alcohol or other drugs are involved.
Suicidal individuals are committed to dying, have no wish to live and will not appreciate being 'rescued'.	Most suicidal people are ambivalent about living or dying.
Suicide is a problem of lifelong duration.	Suicidal intent is not an enduring condition and does not normally last for long.
Improvement after a suicide attempt or crisis means that the suicide risk is over.	Suicidal morbidity (intent) can reappear after or during apparent improvement.
The poor, the rich or the famous are most likely to kill themselves.	National suicide statistics show that all socio-economic strata are proportionately represented.
All suicidal people are insane.	Someone who is clinically depressed is suffering from a psychiatric illness.
Suicidal people should be allowed to die.	Suicidal people are extremely unhappy, depressed and overwhelmed by hopelessness and do not deserve to die as a result.
All people suffering from depression attempt suicide.	Individuals with depression do not automatically have suicidal thoughts.
Talking about suicide and self-harm is bad as it may give somebody the idea to try it.	People who have felt suicidal will often say what a huge relief it was to talk about what they were experiencing.
People who talk about killing or harming themselves are attention seekers.	People who talk about killing or harming themselves must be taken seriously. Doing this may just save their life.
People who self-harm must enjoy it.	There is no evidence that people who self-harm feel pain differently than anybody else.
People who self-harm are suicidal.	For many people self-harm is about trying to cope.

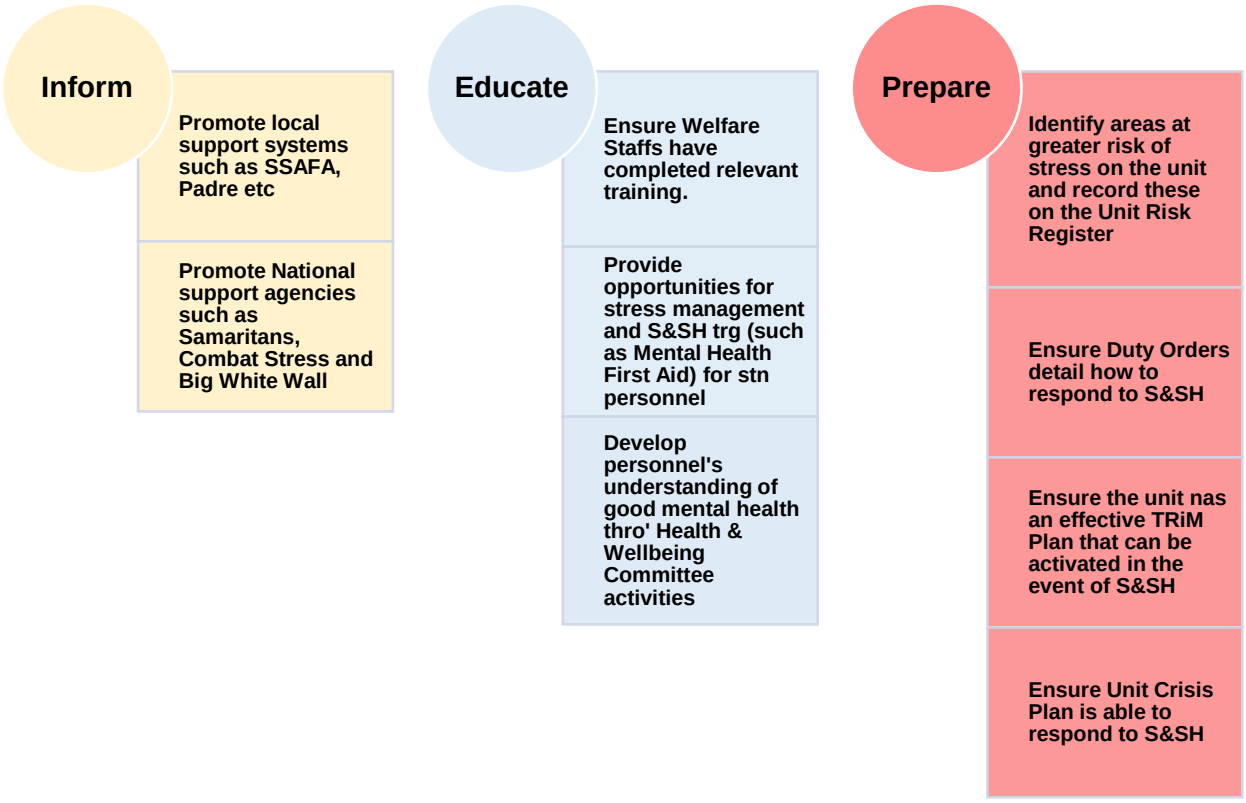
[26] Taken from research through the World Health Organisation (Preventing Suicide A global imperative) dated 2014, Samaritans, MIND, NHS et al dated 2018.
[27] Mental Health Foundation (The Truth about self-harm), MIND, NHS et al,

1-3 RAF S&SH 3-Vention Model

16. S&SH is often the response to a complex history of risk factors and distressing events. This model is intended to provide an approach to suicide prevention, intervention and postvention that recognises the contributions that can be made by individuals, line management and welfare staffs throughout the entire RAF. It draws on local experience, research evidence from national organisations (such as NICE and the Samaritans) and the expertise of our people, some of whom have experienced the tragedy of a suicide within their own families. In fact, one of the main changes from our previous policies is the greater prominence of measures to approach this subject from an individual and line management perspective. This model is intended to be up to date, wide-ranging and ambitious. Its creation marks the beginning of a new drive to increase further the awareness of S&SH across the RAF and what steps can be used to provide the necessary support.

Prevention

17. Prevention is about setting the conditions to promote good health and behaviours, increase the knowledge of personnel about themselves and where to seek help, and for units to have given prior thought to how incidents will be handled. The RAF has the opportunity to support and develop a mentally healthy workforce through a simple framework that can be implemented at unit level to support all our people. In short, there are 3 areas to prevention as follows:



Reasons to Live

18. Extensive research into suicides has shown that where certain factors are present in an individual's life, they will inherently be less likely to suffer from mental ill health or, in extreme cases, contemplate suicide. Some examples of reasons to live are as follows:

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

b. Peer friendship and support.

c. Social and family support and a sense of inter-dependence.

d. Marriage (strengthened if there are dependent children).

e. Physical and mental activity where there is a sense of purpose such as caring for a beloved pet

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

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

h. Religious, spiritual and moral context and awareness.

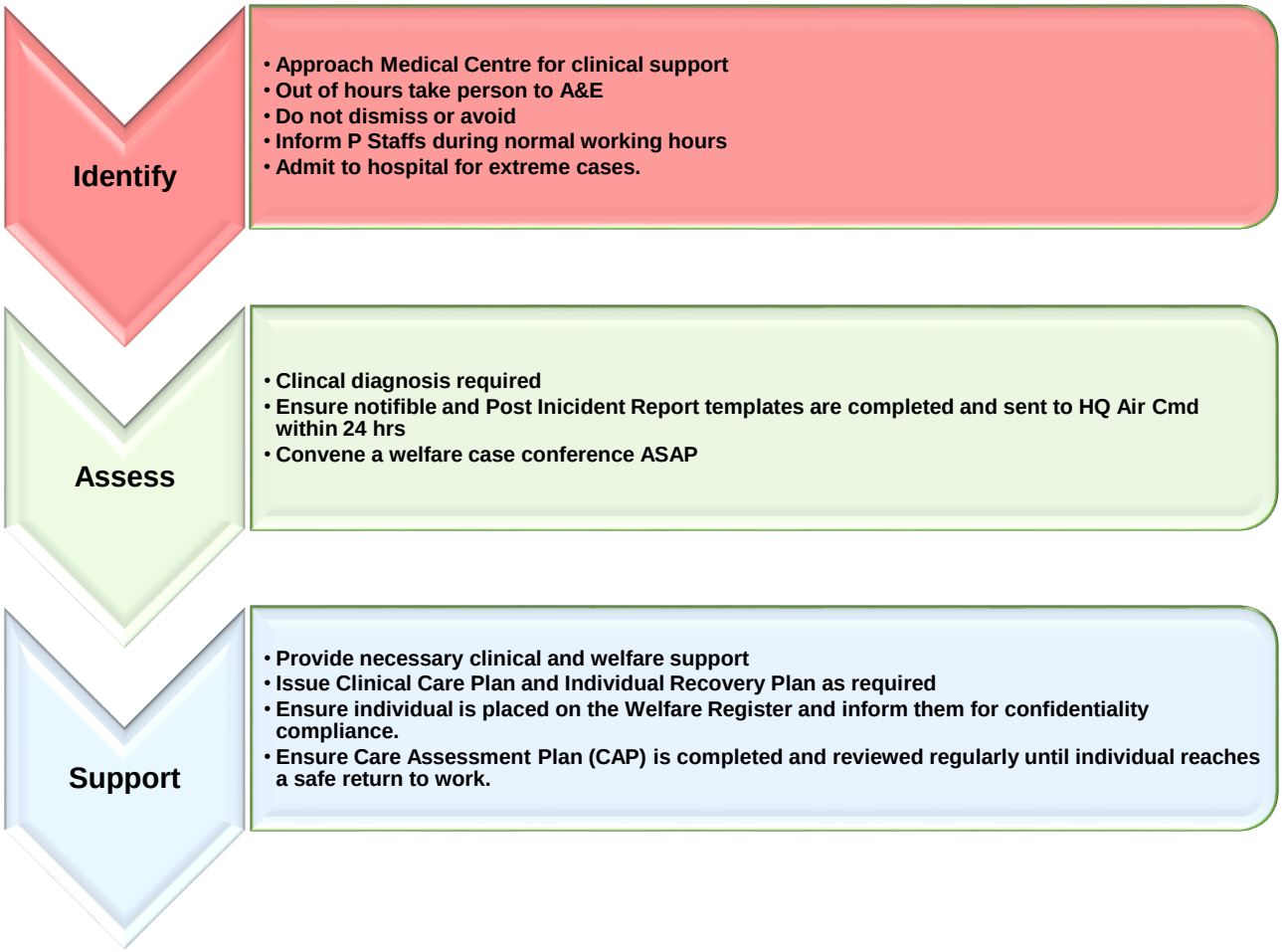
i. Easy access to helping resources.

j. Hope that things will get better.

19. Some of these reasons to live cannot be artificially generated and some are purely personal. A number can be engineered or contrived by a unit to provide these key elements of personal support to all personnel under command. It is probable that in units where such protective factors are fostered and safeguarded, the general likelihood of suicide will be reduced.

Intervention

20. **Suicide intervention.** This is a direct effort to prevent a person from attempting to take their own life intentionally. This requires the individual to be identified as being at risk[28], a formal assessment made, and then appropriate protective measures being put in place to support them back to a position of wellbeing.



[28] The informing of welfare staffs, convening a case conference etc needs to be justified and with the consent of the individual concerned. Whilst there may be cases where the individual refuses consent and there are third party concerns – such as Flight Safety, this would need to be articulated on the welfare register.

Postvention

21. "Postvention" is the term used for activities that help people following a suicide. Death by suicide can have a profound effect on an organisation and its staff. An organisation needs to be able to respond by providing support to those effected to help them come to terms with their loss while ensuring the impact on day-to-day activity is minimised. Responding in a compassionate and supportive manner demonstrates that the organisation values its staff. There is no single or right way to respond to suicide but this guidance has been based on that provided in the Business in the Community Postvention Toolkit[29]. The unit's senior leadership plays a critical role in setting the tone for how the rest of the Unit will respond to a suicide.

22. The RAF proactive suicide prevention strategy may reduce the risk of S&SH; however, we need to be prepared to deal with these tragic situations at different levels.

a. Individuals can experience a profound and lasting impact as the colleague, family or friend of someone who dies by suicide.

b. Line Managers may also be affected by the suicide of a friend, family member, the relative of a colleague or somebody else known in the workplace.

c. Organisations need to be prepared to respond by providing access to appropriate support for their people to help them come to terms with their loss. It might also save another life.

[29] Business in the Community have partnered with Public Health England to produce a suite of toolkits - https://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-postvention-toolkit

1-4 Stakeholders of S&SH

Individual/Peers

23. If you are reading this chapter due to you experiencing thoughts of S&SH (or indeed somebody you know), detailed assistance is available now; you must not struggle alone. Please take the following steps urgently:

Phone the medical centre, GP or a helpline.

Stay away from drugs or alcohol.

If you have seriously harmed yourself – call 999 for an ambulance or get straight to A&E.

Do something you enjoy.

Try not to think too much, just concentrate on the now.

Be around others & talk to somebody you trust.

Get to a safe place.

Seek help from unit welfare staff.

Line Management (LM)/Chain of Command (CoC)

24. The LM role responsibilities in S&SH cases are as follows:

Be aware of the training, assistance and awareness resources available.

Actively support S&SH pre/inter/postvention efforts and recognize the effort required from all members of the RAF.

Be S&SH aware in order to identify personnel at risk.

Develop a culture that encourages people to seek help without discrimination.

Encourage awareness of S&SH across teams.

Take all S&SH behaviour seriously.

Unit Welfare Staff

25. The Unit Welfare Staff provide oversight, coordination and internal governance of all welfare resources provided in the support of the individual and line management. It has the following key members:

OC PMS/PMF/HR - Normally the chair of the welfare casework committee who directs and coordinates all welfare activity on the unit from a strategic viewpoint.

SMO – responsible for providing the Welfare Staffs with expert clinical advice iaw CALDICOTT.

Padre – will provide pastoral care for all personnel and their families and is a standing member of the welfare committee.

SSAFA – contracted by the RAF to provide a social services capability. Will offer visits to individuals and maintain contact until mutually no longer required.

1-5 Other Considerations

26. **Reporting of Suicide, Suicidal Episodes.** The Suicide Act, 1961 provides that suicide and attempted suicide are not in themselves criminal offences under English law[30], although it remains an offence punishable with imprisonment for up to 14 years to encourage or assist the suicide or attempted suicide of another. Thus, attempted suicide is not in itself an offence for which disciplinary action can be taken under the Armed Forces Act. Nevertheless, it is necessary that every suicide or suicidal episode be fully investigated to establish the facts surrounding the occurrence and to determine whether there are any wider implications (security, media interest, welfare, safety & safety critical duties). COs are, therefore, to notify the nearest RAF Police formation and Air Personnel Casework (APC), via a Notifiable Report, of any instance of suicide, suicidal episode[31].

27. **Confidentiality.** When individuals have presented to the medical services for a S&SH episode, the Commanding Officer will be advised iaw AP1269, Leaflet 4-01, para 11 which requires the notification of personnel when they are a threat to self or others. All cases of S&SH may require the award of a temporary JMES, with limitations, for an initial period of 6 months[32].

28. **Other Services.** RN & Army (incl) MPGS personnel are to be supported in accordance with their Single Service S&SH and Welfare Policies[33] when based at an RAF unit. Army policy requires Army personnel CAP management to be conducted using their Vulnerability Risk Management Information System (VRMIS). Details can be found on the Army webpage - http://defenceintranet.diif.r.mil.uk/Organisations/Orgs/Army/Organisations/Orgs/ag/Organisations/Orgs/dgpers/Organisations/Orgs/dpsa/Orgs/PS4A/HealthPromotionHealth/MentalWellbeing/Pages/SVRM.aspx.

[30] The suicide act of 1860 stated attempted suicide was punishable by death which seems a little backwards.
[31] All of this will need to be articulated to the individual concerned as part of the informed consent process.
[32] AP 1269A, Leaflet 5-12, paras 25-27.
[33] BR3, Part 5, Chapter 24 – RN Welfare, AGAI 110 – Army Suicide Vulnerability Risk Management (SVRM) Policy.

2-1 Prevention

29. The three areas of Inform, Educate and Prepare set the framework for Prevention activity.

Inform

30. There are many avenues of support available but often personnel know little of these and could miss the opportunity to seek help early. It is important that the unit takes steps to inform staff of what support they can access. Support operates locally and nationally as follows:

a. **Local Support Systems.** When faced with a problem support and guidance can be sought from several sources. They can speak with their Line Manager or alternatively seek help from the Padre or SSAFA worker (SSAFA out of hours helpline is 0300 0111 723), who are also open to direct approaches from families. Civil Servants have 24/7, 365 days a year access to externally provided Employee Assistance Programme[34].

b. **National Support Agencies.** The Big White Wall is an online Mental Health and Wellbeing service with a range of self-help programmes. MOD has a contract, running for several years now, with Big White Wall that allows free access for Armed Forces, Veterans and families. The Ministry of Defence and Combat Stress 24-hour mental health helpline (0800 323 444) for serving personnel and their families. The Samaritans[35] are a well- recognised charity who can be easily contacted via telephoning 116123.

Educate

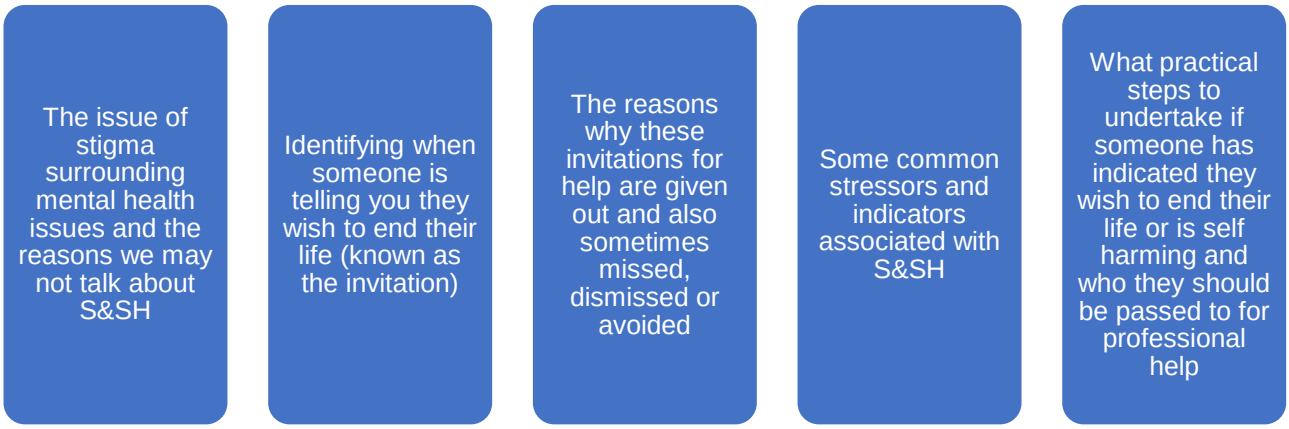
31. Equipping personnel, personally and professionally, with knowledge will enhance resilience and support prevention. Some training is imbedded within existing training courses but others need to be specifically applied for.

a. HR Welfare staffs will often be called upon to help Line Managers to support their staff. There are a number of courses open to HR staff that can be undertaken that will develop their knowledge and understanding listed in AP 3392, Vol 2, Leaflet 2429 – Station Welfare Casework Committee.

b. While there are civilian courses about S&SH none have been identified by the MOD that fully meets its requirement. Therefore, the Stress Management and Resilience Training Team (SMARTT) have developed a RAF S&SH Awareness training package that can be delivered to units on request[36]. This training aims to provide additional awareness to selected leaders, managers and personnel in selected positions to develop their awareness of related signs

[34] See your departmental HR Intranet site for further information.
[35] Samaritans - Guide for the Armed Forces
[36] Details of the SMARTT can be found on their website: Home - Stress Mgt and Resilience

and symptoms to improve their ability to deal with situations that may arise in the homeland environment or on operations. It does not require any prior knowledge of the subject and is designed to raise awareness and reduce the stigma of suicide and SH amongst the audience and covers the following:



c. Understanding what good mental health looks and feels like will enable personnel to better recognise when it deteriorates and when to seek help. This begins in Phase 1 training and on other management courses but can be reinforced through unit activities undertaken by Unit Health & Wellbeing Committees such as Mental Health Awareness Week (held every May) or 'Time to Change'.

Prepare

32. Being prepared to deal with S&SH will ensure that responses can be achieved quickly and be more effective.

a. **Identify areas at Risk.** Some areas may be at greater risk of strain, e.g. operational squadrons and HQ staff (where those subject to workplace stressors may be less easy to identify). Once identified this should be recorded on the unit Welfare Risk Register. Being identified as a risk should enable the unit to consider how best to target resources and support that area to help reduce stressors.

b. **Duty Orders.** Duty staff operating out of hours may not have the knowledge or experience to deal with an incidence of S&SH. Inclusion of a suitable order will ensure a response is correctly managed. A suggested inclusion into local orders for out of hours staff is as follows:

Duty Clk

- **INCIDENTS OF SUICIDE & SELF HARM (S&SH)**
- Any incident of Suicide, attempted Suicide, self-harm or any other serious welfare related incident is to be immediately reported to either the Chf Clk, WO PMS, OC PSF or OC PMS. Should there be any doubt concerning the matter then contact is to be made for further clarification.

Orderly Officer

- **INCIDENTS OF SUICIDE & SELF HARM (S&SH)**
- In the event of an incident involving suicide, attempted suicide, suicidal thoughts or SH, the Duty Clerk is to be contacted. The Duty Medic should also be contacted for advice. If necessary, the Duty Clerk will arrange for a senior member of PMS to contact the OO and offer advice as required. Depending upon the severity of the case, the Duty Exec should also be made aware. Should an incident involve attempted suicide or SH then the following course of action should be undertaken:
  - If the case is of an overdose or attempted suicide and the SPs condition is considered life threatening then the emergency 999 number should be called. All SP should be accompanied to hospital by a responsible Service Person.
  - If the SPs condition is considered non-life threatening then call the NHS 111 Helpline.
  - The RAF Police are to be informed of the incident in all cases.

c. **TRiM Plan.** An incidence of suicide can be potentially traumatic for colleagues, line managers and Stn Leadership. TRiM is the principle tool the Unit Executive has to respond. All units should have a TRiM plan that needs to be regularly reviewed and covers all areas of the unit[37].

d. **Crisis/Disaster Plan.** All units will have a crisis plan or similar. Considering how the unit would respond to an incident of S&SH as part of the plan will allow the identification of resources in advance and allow staff to respond effectively during a difficult or traumatic period. Units may consider rehearsing this through a desktop exercise.

Prevention of Self Harm for Personnel Under Investigation

33. It has been identified that there is a high risk that individuals under investigation for serious offences may self-harm. This has been seen to be particularly relevant to, although not confined to, suspects in cases related to Operations ORE and FALCON (International Child Pornography Investigations). The police investigating a case, whether civil, MOD or Service, have guidelines in place regarding the prevention of suicide or SH. This section is intended to give station executives guidance on the actions to be taken should a member of the Service become involved as a suspect in a serious crime.

a. **RAF Police Actions.** The police have guidelines on when the chain of command should be notified and what level of information will be disclosed. In most instances the police will make a notification both prior to and post any formal dealings with the suspect, particularly when there are welfare concerns. Notification will normally be made to the Station Commander or his appointed

[37] AP9012, Chapter 10

deputy who should, in normal circumstances, immediately inform OC PMS and OC Police, if not already involved. It is important that close co-operation is maintained with the investigating police force as notification may in some instances be made before the suspect has been interviewed or informed of the investigation and any possible charges. Additionally, it is essential that confidentiality be maintained, as breaches may not only prejudice the investigation but may also be the trigger that causes the suspect to attempt self-harm.

b. **Station/Unit Actions**. Notwithstanding the requirement for confidentiality, following notification by the police OC PMS is to notify the Command Personnel Casework staffs using the extant 'notifiable' process.

c. As soon as possible after being given permission by the investigating police force OC PMS or equivalent, but not below the rank of sqn ldr, is to interview the suspect; this will normally be following the initial search or interview. Remember that if the suspect has come straight from an interview with the police he/she is likely to be in an emotional state and need reassurance. As part of the reassurance process OC PMS is to be completely non-judgmental in his dealings with the accused. It is important that, as a minimum, the following aspects are discussed during this initial interview:

(1) It is to be emphasised to the suspect that OC PMS is in no way involved in the outcome of the investigation but is there to assist with the welfare needs of the suspect and their family.

(2) OC PMS is to remain the main point of contact for the suspect regarding welfare issues and any other concerns that may be raised. The individual's chain of command will normally be consulted regarding any decision as to his/her suitability to continue working, with further involvement determined by the circumstances of the case and discussion with the suspect.

(3) It is to be emphasised that strict confidentiality will apply and that only those whose help is essential will be informed.

(4) The aim of this interview is to set in place a support package for the suspect, and where necessary, the family. To that end the following points should also be considered:

i. **The individual's suitability to remain in post**. In coming to this decision, the likelihood of the stress of the investigation adversely affecting the individual's performance of his duties is to be considered along with the concomitant effects on safety in the work place. This will be especially important where the individual is normally employed in an aviation related or safety critical area. The individual's suitability to carry out guard duties and their access to firearms is to be included as a factor in this decision.

ii. The decision on whether the individual should be permitted to continue working will in much of cases be dependent on the branch/trade of the individual and the nature of the alleged offence. Where necessary, further advice should be taken from Air Personnel Casework.

iii. Should it be decided to suspend the individual from their primary, additional or secondary duties a robust schedule of contact should be set up with follow-up meetings arranged. These meetings can take place wherever the individual is most comfortable and bearing in mind the need to maintain confidentiality.

iv. Where the individual's command chain is involved in the welfare support package, either providing support or monitoring the situation at work, it is essential that they keep in contact with OC PMS who is responsible for coordinating the overall support for the suspect. As a minimum OC PMS is to be updated on a weekly basis.

v. **Family considerations**. Consideration is also to be given to the involvement of other welfare agencies such as SSAFA, Social Services and Chaplains particularly where the investigation may impact on the family of the suspect. When involving other agencies, due consideration is to be given to the level of disclosure; it will generally not be appropriate or necessary to reveal full details of the investigation. The decision on how much to reveal should normally be made in consultation with the suspect.

vi. The involvement of an individual's family in the case will vary per the type of offence but may range from involvement as a co-suspect, a victim, a witness or just as a family member. No matter what level of involvement it should be remembered that the cohesion of the family unit and their support for the accused cannot be guaranteed.

vii. Before approaching the family, confirmation must be obtained from the individual that they have been informed of the circumstances of the investigation.

Record Keeping – Diary of Events

34. OC PMS is to ensure that a detailed diary of events is maintained including details of interviews, actions taken and full justification for any disclosure of the facts of the case to third parties such as welfare agencies. The diary of events is to be kept secure in accordance with the Data Protection legislation and only disclosed to those with an absolute need to be made aware of the facts. In accordance with AGAI 110, Army personnel who are OPCOM RAF and require a CAP must be placed on VRMIS as well as the Welfare Register.

2-2 Intervention

35. The intervention 'process' requires the individual to be identified as being at risk, a formal assessment made, and then appropriate protective measures being put in place to support them back to a position of wellbeing.

Identify

36. There are different ways an individual may be identified as being at risk. In all cases the unit welfare team need to be informed, if not already, for the follow-on actions.

a. This may be from a concerned friend or family member to a colleague, the CoC or member of the unit welfare team.

b. Line management may recognise indicators of an issue and bring this to the attention of the unit welfare team.

c. The individual may seek help from welfare or medical staffs. In rare circumstances (see QR1474) the MO may have to disclose information to the Commanding Officer (CO) without consent or contrary to the wishes of the patient. Such occasions arise when the security, health, safety or welfare of the unit or the individual are at serious risk, (examples may include, cases of self-harm, drug abuse and alcoholism). Prior to disclosure the MO must try to obtain consent, in accordance with paragraph 10. Any disclosure by a MO to the CO should be made orally and in-confidence. What exactly can or cannot be disclosed is a matter for the MO's judgement, but it is to be the minimum necessary for the particular purpose. A record is to be kept of the information disclosed. The MO may be required to justify disclosure of information to the CO to the GMC or to the Courts. The MO may, if circumstances permit, wish to seek the advice of Med Legal(RAF). (The management of cases involving the misuse of drugs and alcohol are contained in AP3392, Vol 5, Leaflet 106 and 117 respectively.)[38]

d. It could even be through an unsuccessful suicide attempt. In this case the emergency services should be contacted; in extreme cases the individual may be involuntarily admitted to a secure medical facility.

(1) **Suicide & Self-Harm Reporting**[39]**.** It is necessary that every suicide, suicidal episode or self-harming be fully investigated to establish the facts surrounding the occurrence and to determine whether there are any security implications. COs are, therefore, to notify the nearest RAF Police formation and Air Personnel Casework (APC), via a Notifiable Report, of any instance of suicide, attempted suicide or self-harm.

[38] The MO may wish to discuss with a senior colleague and/or Defence Union prior to disclosure.
[39] This section is provided by HQ RAFP, A5 Policy.

(2) When investigating any suicidal episode or SH, Commanding Officers are to complete a PIR to identify if there is anything of consequence that could be learned to prevent the incident from occurring again. This report should look at the circumstances of the event and provide information to the Single Service Inquiry Coordinator (SSIC). The PIR should be considered by the CO with SME SSyO/RAF Police support to consider the requirement for the CO to submit an Aftercare Incident Report[40] under the terms of JSP 440[41] and to APC to determine if any further personnel casework should be staffed. On receipt of Aftercare Incident Reporting, appropriate UK Security Vetting staff will engage with subject and medical staff (subjects consent required) to consider future suitability to hold national security clearance; where appropriate PSyA Pers Sy and APC are to be consulted to ensure best COA.

37. Out of hours if the safety of the person is in question they should be taken to A&E. In-hours the person should seek an immediate appointment with their MO or GP or go to A&E.

Assess

38. Any person who is potentially suicidal should always be taken for a clinical assessment in the first instance to ensure that the risk is held appropriately. At no point, should CoC's or PMS staff hold this risk. Any additional information regarding the incident should always be passed to the appropriate clinician, who will factor this into their care plan. Clinical staff will advise unit HR[42] where appropriate and a welfare response can be developed alongside any clinical care plans. Where a person remains at risk the unit should produce a management and care plan (Care Assessment Plan (CAP)[43]) and Unit HR staff will undertake any reporting requirements and convene a case conference to begin co-ordination of subsequent welfare activities. A CAP can be completed as part of the initial assessment process even if an individual is not subsequently placed on the unit risk / welfare Register.

39. **Confidentiality.** When individuals have presented to the medical services for a S&SH episode, the Commanding Officer will be advised iaw AP1269, Leaflet 4-01, para 11 which may require the notification of personnel when they are a threat to self or others. All cases of S&SH will be awarded a temporary JMES, with limitations, for an initial period of 6 months[44]. In accordance with CALDICOTT procedures, a consent form for disclosure of medical information[45] should be requested from the individual concerned; if the individual refuses consent, the welfare register and WISMIS are to be updated with a note to this effect.

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[40] Aftercare includes reasonable risk management measures to monitor the security reliability of individuals, who hold a security clearance and their potential increased vulnerability to exploitation by a third party, whilst maintaining Medical and Vetting in Confidence.
[41] JSP 440 – Version 6, Apr 17, Part 2 Leaflet 7.
[42] Within existing data protection/welfare policy limitations.
[43] The Care Assessment Plan is designed to manage the risk of an SP who has demonstrated that they require safeguarding. It is about ensuring that the risk is held by appropriately trained clinicians/agencies and augment, it does NOT replace Clinical Safeguarding/Care Plans.
[44] AP 1269A, Leaflet 5-12, paras 25-27.
[45] Appendix 2 to AP3392 Vol 5, Leaflet 125.

Support - Care Assessment Plan (CAP)

40. Once an individual has been designated to be at risk of suicide, it is vital to actively manage this risk and provide a programme of proactive management and care. It will invariably have multi-agency input and, most importantly, the engagement and consent of the individual in most aspects of the plan. The individual should be placed on the unit risk / welfare Register and it is mandatory for relevant information to be recorded, not least to ensure that guidance and information reaches those who need it (including, if appropriate, on assignment to another unit. The CAP at Annex A is to be completed with the guide at Annex B.

41. **Medical Referral.** Medical advice and referral is mandatory for any individual deemed to be at risk and medical advice will be required on an ongoing basis at risk conferences. The MO / Medical Centre must be informed immediately if an individual has been placed on a unit Risk / Welfare Register (although in all normal circumstances, the MO would have been fully involved in the risk conference leading to that decision). If any individual on a Risk / Welfare Register fails to attend a medical appointment, then it is mandatory for the MO / Medical Centre to inform the unit chain of command so that robust arrangements can be made for a new appointment. Equally, the chain of command must never interfere with, arbitrarily change or cancel a medical appointment for an 'at risk' individual; such appointments should take priority over all other activities. Furthermore, the chain of command should never overrule or interfere with clear medical advice from qualified medical professionals (MOs, psychiatrists or Community Psychiatric Nurses (CPN) about a treatment or rehabilitation regime, sick leave or fitness for duty concerning at risk individuals who are currently on a Risk / Welfare Register[46]. Dialogue can take place but a clinician's medical opinion must always prevail.

42. **Post Clinical intervention.** Once a clinical assessment has taken place the individual should be supervised appropriately in line with the Clinical direction. In a number of cases, the individual will be signed off sick to spend time with family who will be able to provide appropriate supervision and care.

43. **Initial CAP Case Conference (Within 48 Hrs).** The Unit SWCC is to convene a case conference within 48 hrs of the risk identification; as a minimum this should consist of SWCC Chair, SMO, DCMH (unit dependent), individual's CoC (Minimum SNCO) and SSAFA. The case conference is to implement measures which will augment the Clinical Care Plan and mitigate any workplace factors, enable the individual to access medical/outside agency support and to ensure that the CoC understands their role in safeguarding the individual. A named member of the unit welfare staff[47] is to be allocated as the owner of the CAP and responsible for its maintenance, but not necessarily the actions to be undertaken.

44. **Engagement with the Individual.** People who die by or attempt suicide will generally face problems they feel cannot be resolved. Normally, there are

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[46] This advice (only for those on a Unit Risk/Welfare Register) specifically supersedes the rules in PULHHEEMS Administrative Pamphlet 200, paras 0714-0717 and JSP 760, para 15.003.

[47] The owner must have the consent of the individual to access the CAP.

alternatives to these problems. However, someone who is suicidal may not be thinking clearly and usually cannot see any other possible positive solutions. In the process of finding these solutions, it will be vital to engage both the individual and other agencies that can assist as soon as possible. Ultimately, engagement with the individual is of primary importance, both in acknowledgement that the individual has problems that require resolution, which can itself be cathartic, and in the development of a care plan to manage this risk. In some instances, it may be appropriate for the individual to be present for part, or all, of case conferences when their case is considered.

45. **Identify the Underlying Causes of Suicidal Morbidity.** This will require careful and possibly prolonged interviews and counselling, often by professional agencies, as well as consultation and advice from family, friends and colleagues. Once the problems have been identified, they must be mitigated and explained in detail to the individual. The individual must be made to understand that something can be done and is being done and, in time, they must be shown real and positive progress. Broken promises will be immensely debilitating and extremely dangerous.

46. **CAP Development.** Central to the development of a CAP is the requirement to focus on 'protective measures' – both physical measures, such as removing access to means, as well as psychological measures, such as counselling. The instigation of protective measures should reduce the possibility that an individual will attempt suicide. They must address both the underlying causes of the mental condition, as well as the potential physical consequences of that condition. Some generic examples are included in the Template at Annex A.

47. **CAP Consent.** The rules surrounding information sharing and confidentiality are strict as the information contained within the CAP will be governed by GDPR and DPA. Once an individual has been assessed as being at risk, they must be offered an explanation of the unit risk / welfare process and asked to agree that summary information about their management and care can be shared with those who can implement the plan and provide support for them. They should be asked to sign the information sharing agreement in the relevant section of the CAP on the understanding that the information can only be used for the purposes of implementing the CAP. Thereafter, in principle, the individual must remain fully involved in subsequent reviews of the CAP, which will usually be beneficial in helping them to understand their mental state. The CAP should only be shared with the named individuals on the CAP. Changes to this list must be made only with the consent of the individual. If the individual does not agree to information being shared, the relevant agencies (padre, MO, UWO and others) may be forced, at their own discretion, to abide by their respective confidentiality rules at the risk conference and subsequent discussions will be consequently limited in their effectiveness. Any decision not to allow information sharing must be documented and confidentiality can only be breached if permissible in law.

48. **CAP Management/Access.** The CAP is a live document that is in use for the duration an individual is deemed to be at risk. As long as an individual is at risk, an up-to-date copy is to be held within the individual's unit on behalf of the CO by the Chair of the SWCC. This should be a Ltd area only accessible to those personnel

with consent. It will be the responsibility of a named individual, usually OC PMS/PSF, or the UWO as the owner of the CAP, to ensure it is current. This can be updated electronically and used as a diary of events in between formal reviews and can contain information which would not normally be contained in the welfare register. All those who are involved in implementing the plan, providing support, and with the consent of the individual are to be directed to read the relevant CAP, take any necessary action arising from risk conferences or other assessments and record the results as appropriate. Should an individual subsequently die by suicide, the CAP will be used as evidence by the investigating authorities.

49. **CAP Case Conference/Reviews.** The individual should be reviewed by all parties, either verbally or by email as a minimum every week for the first month or until the situation has stabilised. Additionally, key parties should further review the individual at every SWCC meeting and a formal CAP Case Conference should be held every 3 months. In acute cases the timelines may need to be condensed.

50. **CAP Closure.** When the welfare staffs (including the SMO) decide that the individual's safeguarding risk has reduced to a point that it can be handled by the normal SWCC battle rhythm, then OC PMS is to organise a final CAP Case Conference, to review any outstanding actions. A final CAP interview is to take place between the CoC and the individual, where they will be informed of the SWCC's decision. The CAP is to be removed from the live section of the unit risk / welfare Register, clearly marked as closed, and retained for a further 3 years under a 'closed' section of the Register, which is accessible only to the CO/SWCC Chair; after 3 years, this copy is to be destroyed. The relevant dates for initiation of a CAP, closure and projected destruction are to be clearly shown on the front page. A closed CAP register is to be maintained within the unit welfare register and OC PMS is to monthly check if an individual with a closed CAP is posted or leaving the Service.

51. **CAP Transfer/Individual Assignment.** If an individual who is subject to (or has been the subject of) a CAP, is assigned to another unit then their CAP is to be forwarded for the personal attention of their new parent CO, irrespective of whether the CAP is still live or closed. The new CO is to review the CAP and ensure that confidentiality is maintained as per para 47 in terms of GDPR and DPA. This procedure applies equally to individuals attending courses at other units where the duration of the attachment is such that the sending CO judges it appropriate. For all such transfers, the CAP must reach the receiving unit's CO in time for any appropriate measures to be put in place before the individual reports for duty.

52. **Leaving the Service.** In the event an individual who has a closed CAP leaves the Service the unit should retain the CAP until the 3-year point of closure. For an individual who leaves the Service with an open CAP consent should be sought to transfer the information contained to the applicable authorities such as NHS or VWS.

53. **Employment/Deployment Restrictions.** The MO will advise on medical employment restrictions as a result of inclusion on the unit risk / welfare Register and the individual's medical grade may be altered if necessary. Deployment on

operations, however, will be a command decision and the CO must liaise with the MO before taking the decision to deploy an individual who is on a unit risk / welfare Register. In principle, individuals who have been placed at risk are not to be deployed on operations unless the CO feels that an individual's condition will substantively improve from the experience or will substantively degenerate from being left behind. The same principles apply if the individual is already deployed on operations whereby consideration should be given as to whether there would be appropriate resources in theatre to support the individual remaining there.

2-3 PostVention

54. "Postvention" is the term used for activities that help people in the aftermath of a suicide. This section is designed to support welfare staffs and line management in their response to the suicide of an employee, at work or outside the workplace. For this reason, this area refers to 'suicide' rather than 'suspected suicide'. Please note that the cause of death may not be formally established for days or weeks. Further, legal confirmation of suicide as the cause of death can only be made by a coroner following an inquest, which can take months or years to complete.

55. This section provides advice when there is strong evidence that suicide is the cause of death, and when the community; colleagues, relatives and friends are responding to what they believe is a suicide and so experiencing the corresponding impact and emotions. Death by suicide can have a profound effect on an organisation and its staff. An organisation needs to be able to respond by providing support to those effected to help them come to terms with their loss while ensuring the impact on day-to-day activity is minimised. There is no single or right way to respond to suicide but this guidance has been based on that provided in the Business in the Community Postvention Toolkit[48].

56. The unit Welfare and HR staff will play a key role in the actions following a suicide. This should be managed in in line with procedures for any other death.

57. **Immediate actions**. The following actions are to be undertaken immediately following a suicide:

a. Casualty reporting is to take place in accordance with JSP 751[49].

b. AP8000, Lflt 8207[50] directs a Post Incident Report (PIR) is to be raised and forwarded to the Single Service Inquiry Coordinator (SSIC)[51]. For cases of suicides a Service Inquiry may be convened subject to sS authority advice to the relevant AOC.

[48] Business in the Community have partnered with Public Health England to produce a suite of toolkits - https://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-postvention-toolkit
[49] JSP 751 – Joint Casualty and Compassionate Policy and Procedures.
[50] AP8000, Leaflet 8207 - Conduct and Management of RAF Service Inquiries.
[51] Further details are contained in Section 1-5 of this chapter, Paragraph 26.

c. Every instance of suicide, attempted suicide or self-harm is to be fully investigated to establish the facts surrounding the occurrence and to determine whether there are any security implications. COs are, therefore, to notify the local RAF Police organisation of any instance of suicide, attempted suicide or self-harm.

Communications

58. Effective communication is crucial in any response to a suicide in the workplace. The death should be addressed openly and directly in any communication within the workplace and the wider community. After a suicide, once the basic facts are known, you should not delay informing staff as this could encourage rumours and misinformation.

59. There is no exact protocol or process for communication after a suicide but you should consider the following points:

a. Decide on levels & methods of communication. Who will write and who will be the spokesperson? How will communications be disseminated?

b. The Samaritans' guidelines for safe reporting on suicide[52] may be useful.

c. Communications should balance staff desire for information with the next of kin's wishes around privacy. Medical confidentiality continues after death and care must be taken not to breach this.

d. The most efficient strategy for providing details of the death is via a written statement that can be shared by email. Statements should generally include:

(1) Condolences to family and friends.

(2) Plans to support to those affected.

(3) Any changes in work schedule during the upcoming days.

e. Statements about a death by suicide should only offer confirmation in specific circumstances:

(1) If the family approves.

(2) If the SWCC decide it would be disingenuous to leave out this information, particularly if factual information is already known in the community.

(3) Where a coroner has confirmed a verdict of suicide, although this can take months or years.

[52] Samaritans Media Guidelines

Providing Support

60. It is important that personnel affected are made aware of the support they can access. This includes: MOs, Padres, SSAFA and CRUSE. Depending on the circumstances the unit could also consider implementing TRiM. It is important for the CoC not to lose sight of the fact that it is their responsibility to stabilise the workplace. There will be an inevitable challenge to balance the needs of those affected while ensuring that work gets done.

61. **Grief**. This is a highly complex but normal and natural human response to the death of a loved one. When the death is sudden, unexpected and potentially traumatic, as in a death by suicide, the grief process can become complicated by blame, guilt, shame and anger. Some people will need time to get 'back to normal' while for others this will happen more rapidly.

62. **Supporting Line Managers.** Often line managers may be unsure about how best to support their team in the aftermath of a suicide by over/underreaction. Line managers are not expected to be experts in grief, but it is important to know that grieving is a process that varies from person to person and there is no one size fits all. They may themselves feel they could have done more and need support from their CoC and welfare staff.

63. **Personal Effects**. In the event of a death, the personal effects of the individual are gathered together for eventual return to the family via the RAF Standing Committee of Adjustment[53]. This requirement should be effectively explained and communicated in the workplace to reduce what can be an emotional action for some people.

64. **Anniversaries and Events.** For those most deeply affected by the suicide, anniversary or milestone reactions might emerge. Staff should be reassured that this is a normal response.

65. **Coroner's Inquest.** If a death is unexplained there will be a coroner's inquest. Although the inquest will be opened soon after the death it is likely to adjourned until after other investigations have been completed. A verdict can take months or even years after the event. Inquests do not seek to establish whether anyone was responsible for a person's death. However, the conclusion could cause relatives, colleagues and friends to ask themselves whether anything could have been done to prevent the suicide.

[53] AP3392 Vol 2, Lflt 2430.

Annex A to
AP9012
Chapter 6

CARE ASSESSMENT PLAN – TEMPLATE

CARE ASSESSMENT PLAN (CAP)					
Date initiated:	DD/MM/YY	**Date closed:**	DD/MM/YY	**Date to be destroyed:**	DD/MM/YY
Reviewed on:	DD/MM/YY				
Reviewed by:	SWCC				

Assessment Completed For:				
Unit:	**Sub Unit:**	**Number:**	**Rank:**	**Name:**
RAF Station	A Sqn	12345678	Cpl	Serviceperson

Individual Referred by / from / as a result of:
e.g. *Medical referral with the consent of the individual following incident of self-harm.*

Presentation of Risk Factors including behavioural distress
Risk factors are characteristics that make it more likely that individuals will consider, attempt, or die by suicide. Refer to Section 1-2, para 2 for details. *e.g.* *Breakdown of relations with parents.* *History of suicide in family. Uncle committed suicide in 2010.* *Incident of Self-harm.*

Previous History
Is there any recorded history in the form of a closed CAP or has the individual advised on any previous history for which no records exist?

Individual's perception of or reaction to current distress or situation
e.g. *The individual feels there is no solution to their current issues*

Chronological Summary of Key Events (including Risk Conferences, Interviews and Referrals)		
Date	**Event**	**Remarks/Result**
02 Feb 18	*Risk Conference.*	*Decision to place the individual onto the unit Welfare Register made by SWCC, taking into account the Self Harm incident and taking into account all of the immediate circumstances and input from the individuals immediate CoC and the MO.*
03 Feb 18	*Individual Advised that he is being placed on VRM register.*	*Individual advised by UWO that he has been placed on the Unit VRM register and the measures that have been in put in place to support him.*
08 Feb 18	*Informal meeting with WO PMS*	*Variety of issues discussed with Individual, of particular concern were the relationship problems that the individual has with his parents. Family mediation presented as an option to consider.*
09 Feb 18	*DCMH confirmed first appt due on 12 Feb 18*	*CoC to ensure transport is arranged*
17 Feb 18	*Family Mediation session*	*Family relations improved. Further sessions to follow but initial barriers overcome.*
12 Mar 18	*Individual consider to no longer be at Risk.*	*Can be removed from welfare register and CAP to be archived with stn cdr.*

Case History and Assessment Summary		
Date:	Rank:	Name:
Date:	Rank:	Name:
Date:	Rank:	Name:

Case History and Assessment Summary		
Date:	Rank:	Name:
Date:	Rank:	Name:

Management and Care Plan			
Date	**Measure/Action**	**Responsibility**	**Action/Result**
02 Feb 18	*CoC to ensure that Individual has no access to firearms or live ammunition with immediate effect until further advised.*	*Line Manager*	*Arrangements made to restrict access*
02 Feb 18	*CoC to ensure that individual is removed from guard duties with immediate effect until further notice.*	*Line Manager*	*Removed from guard duties*
02 Feb 18	*MO to refer individual to DCMH at the earliest possible opportunity.*	*MO*	
03 Feb 18	*Weekly meeting to be held with unit welfare staff*	*WO PMS*	*First meeting scheduled for 8 Feb 18*
09 Feb 18	*CoC to arrange transport to DCMH for 12 Feb 18 appt*	*Line Manager*	*Booked.*

Authorised Access to this CAP					
Name	**Appt**	**Date Seen or Reviewed by individual (with initials)**			
Sqn Ldr Smart	*OC PMS*	*03 Feb 18*			
WO Helpful	*WO PMS*	*03 Feb 18*			
Wg Cdr Bones	*SMO*	*03 Feb 18*			
Wg Cdr Prayer	*Padre*	*03 Feb 18*			
Mrs Nice	*ssafa*	*03 Feb 18*			
WO Engineer	*WO A Sqn (LM)*	*04 Feb 18*			

AGREEMENT TO SHARING OF INFORMATION	
I agree that summary information about my needs may be passed to relevant staff involved in my care and I agree that those authorised above may read this CAP. I understand that only information relevant to my plan of care will be shared and that detailed information contained within my health records will not be disclosed. *	
OR	
I do not agree that summary information about my needs may be passed to relevant staff involved in my care and I understand that the care provided to me will be limited in its effectiveness as a result. *	
Signed by the individual for whom this CAP has been initiated	Signed: …… Date: Name: Place:
Authorised by the Commanding Officer of this individual	Signed: …… Date: Name: Place:

Suicide & Self-Harm - A Guide To Management And Care (Care Assessment Plan (CAP))

1. The construction and delivery of management and care to the individual at risk is an essential part of the Suicide and SH policy. It will invariably have multi-agency input and, most importantly, the engagement and consent of the individual in most aspects of the plan. It is likely to involve a combination of physical measures (such as limiting access to weapons), engagement of professional help and maximising other protective factors.

2. Extensive research into suicides has shown that where certain factors are present in an individual's life, they will inherently be less likely to suffer from mental ill health or, in extreme cases, contemplate suicide. These 'protective' factors are as follows:

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

   b. Peer friendship and support.

   c. Social and family support and a sense of inter-dependence.

   d. Marriage (strengthened if there are dependent children).

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

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

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

   h. Religious, spiritual and moral context and awareness.

   i. Easy access to helping resources.

3. Some of these protective factors cannot be artificially generated and some are purely personal. A number can be engineered or contrived by a unit to provide these key elements of personal support to all personnel under command. It is probable that in units where such protective factors are fostered and safeguarded, the general likelihood of suicide will be reduced.

4. Once an individual is deemed to be at risk, a pragmatic management and Care Assessment Plan (CAP) must be identified, instigated and followed through under the direction of the SWCC if the risk of suicide is to be mitigated. The response will never be simple and it will never be sufficient to simply tick boxes and assume that the individual will now not complete suicide or that the chain of command will be 'covered' in the event that they do. A suicide prevention response will only be successful if it does precisely that, but the irony is that those involved may never know if they have been successful, because the original risk may have been unquantifiable. They will only know if they have failed. Individuals, however, will continue to complete suicide; sometimes they will not be identified as being at risk, sometimes the response will be inadequate or inappropriate. In

the vast majority of cases, measures will be put in place where the real possibility of suicide was never prevalent in the first place; but **'doing nothing is never an option'**.

5. Listed below are a number of generic responses that could be incorporated into a management and care plan and which would be articulated in the CAP at Annex A. The list is not exhaustive and these are possible options only, which can be selected to suit individual circumstances. Furthermore, the management and CAP must be responsive to circumstances; the range of options chosen and implemented will remain fluid as the 'at risk' individual's suicidal morbidity changes and responds. **The key to suicide prevention is to increase the protective factors and to decrease the risk factors.**

SER (a)	RESPONSE (b)	EXPLANATION (c)
1	**Identify the underlying causes of suicidal morbidity**	This will require careful and possibly prolonged interviews and counselling, often by professional agencies, as well as consultation and advice from family, friends and colleagues. Once the problems have been identified, they must be mitigated and explained in detail to the individual. The individual must be made to understand that something can be done and is being done and, in time, they must be shown real and positive progress. Broken promises will be immensely debilitating and extremely dangerous.
2	**Medical referral**	Medical advice and referral is mandatory for any individual deemed to be at risk and medical advice will be required on an ongoing basis at risk conferences. The MO / Medical Centre must be informed immediately if an individual has been placed on a unit Risk / Welfare Register (although in all normal circumstances, the MO would have been fully involved in the risk conference leading to that decision). Once started, one copy of the CAP must be submitted to the Medical Centre for inclusion in the individual's F Med 4 and updated regularly by a nominated officer. If any individual on a Risk / Welfare Register fails to attend a medical appointment, then it is mandatory for the MO / Medical Centre to inform the unit chain of command so that robust arrangements can be made for a new appointment. Equally, the chain of command must never interfere with, arbitrarily change or cancel a medical appointment for an at risk individual; such appointments should take priority over almost all other activities. Furthermore, the chain of command should never overrule or interfere with clear medical advice from qualified medical professionals (MOs, psychiatrists or Community Psychiatric Nurses (CPN) about a treatment or rehabilitation regime, sick leave or fitness for duty concerning at risk individuals who are currently on a Risk / Welfare Register[1]. Dialogue can take place but a clinician's medical opinion must always prevail.

[1] This advice (only for those on a Unit Risk/Welfare Register) specifically supersedes the rules in PULHHEEMS Administrative Pamphlet 200, paras 0714-0717 and JSP 760, para 15.003.

SER (a)	RESPONSE (b)	EXPLANATION (c)
3	**Engage professional agencies**	Referral for professional help will usually be decided by the medical chain but advice can be obtained from the relevant CPN or Department of Community Mental Health (DCMH). The appropriate Welfare Service or Social Welfare Service (overseas) should usually be informed. The individual must also be made aware that confidential support and advice is always available from agencies such as ForcesLine, Samaritans, RELATE, Combat Stress and padres or civilian ministers.
4	**Remove or control access to means**	Removing or controlling the access to means is always going to be a critical element in a suicide prevention response. The first issue is to make an informed 'risk assessment' of the possible means of suicide open to the individual. It will not be sufficient to simply prevent future access to weapons or ammunition; in one suicide, an individual smuggled a single live round from a range practice, only to use it many months later. Inter alia, the CO should consider: • Checking and tightening procedures for the issue of weapons and live ammunition, particularly in the immediate environment of the individual. • Ensuring that the individual cannot be 'accidentally' issued with a weapon (access to private weapons must be checked). • Searching the individual's room (under the guise of searching an entire block) for any contraband ammunition. Metal detectors should be used if available (in a police search of a block following a suicide, over 50 live rounds were discovered scattered across various rooms). • Removing or limiting, with medical agreement, all prescription drugs. • Removing or limiting all non-prescription drugs. • Restricting or removing the ability to drive vehicles, particularly armoured vehicles or troop carriers. Additionally, the individual could be advised not to drive civilian vehicles.
5	**Engage peer support**	Peers provide a natural source of support. There will always be a difficult balance between confidentiality and disclosure of concerns to peers but, on balance, a degree of honesty with friends and colleagues of an individual who is having problems is usually helpful. However, information sharing with carefully selected, responsible peers must be strictly limited and tightly controlled – and caveated with guidance about the moral and social responsibilities that such knowledge carries.

SER (a)	RESPONSE (b)	EXPLANATION (c)
		Peer support includes a wide range of activities from simply being there and listening to a colleague, to more active planning and intervention aimed at helping the person in need to address their problems. Peer support is essential for minimising social isolation and alleviating distress.
6	**Engage family support**	In many suicide cases, the potentially benevolent influence of the family has been underestimated. This is not always the case, however, and so it is always important to clearly establish the individual's domestic situation and relationship with their family. Whenever possible, the individual should be encouraged and persuaded to voluntarily tell their family about their problems and difficulties. If they will not, then if possible, they should be persuaded to allow the chain of command to speak to their family – even if it is only to tell them that the individual is not happy. In exceptional circumstances, the chain of command may approach a family without the individual's permission but in such a situation no personal information may be disclosed other than to say that there is concern about the individual's welfare and it would be helpful if the family made contact. Where an individual is under 18, it is mandatory for the CO to make contact with the family, with or without the individual's permission. When contacting families (NOK or EC), discretion should always be used in passing confidential information or in unduly worrying the family; over-reaction by the family will be thoroughly unhelpful. Where appropriate, arrangements should be facilitated for the family to visit the individual or for the individual to return to their family on leave. In such instances, travel at public expense can be exceptionally authorised at the discretion of the CO. All contact with family members must be documented.
7	**Organise a visit programme**	The unit padre can be tasked to initiate a carefully coordinated and controlled visit programme to ensure that the individual is seen and spoken to at least once every day by someone in authority, including week-ends, holidays and down-time. If a leave period is approaching, it is essential to ensure that the individual has a structured and monitored plan, with consultation where necessary with those involved.
8	**Assess employment options**	Employment can be a contributory factor in mental ill-health but, if well handled, it can also aid recovery. Depending entirely on the individual's circumstances, personal needs and the reasons for their suicidal morbidity, the CO should consider: • Requesting an assignment for the individual to another unit or location. • Assign them on temporary duty or detachment.

SER (a)	RESPONSE (b)	EXPLANATION (c)
		• Changing their immediate employment within the unit. • Giving them more / less challenge and responsibility (either might be appropriate). • Ensuring that they are given more recognition and appreciation. • Giving them specific targets or goals to focus their mind beyond their immediate perturbation. • Restricting or removing: guards; other duties; minor punishments; week-end work; night work; exercises; and nights away from home. • Supervising, restricting or removing any potentially hazardous work activity, particularly if it involves driving or heavy machinery.
9	**Implement special leave arrangements on compassionate grounds**	Sometimes suicidal thoughts (usually temporary) can be generated by compassionate and welfare difficulties at home, particularly for young individuals. An inability to take leave to get home and deal with the problem and / or an inability to pay for travel and leave will exacerbate the problem. Where an individual has been placed on the unit Risk / Welfare Register, COs may authorise leave on compassionate grounds in accordance with JSP 760 (Tri-service regulations for leave and other absence) if they judge that it would be beneficial for the individual. Such leave should be monitored and controlled and those at the leave destination should be informed of the arrangements and given contact numbers in case of difficulty.
10	**Restrict access to firearms and live ammunition**	Any individual who is deemed to be at risk should not routinely be allowed access to weapons or live ammunition. If access is permitted then it must be carefully controlled and the individual must never be left alone with the weapon. Following a live fire range practice, it is essential to ensure that the individual is unable to smuggle out any live ammunition. Whilst usually it would be counter-productive to publicise the fact that an individual is not permitted to handle weapons, it must be made abundantly clear, without naming names, to others in routine proximity to the at risk individual that under no circumstances can a weapon ever be lent or 'looked after' by another individual even in the most mundane circumstances. Individuals have completed suicide with somebody else's weapon while the owner smoked a cigarette or went to the toilet.

SER (a)	RESPONSE (b)	EXPLANATION (c)
11	**Access to alcohol**	Individuals at risk should be carefully counselled about the dangers of excessive alcohol consumption.
12	**Minimise boredom and isolation**	Ensure that an individual is kept occupied with structured and monitored activity, both physical and mental. This must not be mindless activity for the sake of it, nor must it appear to be overtly contrived. Consider allocating specific projects or tasks, perhaps in part associated with work, with achievable goals. Physical activity, particularly organised sport and recreation, will usually help those suffering from mental ill-health. The key is to ensure that an individual is kept usefully occupied within their capabilities but not significantly imposed upon. Family, friends and colleagues will play a vital role in ensuring that the individual feels involved in normal activities and is not allowed to 'fester' in introverted isolation.
13	**Reduce or remove guard duties**	Over recent years, a number of suicides have occurred whilst individuals have been on guard duty – isolated, at night and in possession of a weapon and live ammunition. Taking an individual off guard roster, however, can have negative effects. It might advertise the fact that the individual has a problem and it might lower their self-esteem because they are unable to complete the full extent of their job. It will also increase the burden on their colleagues and might cause resentment. In principle, an individual deemed to be at risk should not be placed on guard duty. Certainly, they should not be left alone in possession of a weapon and live ammunition.
14	**Instigate a 'buddy-buddy' system**	The 'buddy-buddy' system, whereby one or more individuals are specifically detailed to act as 'minders' for an individual at risk, is already widely used. As always, there is the issue of balancing confidentiality against unnecessary disclosure of private information. The 'buddy' may also require additional support from unit staff / line management during this time.

15	**Introduce communal living arrangements**	Although there is, as yet, no evidence to link single room accommodation with a propensity to commit suicide, there are concerns that segregated accommodation arrangements may lead, in some individuals, to increased loneliness and isolation. Single room accommodation will certainly make it more difficult to monitor an individual at risk and it may make it easier for an individual to find the means to complete suicide. Where at risk individuals are in single room accommodation, COs should always consider the benefits of moving them into shared accommodation with friends they know and trust.
16	**Implement constant supervision**	24 hour supervision will rarely be necessary unless an individual is deemed to be at immediate and significant risk; perhaps following an unsuccessful suicide attempt with an indication that another attempt might be made. An individual in this state will need urgent medical attention. It will usually be unhelpful to place such an individual in the guardroom but very close supervision, involving a roster, should be maintained in their normal living environment until such time as DCMH staff can take over or admission to hospital can be arranged. Proper control and coordination, much like guard duty, will be important. Supervision should be as unobtrusive as possible, commensurate with the need to be able to physically stop the individual should suicide be attempted. Close supervision is best carried out by peers and immediate superiors (not provost staff) but appropriate people in authority need to be on call at all times and aware of the situation. Constant supervision should rarely be necessary for more than a day or so, although it could continue for longer on a more informal and less constrained basis. Physical restraint should never be contemplated other than as a last resort in the face of an actual suicide attempt. The 'supervisors' may also require additional support from unit staff / line management during this time.

7 STRESS MANAGEMENT TRAINING (SMT)

Overview

1. As established earlier in this policy, commanders and line managers are required to identify and manage stress in both operational and non-operational environments and where possible take action to alleviate it. Although commanders have this responsibility, individuals are also charged with recognising the signs of stress in themselves and others, and informing the chain of command accordingly.

2. SMT is integral to the delivery of the RAF's Stress and Resilience policy and wider stress management throughout the RAF. The SMT approach of incremental through-life (through-career) delivery. It is intended to prepare individuals for the rigours of operations, promote awareness and considerate working practices, encourage resilience and develop self-confidence without causing foreboding and trepidation. Some training is mandatory for all personnel whilst some is targeted at commanders and line managers with the aim of supporting those at a higher risk (e.g. personnel who have recently joined their Service, those about to deploy on, currently deployed on or recently returned from operations). The intention is to equip personnel to "be resilient in stressful situations" and, at the same time, seeks to remove the perception of stigma that is sometimes associated with those adversely affected by stress and traumatic events.

SMT Levels

3. Defence SMT has been categorised into 5 levels appropriate to the seniority and specific responsibilities of the individual. Annex A outlines the SMT Training Objectives (TOs) against these 5 levels. SMT is conducted throughout RAF career training, as detailed in the RAF Generic Performance Statement (GPS)[1].

4. The 5 levels are identified in the table below:

<table>
<tr><th>Level 1</th><th>Level 2</th><th>Level 3</th><th>Level 4</th><th>Level 5 Operational Training</th></tr>
<tr><td>Initial/Induction training and any refresher training.</td><td></td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="4">a. Pre-deployment.

b. During deployment (when required).

c. Post-deployment.</td></tr>
<tr><td rowspan="3"></td><td>'Managing Others' training.</td></tr>
<tr><td>Command[2] & Senior Managers of Civ/Mil personnel.</td></tr>
<tr><td colspan="2"></td><td>Specialist SMT training e.g. TRiM[3].</td></tr>
</table>

[1] The GPS, formerly the Generic Education Training Requirement (GETR), is published by 22 (Trg) Gp, Generic Training Wing (GTW), Cranwell
[2] This refers to Unit Command primarily, although it may include sub-unit Command in some instances.
[3] Traumatic Risk Management.

5. **Basic Stress Awareness (Level 1).** Level 1 training is intended to equip the individual with the knowledge to recognise the signs and symptoms of stress in themselves and where to seek help if required. This training is a common training package delivered during all Phase 1 training and can also be delivered as refresher training by units if necessary.

6. **Management of Stress (Level 2).** Level 2 training is intended to equip line managers with the knowledge to: recognise the signs and symptoms of stress in personnel working for them; guidance on how they can mitigate the impact of stressors; and advice on where to seek help. This training can be delivered by the SMARTT at units on request and where resources permit.

7. **Commanders Management of Stress (Level 3).** A specific level 3 training programme has not yet been developed, pending guidance from the MOD.

8. **Specialist Stress Training (Level 4).** All specialist SMT courses are categorised as Level 4. To build on the training already provided during Levels 1-3, additional or 'as required' training may also be required at specific points in an individual's employment. The following training packages are available for delivery through Management or Specialists, dependant on the requirement:

a. Suicide and Deliberate Self Harm (DSH) Awareness training (See Chapter 6, Annex E).

b. TRiM Practitioner, Team Leader & Instructor training (See Chapter 10).

c. Mental Health First Aid (MHFA) awareness. This course has been developed within the NHS and is related to stress but more specifically provides an insight on mental ill health. It is aimed at personnel involved in the delivery of welfare support as they are more likely to have contact with individuals whose support benefits from an understanding of their mental health. Bookings for this course can be made through the SMARTT.

9. **Operational SMT (Level 5).** Operational SMT should normally be an integral part of any pre-deployment IPDT and form part of a unit's post deployment Station Recall Day (See Chapter 4). Particular requirements can be discussed with the SMARTT if necessary.

Sponsor

10. Section 40 is the sponsor for RAF SMT. The Stress Management Training Centre (SMTC) is the sponsor for Defence SMT.

Trg Course Information

11. Information on any of the SMT highlighted in this chapter can be obtained through the Stress Management and Resilience Training Team (SMARTT) at RAF Halton, 95237 6621.

Annex:

A. Stress Management Training (SMT): Training Task Objectives.

STRESS MANAGEMENT TRAINING (SMT): TRAINING TASK OBJECTIVES

TO No (a)	Training Task Performance Statement (b)	Training Task Condition Statement (c)	Training Task Standard (d)	Requirement[1] C (e)	L (f)	A (g)	***Notes*** (h)
	Initial Training (Level 1[2])						
1.1	*Define* pressure, stress, stressors, strain, depression, trauma and other forms of mental unease or distress.	1. On entry to Military Service/Civil Service.	**JSP 375 Leaflet 25, JSP 770 and single-Service procedures:**	X			
1.2	*Identify* the different types of stress.	2. As an individual or as a member of a team.	RN	X			
1.3	*Describe* the causes of stress (and depression)		**BR 1992**	X			
1.4	*Identify* the signs and symptoms of stress (and depression).	3. Supervised and Unsupervised.	**PLAGO 0108** **TRiM Course Manual**	X			
1.5	*Recognise* the effects of traumatic stress.	4. In and out of working hours.	ARMY	X			
1.6	*Describe* methods of stress management (primarily buddy/buddy).	5. On or off duty.	**AC 64204** RAF	X			
1.7	*State* the sources of support that are locally available.	6. In all environments.	**AP 9012** Civil Service **JSP 375 Leaflet 25**	X			

[1] Core, Legal, Accreditation
[2] Levels 1-4 refer to the descriptions at Chapter 7 Paragraph 4 of this policy.

TO No (a)	Training Task Performance Statement (b)	Training Task Condition Statement (c)	Training Task Standard (d)	Requirement[1] C (e)	L (f)	A (g)	***Notes*** (h)
	Managing Others (Level 2)						
2.1	*State* the impact that stress, traumatic stress and depression can have on individuals operational and occupational performance	1. In context of additional command or supervisory responsibilities as a team leader. 2. As an individual or as a member of a management group.	**As above.**	X			
2.2	*Identify* ways in which stress can be managed for: a. Self b. Subordinates c. Peers	3. Supervised and Unsupervised. 4. In and out of working hours.		X			
2.3	*Describe* measures to prevent Deliberate Self-Harm (DSH) and suicide.	5. On or off duty. 6. When dealing with civilian and military personnel.		X			
2.4	*Describe* the assistance - short of medical care - available to address traumatic stress and other forms of stress.	7. In all environments.		X			
2.5	*Describe* the procedures used to access specialist medical care in the management of stress cases.			X			

TO No (a)	Training Task Performance Statement (b)	Training Task Condition Statement (c)	Training Task Standard (d)	Requirement[1]			***Notes*** (h)
				C (e)	L (f)	A (g)	
	Command/Senior Management (Level 3)		**As above.**				
3.1	*Identify* ways of managing stress to maintain operational and occupational performance of the unit/ directorate/ department.	1. As an individual or as a member of a team. 2. Supervised and Unsupervised.		X			
3.2	*Identify* ways of managing stress that include interventions away from the workplace.	3. In and out of working hours. 4. On or off duty.		X			
3.3	*Recognise* the appropriate level of pressure as a means of training and developing subordinates.	5. When dealing with civilian and military personnel. 6. In all environments.		X			
3.4	*Recognise* duty of care responsibilities including regard to traumatic stress, DSH and suicide prevention.			X			

TO No (a)	Training Task Performance Statement (b)	Training Task Condition Statement (c)	Training Task Standard (d)	Requirement[1]			***Notes*** (h)
				C (e)	L (f)	A (g)	
	Specialist Stress Training (Level 4)						
4.1	*Operate* post traumatic incident procedures.	1. As an individual or as a member of a team.	As above.	X			
4.2	*Identify* individuals/groups at risk from traumatic stress.	2. Supervised and Unsupervised.		X			
4.3	*Perform* non-medical traumatic stress functions (e.g. mentoring).	3. In and out of working hours. 4. On or off duty.		X			
4.4	*Operate* traumatic stress reporting and administration procedures.	5. When dealing with civilian and military personnel.		X			
4.5	*Conduct* stress audit procedures for (up to) 1* organisations.	6. In all environments.		X			
4.6	*Plan* stress management interventions (up to) for 1* organisations.			X			

TO No (a)	Training Task Performance Statement (b)	Training Task Condition Statement (c)	Training Task Standard (d)	Requirement[1] C (e)	L (f)	A (g)	***Notes*** (h)
	OPERATIONAL SMT **Pre-Deployment**	1. As an individual or as a member of a team.	As above.				
5.1	*Identify* the particular stressors, signs, symptoms and strategies likely to be encountered in theatre.	2. Appropriate to rank and responsibility.		X			
5.2	*Prepare* individuals for heightened stress levels in the face of increased risk.	3. Supervised and Unsupervised. 4. In and out of working hours.		X			
5.3	*Prepare* individuals for heightened stress levels in the face of separation and concern for family members.	5. On or off duty. 6. When dealing with civilian and military personnel. 7. In the context of the (planned) operational environment.		X			
	Through-Deployment		As above.				Managing personnel is an Operational task not a Training task (some training to achieve this task
5.5	*Identify* personnel at risk following circumstances/events in theatre which pose an acute source of stress or trauma.	1. As an individual or as a member of a team. 2. Supervised and Unsupervised.		X			

TO No (a)	Training Task Performance Statement (b)	Training Task Condition Statement (c)	Training Task Standard (d)	Requirement[1] C (e)	 L (f)	 A (g)	***Notes*** (h)
		3. In and out of working hours. 4. On or off duty. 5. When dealing with civilian and military personnel. 6. In the context of the operational environment.					may be given if the operational circumstances permit
  5.6 5.7 5.8	**Post-Deployment** *Identify* personnel at risk following circumstances/events in theatre which pose an acute source of stress or trauma. *Revise* specific knowledge and skills to manage stress. *Review* appropriate support methodologies and procedures used to access specialist medical care in the management of stress cases.	1. As an individual or as a member of a team. 2. Supervised and Unsupervised. 3. In and out of working hours. 4. On or off duty. 5. When dealing with civilian and military personnel. In the context of the events that were experienced on operations.	As above.	 X X X			Managing personnel is an Operational task not a Training task (Retrospective training to achieve this task may be given if operational events have dictated additional support is needed - hence Ser 5.6 – 5.8

8 THE LINK WITH FAMILIES

Overview

1. Integrating families into stress management procedures directly, through communications and activities, and indirectly, through the Service member, can greatly enhance the performance of the individual in the workplace. Reduction of stress on families and RAF personnel can enhance operational effectiveness and at the same time enhance the work-life balance and an individual's well-being. The RAF has many resources dedicated to family support in an effort to reduce the stress military service generates; commanders/LMs and individuals are encouraged to utilise them whenever possible and to enhance their effect with local initiatives.

2. Commanders/LMs have a role to play and should work with the individual to achieve what is best for them and their family, and in the interests of the RAF. Whilst this policy cannot prescribe detailed processes to management due to the vast variation between families throughout the RAF, there remain some fundamentals to good practice. The aim of this Chapter is to detail the expected level of support to be afforded Service families to reduce stress and increase resilience. It will outline best practice and available resources, applicable to Stress Management principles.

Working With Families

3. In Chapter 2, families were defined as 'who the individual assigns as family or is closest to on a day to day basis'. This definition is to be used rather than using the NOK definition for notification and benefits. This extended definition brings with it challenges in supporting individuals; however, as all families place different needs on the Service person and the Service, the needs of the family should be accommodated, provided they are realistic.

4. **RAF Community Support.** The RAF aims to deliver comprehensive community support to the Service (including its reserve forces, their dependant communities, and, where appropriate, RAF veterans) incorporating access to a full social welfare service. This is achieved primarily through the RAF Community Support Organisation. The RAF Community Support internet website contains a vast amount of information for families, individuals and commanders on a raft of areas related to stress management ranging from separation and reunion, to marriage breakdown and loss. The Community Support Handbook, which can be found on the website, is a guide to the current range of community support services that are available to all personnel and their families. The website can be accessed via the MOD intranet or internet on the following links:

Community Support - Intranet

Community Support - Internet (WWW)

5. **Local Commanders' use of Deployment Welfare Package (DWP)[1].** In addition to the support provided by the RAF Community Support organisation, local commanders have access to DWP funds which they can use to further enhance support and engagement to families.

6. **Information Management**. When working in the military environment it is easy to forget that families have limited access to information about the military, both in an occupational and operational setting. The limitation is not always driven from an information protection aspect, but more so to the small amount of information that is in the public domain regarding the 'day to day' work of the military. It can be difficult for non-military people to be exposed to the RAF and to truly

[1] JSP 770 - Tri Service operational and non-operational welfare policy

comprehend how the RAF operates, both at home and on operations overseas. In most cases, contact through the RAF member in their family is the limit of their knowledge, supplemented by media reporting to the general public. This knowledge gap can cause a great deal of anxiety and stress which can be reduced by pre-emptive action. Unit management can help to reduce these concerns easily and effectively with accurate advice and information about issues affecting the military and, specifically, the Station or Unit that their family member is a part of. The timeliness of information is even more important with the current exposure of the military through the media. Conflicting media reports coupled with limited information through official military channels can create tensions and stress within the family unit. Station and unit newsletters, magazines and websites are effective ways of promoting this flow of unclassified information to families. Furthermore, information days held at the station or unit can relieve a great deal of unnecessary family anxiety. This applies to both routine day-to-day employment and operational and exercise activity.

7. **Work-Life balance.** Undoubtedly military service brings with it a unique work-life balance challenge and many MOD polices and entitlements are in place to ensure that the 'life' part of the balance is not adversely impacted. Not only do the Services maintain a raft of policies to support individuals throughout their career, support organisations, as detailed in Chapter 9, have also been established to specifically support families. Individuals should be well aware of these arrangements and are responsible for ensuring their families are also aware of the support available. Units can facilitate this understanding with regular communications.

8. **Separation.** One of the characteristics of Service life which causes a great amount of stress to the individual and the family is separation. Whether the separation is for a long residential course, an exercise or a deployment, families will have to adjust to the absence of the Service person. At the same time as the family is preparing / adjusting for / to the separation, it is not unusual for the individual themselves to be pre-occupied in the preparation for the task and even looking forward to the event. These behaviours will be at odds with the family and as such may create a stressful situation. To ease this, the maximum amount of warning time prior to the event should be given to allow the family time to adjust and modify any domestic arrangements prior to the separation; in addition, should any community support organisations need to be contacted, the more notice that is given, the better the chances of assistance. It is accepted that long lead times will not always be possible but, regardless, this remains the ideal. Additional consideration should be given to military families who are regularly living apart during the working week. They may require ongoing support, and flexible working arrangements should be considered. This type of separation, although voluntary in most cases, places additional stress on the individual and certainly has the potential to affect their workplace performance.

9. **Detection of Stress**. Families are instrumental in detecting the effects of workplace stress, both as a result of occupational and also operational stressors. As a result, giving them the opportunity to contact the RAF when they have concerns about the military individual is essential. They must be confident that the RAF will take up the concern and work with the family to manage the situation before a lasting mental illness develops. The link with families is paramount. Units should use a Single Point Of Contact (SPOC) to generate rapport and confidence with families, and a standard approach across the unit, although it is recognised that families may choose to opt out of contact with the SPOC. Confidentiality and sensitivity will be key to addressing any issues and it should be noted that the Service person may feel that the spouse has gone behind their back and this may place further pressure on the domestic relationship. Also, the family must have confidence that such an approach will not have a detrimental affect on the Service persons career / performance appraisals.

Working With Families Of Deployed Personnel

10. Notwithstanding the ongoing requirement to support families throughout the career of military personnel, when an individual deploys, as part of a FU or as an IA, further arrangements are to be

made available to support their family as a deployment will create additional pressure on the individual and their family.

11. 'Family readiness' is something which partners, mothers, fathers and legally designated next-of-kin should proactively prepare for when their serving relative or partner is to be deployed. The pressures and demands upon those left behind by deploying personnel occur in the same 3 stages of Operational Stress Management detailed in Chapter 4: Pre-deployment, Deployment and Post-deployment (Reunion).

Stage 1 - Pre-Deployment: Preparing the Family

12. It is incumbent on the individual to advise their family about the deployment and give them a clear picture about their role and task, subject to the normal security restrictions applied to operational deployments.

13. Commanders/LMs are to ensure that families are able to access a designated SPOC during the period they are separated from their Service partner. The designated SPOC must have access to timely information on the deployment as well as accurate listings of personnel in theatre. Families should be advised that this contact is to be used whenever they have concerns and the SPOC is to be linked into the standing after-hours emergency arrangements. Additionally, family briefings should be offered throughout the deployment for FU groups and IAs when appropriate.

14. With the extended definition of the term 'families' applied, when commanders/LMs consider the requirements for pre, during and post deployment briefings to Service families, they should include all 'family' members falling into that definition. Where the family members are not part of a military community and /or live off-base, commanders/LMs are to ensure that relevant briefings and information are communicated to them. It is strongly recommended that all families be afforded the opportunity to attend briefings, irrespective of distance. Whilst it is recognised that some may have difficulty in travelling, alternative methods should be identified to provide as much information as possible. The SPOC should be available at these briefings.

Stage 2 – Deployment: Supporting the Family

15. One of the easiest ways to reduce the stress suffered by families' during the deployment is the provision of up to date information and offers of available assistance. Many methods of communication can be used by commanders to ensure the flow of rapid, relevant and accurate information to families. 'The Community Support Handbook' issued by the RAF Community Support organisation, details numerous methods. The Community Support website provides best practice drawn from several RAF stations.

16. The Operational Welfare Package (Family Package Element)[2] provides an allowance to commanders and offers the opportunity to be imaginative and creative in how they support activities that enhance communication or relieve hardship generated by the deployment. Some examples of initiatives used to date are; FU Families Briefings, funding of increased HIVE hours, 'home alone' events, purchase of communication and imagery equipment (e.g. Webcams), and production of media containing contact details of unit staff and the SPOC.

17. During this stage families should be made aware of *potential* problems with the re-integration of the returning individual into the family unit after deployment. It is useful for families to be given information on the possible symptoms of operational related stress and the ways in which it can be dealt with and by whom. Furthermore, they should be made aware that many of these issues will be completely normal re-adjustments and advised of the timelines which re-integration typically takes. Such briefings are typically given in the last month of deployment. Likewise, families should be kept up to date with details of when the individual is expected to return and what arrangements

[2] AP3392 Vol 2 Lflt 2420 – Support for Families During Deployments.

have been made; this can significantly differ depending on whether the individual is part of a FU or is an IA.

18. **Detained Person Situations**. Families that have the military member detained against their will whilst deployed require further support in managing this particularly stressful situation; this is likely to be exacerbated by massive media interest and the close hold of information by the MOD, both of which will be out of the control of the PU and the individual's family. In this circumstance, commanders are to assign a Visiting Officer (VO) to the family to ensure they have the most current and accurate information, and more importantly, that they understand the reunion process the RAF will undertake once the individual is recovered. Due to possible conflicting interests, ideally, the assigned officer should not be a family friend or a close friend of the individual detained; however, this is a decision for the CO to make.

Stage 3 – Return and Post-Deployment: On–going Support to the Family

19. When providing information in Stage 1 and 2, it is vital for commanders/LMs to maintain the lines of communication with families once an individual returns from deployment. On return from an operational deployment individuals are encouraged to take their full entitlement to Post Operational Leave (POL), unless exceptional circumstances dictate. The POL period is a critical time for a family to re-bond, to re-establish their family routine and to re-familiarise themselves with their surroundings. The opportunity for families to link into the SPOC during this stage is particularly important in the detection of operational stress issues which may present themselves in the post deployment stage of 1-3 months.

20. The 'Community Support Handbook', issued by the RAF Community Support organisation, introduces the return from deployment as a process rather than an event and provides valuable advice and guidance for families in dealing with this process. In addition to the Station Community Support Teams comprising OC PMS, Station Chaplains, Station Medical Officers and SSAFA-FH staff, there are many other agencies which are able to assist in providing support to families who are experiencing difficulties. A list is at Chapter 9.

9 RESOURCES & RELATED AREAS

Overview

1. In respect of stress management and stress related illness, a range of resources, policies and advice are available to assist commanders, individual RAF members, and their families throughout a Service person's career and after they have left the RAF. The aim of this chapter is to pull together various policy and guidance, related orders and publications which are useful in the management of stress or stress illness. The documents detailed herein, though not exhaustive, may be used by commanders, administrators and individuals. The documents have been grouped into In-Service Assistance and External Assistance categories. Also, a 'Related Areas' section is provided, which give details of relevant publications and research. All web pages shown can be found on the Internet unless stated otherwise.

In-Service Assistance

2. **Medical and Psychiatric Resources.** The RAF, in conjunction with the MOD, have superb medical services which are available to provide advice and treatment in respect of stress and mental illness. The care begins on stations and units with the Medical Services Flight staff, and extends to full specialist and hospital services. Extensive specialist services are available for the treatment of the effects of stress such as smoking, alcohol and drug misuse, suicidal thoughts, attempted suicide and deliberate self harm. Commanders and individuals can call on these resources whenever they feel the need and should have full confidence in a professional and caring response.

3. **Pastoral Services.** The RAF also maintains exceptional pastoral services for both commanders and individuals. Many pastoral care staff are trained to deal with trauma, loss and grief, anger, alcohol and drug misuse and suicide intervention; they too can be called on for advice and guidance by commanders and individuals.

4. **RAF Community Support. [www.raf.mod.uk/community/]**. The RAF aims to deliver comprehensive community support to the Service, its reserve forces, their dependant communities, and where appropriate RAF veterans, incorporating access to a full social welfare service. This is done primarily through the RAF Community Support Organisation with details on the current range of community support services that are available to all personnel, and their families, available from the RAF Community Support Website.

5. **HIVE**. RAF HIVE Information Offices support the Chain of Command and tri-Service community through the provision of up to date and relevant welfare related information. RAF HIVE Information Officers offer an extensive range of information on the availability of unit and civilian facilities, local schools and further education, housing, healthcare facilities, employment and training opportunities, relocation and local interest. Information on RAF HIVEs is available to all personnel and their families on the Internet at:

https://www.raf.mod.uk/community/support/raf-hive-information-service/

Operational Deployment Resources

6. The following resources are specific to operational deployments and service:

7. **Deployment Toolkit**. The Deployment Toolkit provides advice and guidance to individuals and their families about a wide range of deployment-related issues. The toolkit can be accessed on the ***Internet***

www.raf.mod.uk/community

8. **The Demands of Deployment and Return and Reunion Booklet**. The *Demands of Deployment* and *Return and Reunion* booklets are available electronically as part of the Community Support Handbook, and are available in hard copy through the Station Chief Clerk or the HIVE. RAF HIVE staffs are also involved in providing Operational deployment support, including information on ways of communicating with deployed personnel and other useful info.

Operational Stress Instructional Videos

9. Three films, held by the British Defence Film Library, are available that show how changes in people's behaviour following involvement in a traumatic event should trigger the need for sympathetic and effective management throughout the command chain. The followingvideos also outline the help and support required once it has been recognised that all is not well with an individual.

'Irony' (AF9523): is aimed at senior officers (OF4 and above).

'Combat Stress – What You're Fighting' (AF9522): is aimed at junior and middle ranking officers and SNCOs.

'Combat Stress – The Honour Thing' (AF9521): is aimed at entry level personnel.

10. **Veterans and Reserves Mental Health Programme (VRMHP)**. The VRMHP provides assessment and treatment advice for veterans (who have deployed since 1982) and reserves who have been deployed overseas since 1 January 2003 as a reservist, and believe that their deployment may have affected their mental health. All veterans referred to the VRMHP will receive a full psychiatric assessment completed by a consultant psychiatrist; this assessment report is then sent on completion to the veteran's GP and if involved, the local mental health service, with advice on further treatment and care. Reserves whose condition is found to be operationally related and of a nature that can be treated within the resources of the Defence Medical Service (DMS) can access treatment in a MOD UK Department of Community Mental Health (DCMH) and will be offered out-patient treatment at a DCMH closest to where they live.

http://www.nhs.uk/NHSEngland/Militaryhealthcare/veterans-families-reservists/Pages/veterans-mental-health.aspx

External Assistance

11. A number of external organisations, most with Service-specific links, exist to support individuals and their families both in and out of service life:

The Soldiers', Sailors', Airmen and Families Association [SSAFA] [www.ssafa.org.uk]
SSAFA is a national charity committed to helping and supporting those who serve in our Armed Forces, those who used to serve, and the families of both. Professionally trained staff provide practical and financial assistance, emotional support and a wide range of services to ensure that SSAFA makes a real difference wherever there is a need and when people turn for help.

SSAFA Forcesline: 0800 731 4880 (From UK) +44(0)1980 630 854 (anywhere in the world). 1030hrs – 2230hrs (GMT) 365 days a year, or through their website:

https://www.ssafa.org.uk/help-you/forcesline

RAF Association [www.rafa.org.uk]. The RAF Association (RAFA) provides a wide range of care and support to serving and retired members of the RAF and their dependants.

RAF Benevolent Fund [www.rafbf.org]. The RAF Benevolent Fund provides assistance to those of the extended RAF Family who need support as a consequence of poverty, sickness, disability, accident, infirmity or other adversity.

RAF Widows Association [www.rafbf.org/raf-widows]. The RAF Widows Association offers support, comfort; friendship and advice to those newly bereaved whose spouse was serving in the RAF at the time of their death.

Relate [www.relate.org.uk]. Relate offers advice, relationship counselling, mediation, consultations and support for those suffering with relationship difficulties.

Royal British Legion [www.britishlegion.org.uk]. The Royal British Legion (RBL) provides financial, social and emotional support to those who have served and are currently serving in the Armed Forces, and their dependants.

Samaritans [www.samaritans.org]. Samaritans is available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide.

Combat Stress [www.combatstress.org.uk]. The Ex-Services Mental Welfare Society – better known as Combat Stress – specialises in helping those of all ranks from the Armed Forces (including Reserves) and the Merchant Navy suffering from psychological disability as a result of their service.

Veterans UK [www.gov.uk/government/organisations/veterans-uk]. Veterans UK is part of the MOD and provides pay, pension and support services to both Military Personnel and the Veterans Community, including families. It can help ex-service personnel get appropriate support from government, local authorities, independent bodies and the charity sector.

Related Areas

12. There are a vast number of areas in the management of personnel that are inter-related to Stress Management and Resilience. The list below, split into higher defence publications, RAF publications and other publications, have links to this policy or have informed it.

Higher Defence Publications

JSP 375, Part 2, Vol 1, Leaflet 17 – Stress in the workplace.

JSP 751 - Joint Casualty and Compassionate Policy and Procedures.

JSP 770 Tri-Service Operational & Non Operational Welfare Policy, Part 2, Chapter 3, Post Operational Decompression.

JSP 835 – Alcohol and Substance Misuse and Testing.

JSP 893 – Policy on Safeguarding Vulnerable Groups.

Defencew Training and Education Leaflet 1.12 – Stress Management and Resilience training.

JSP 950: Medical Policy, Part 2, Leaflet 2-7-1 – The Prevention and Management of Traumatic Stress and Related Disorders in the Armed Forces Personnel Deployed on Operations.

JSP 950: Medical Policy, Part 2, Leaflet 2-7-2 – Provision and Management of Defence Mental Health Services.

JSP 950: Medical Policy, Part 2, Leaflet 2-7-3 – Civilian Operational Deployment Assessment – Post-operational Psychological Support (CODA-POPS).

RAF Publications

AP 1269 Medical Management and Administration - Leaflet 4-01 – Medico-Legal: Disclosure of Information.

AP 1269 Medical Management and Administration – Section 7: Welfare.

AP 1269A Leaflet 5-12 – Air Force Manual of Medical Fitness – Psychiatry.

AP 1269A Leaflet 4-02 – Air Force Manual of Medical Fitness – Branch/Trade Standards Aircrew.

AP 1269A Section 2 – Air Force Manual of Medical Fitness – Medical Boards.

AP 3392 Vol 5, Leaflet 106 – Management of Cases involving the misuse of drugs in the RAF.

AP 3392 Vol 5, Leaflet 107 – Personnel deemed unfit to handle live arms.

AP 3392 Vol 5, Leaflet 112 – Reporting of Suicide, Attempted Suicide and Suicidal Gestures.

AP 3392 Vol 5, Leaflet 124 – Service Personnel under Investigations – Management of Risk of Self-Harm.

AP 3392 Vol 5, Leaflet 125 – Management of RAF Personnel on Long-term Sickness Absence.

P1 Policy Letter 10/05 – Management of Vulnerable Individuals.

Queen's Regulations – Chap 15 – Para 994. The Commanding Officer.

Queen's Regulations – Chap 19 – Para 1474. The Medical Officer of a Station.

RAF Community Support Publications:

- Community Support Handbook.
- Better Money Management.
- Debt Management.
- Demands of Deployment.
- Making a Will.
- Policy Letters.
- Operational Welfare Package.

RAF Fitness and Health Strategy Protocols and Procedures Manual.

Other Publications

13. The following documents and publications are of interest and are related to Stress Management and Resilience in UK Forces and the RAF. Again some of the information in these publications has been used to inform this policy:

- The use of Psychological Decompression in Military Operational Environments, Kings Centre for Military Health Research.
- DASA Annual Report Deaths in the UK Regular Armed Forces – 2009.
- Army General Administrative Instruction (AGAI) Volume 3, Chapter 110 – Army Suicide Vulnerability Risk Management (SVRM) Policy dated Nov 07.
- Land Forces Standing Order (LFSO) No. 3209 – Land Post Operational Stress Management, dated Apr 2011.
- Deliberate Self-Harm Presentations to a General Hospital by Members of the UK Armed Forces, University of Oxford Centre for Suicide Research, Aug 06.

Further Guidance

14. Although a great number of resources are available to individuals and commanders, the amount published in a disparate nature can make it difficult at times to satisfy queries. Concurrently, policy and practices continue to develop. As such, the policy sponsor, Section 40 [redacted] is available for consultation and advice as required.

10 TRAUMA RISK MANAGEMENT (TRiM)

SECTION 1

Overview

1. TRiM is a Tri-Service endorsed strategy for providing support to Armed Forces personnel involved in a traumatic event,[1] whether on Ops or in any other circumstance. Tri-Service TRiM policy was formerly detailed in Defence Instructions and Notices (2009DIN01-097), and to a limited extent in JSP 375, Part 2, Vol 1, Chap 17 – Stress in the workplace. These have now been superseded by JSP770.

2. This chapter is derived from JSP770 and sets out the Background, Concept of Employment and TRiM Activation to be used within the RAF and Additional Support available in regards to implementing all aspects of TRiM.

3. TRiM is a chain-of-command function that depends on good leadership and robust Human Resource management. It is conducted by members of the individuals' peer group, rather than by medical or welfare specialists.[2] The intention is to help individuals use their own coping mechanisms in order to keep them operationally effective, and to identify if further support is needed. In relation to Operational Stress, TRiM is not a substitute for effective stress management during the *normalisation phase* of recovery from operations, nor does it replace any requirement for medical intervention. Those identified as psychologically injured should be referred for professional assessment through the medical services.

Background

4. Operational stress and exposure to traumatic events is an unavoidable part of military operations and can be considered an occupational hazard for all UK Armed Forces personnel. In 2005, the Overarching Review of Operational Stress Management (OROSM) produced its final report[3] which formed the basis for Defence SMT.

5. The OROSM recommended the establishment of a 'Traumatic Stress Practitioner' (TSP) to deliver the highest, most specialised level of non-medical advice. OROSM directed that a TSP would be able to identify those at risk of developing poor psychological health after exposure to traumatic events. A TSP would also be able to carry out non-medical interventions, involving the chain of command (where necessary), aimed at providing an optimised environment for recovery.

6. Following a trial in 2006/7[4] TRiM, which was already in use by the Royal Marines (RM), was deemed to be an appropriate tool to meet the TSP requirement identified in the OROSM. TRiM was judged to contribute to operational effectiveness because it ensured a timely and demonstrable 'front-line' response to the welfare needs of those Service personnel who had been exposed to traumatic events. In addition to meeting the individual's needs, TRiM also aims to reduce the stigma associated with mental health issues. It is a tool to assist commanders in discharging their responsibilities for managing stress in traumatic circumstances. It fulfils the MOD's obligations to ensure that, where possible, psychological risks in both the operational and non-operational environments are mitigated. Commanders at all levels must therefore be able to:

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[1] A traumatic incident is any event that can be considered to be outside of an individual's usual experience, and which has the potential to cause physical, emotional or psychological harm. A key feature of traumatic incidents is that there is no universal response to them; individuals respond to incidents in different ways.

[2] TRiM is primarily a joint administrative (personnel) initiative, supported by specialist medical agencies (such as the Defence Mental Health Services) for managing the non-physical impact of a traumatic incident on personnel.

[3] Over-Arching Review of Operational Stress Management: Phase 2 – Training and Communication Strategies (dated 28 Apr 05).

[4] "A cluster randomised controlled trial to determine the efficacy of TRiM in achieving a positive culture change, reducing organisational distress and improving unit response to traumatic events". Surg Cdr Neil Greenberg RN, Consultant and Senior Lecturer in Military Psychiatry published in TRiM in the FLEET Command - FLEET Pers Ops 02/07 (dated 11 Dec 07).

a. Identify a potentially traumatic incident.

b. Determine the level of trauma-related pressure experienced by those under their command.

c. Identify potentially-traumatised personnel and make support and treatment available to those individuals, as appropriate, through use of the TRiM process.

7. In Mar 09 the RAF Command Board directed that, with effect from 1 Jul 09, the use of TRiM was to be mandatory for all RAF formations deploying on front-line operational duties with a substantial risk of traumatic exposure. Further, all RAF Units / Stns were to have a TRiM capability with the intent of Service-wide application and familiarisation by no later than 1 Apr 12.

8. This policy applies equally to all Regular and Reserve Forces. The use of TRiM is also sanctioned for the participation of civilians aged 18 or over but is not suitable for minors and children. Whilst the engagement of minors in a military-related trauma is unlikely, the possibility nevertheless exists, for instance in relation to cadet activity; in this event, further guidance on the handling of potentially distressed minors and children should be sought from qualified health professionals.

TRiM Command and Control (C2)

9. Section 40 has the lead for TRiM Policy in the RAF. The day-to-day C2 of TRiM, including the coordination of training requirements, recording action and the provision of expert guidance, is the responsibility of HQ AIR Section 40 and the Stress Management and Resilience Training Team (SMARTT).

10. The management of TRiM at unit level is a matter for COs and should be articulated in a unit TRiM plan. It is anticipated that units will require a POC from within the A1 (Base Support Wing or equivalent) organisation to act as the focus for TRiM; under normal circumstances it is expected that this role will be fulfilled by OC PMS / OC PSF or equivalent.

Unit TRiM Capability

11. Being peer delivered is at the heart of the success of TRiM. For this to be effective, when required, all RAF personnel should have ready access to a TRiM practitioner. Certain areas may be more likely to be exposed to a traumatic incident and so may require a greater number of practitioners. The practitioners should be organised under a TRiM Team Leader at a suggested ratio of no more than 10-1. On larger units there may be a need to appoint a TRiM committee or TRiM Co-ordinator. TRiM is intended to become self-supporting so units will require TRiM Instructors to facilitate initial practitioner training; smaller units can pool resources on a regional basis with the approval of the SMARTT. Both Instructors and Team Leaders can deliver refresher training for existing practitioners.

12. Units are to ensure that they maintain sufficient numbers of TRiM practitioners, team leaders and instructors to meet the requirements of this policy. A suggested figure is 5% of a unit's strength – akin to CNO/CVO criteria. Trades/Branches with a higher potential for exposure[5] will have a higher number of TRiM trained personnel, normally 20%.

[5] Examples are RAF Regiment, Fire Service, MERT & RAF Police.

SECTION 2

CONCEPT OF EMPLOYMENT

Terminology

13. **Traumatic Incident**. A traumatic incident that may prompt a TRiM response is defined as:

a. Any event which leads to an individual experiencing significant helplessness, horror or fear and, as a result, has the potential to cause emotional or psychological harm.

b. Any event that can be considered to be outside of an individual's usual experience and causes physical, emotional or psychological harm.

c. Such incidents will often be associated with one or more of the following elements:

(1) Sudden death.

(2) Serious injury.

(3) Disablement or disfigurement.

(4) Multiple traumas.

(5) Near miss.[6]

(6) When individuals are encountering overwhelming distress, (examples include disaster relief and body-handling duties).

(7) Engagement with child enemy combatants.

14. **TRiM - Practitioner**. TRiM Practitioners carry out the functions of the TSP. They are carefully selected, non-medical personnel (who should be volunteers) in units and formations who receive training to enable them to identify psychological risk factors that might otherwise go unnoticed. Such personnel are drawn from across the rank range to ensure, whenever possible, that a potential sufferer is supported from within their own peer group. In order for TRiM implementation to be successful, it is necessary for units to apply and maintain an appropriately robust 'selection' programme to ensure that those personnel selected for training are suitably experienced to undertake the TRiM Practioner role.

15. **TRiM – Team Leaders.** Team Leaders are TRiM practitioners who have received additional training to enable them to deliver wider management functions for the supervision of a TRiM response to a traumatic incident, on behalf of the chain of command.

16. **TRiM – Instructors.** TRiM Instructors are Team Leaders who have proven their commitment to TRiM through delivering refresher training and involvement of TRiM on their Unit. Application to become a TRiM Instructor should be made through the SMARTT and will be based upon a positive recommendation by the Unit's TRiM Committee or Unit TRiM Co-ordinator and/ or OC PMS.

[6] A Near Miss (or Near Hit) is defined as an uncontrolled event which did not [physically] injure any person, but if it had, could have resulted in serious injuries.

Context

17. **First Line Support.** Use of the TRiM process provides commanders with a number of options on how best to deal with any traumatic event(s). TRiM allows commanders to be informed about the psychological health needs of their personnel in order that they can plan the provision of the appropriate levels of support. This may include practical support (assurance of physical safety, acknowledgement of the stressful event, group discussions, etc.) and the provision of information and advice about stress reactions, rather than detailed psychological interventions.

18. **Second Line Support.** For major incidents, particularly if they involve death, the unit TRiM team may be deployed in addition to medical, pastoral and welfare services. TRiM aims to assess the initial impact of traumatic stress and to reassure the command chain that any vulnerable personnel are quickly being identified, 'signposting' to specialist support as required.[7]

19. **TRiM Strategy.** There are 3 strands to TRiM strategy:

a. **Education.** Pre-incident *awareness* education is particularly relevant to operational environments where the probability of any traumatic occurrence is considered greater than would normally be expected.

b. **Individual / Group Risk Assessment.** Following any incident, assessments will be conducted after 3 day, 1 month, and when considered necessary after another 3 months. Such assessments enable the facilitation of *early referral* for treatment, where necessary.

c. **Mentoring.** The mentoring process enables access to a TRiM Practitioner(s) to compliment the education and assessment strands of TRiM, and allows further discussion to deal with any issues arising from any particular traumatic incident(s).

20. **Offering TRiM.** Following any traumatic incident(s) and the corresponding requirement to implement TRiM, the decision as to whether an individual *accepts* the offer of TRiM is their decision alone. Whilst advice and support will be given (including the initial briefing), the chain of command can only *offer* TRiM - it is up to the individual(s) concerned to accept or decline this offer. This in no way diminishes the duty of care that the unit or Service has towards that individual. The TRiM Leader must:

a. Continue to engage (throughout the assessment periods) with any personnel who decline the offer of TRiM.

b. Notify commanders of any individuals considered to be at risk to themselves or others.[8]

21. **Confidentiality.** The peer-delivered approach to TRiM is based on trust. It is therefore critical that confidentiality is maintained. This requirement must be clearly articulated to TRiM-trained personnel. During risk assessments and interviews, TRiM-trained personnel must explain the principle of confidentiality, and outline the circumstances in which it may be breached.[9]

[7] The TRiM process requires that, as soon as practicable but within 3 days of any traumatic incident, a planning meeting is to be convened to determine the appropriate strategy for the management of the incident and that of the affected individual(s).
[8] See footnote 9.
[9] Confidentiality may be broken only in the following circumstances: self-harming; if there is a perceived danger to others; should any serious crimes (civil or military) or breaches of security be uncovered; or, if the effectiveness of personnel is being compromised in the course of their duties.

Principles of Employment

22. TRiM is consistent with the objectives of military mental health provision and employed in accordance with the following principles:

a. **Simplicity.** The TRiM principles should be easy to teach and implement. Such a programme should enable commanders at unit level to manage personnel when they have been exposed to potentially traumatic events.

b. **Command function.** TRiM is a command activity. It should be initiated by local commanders and be delivered by peer's not healthcare professionals[10].

c. **Peer delivered.** Support (including the offer of TRiM) should be provided at unit level, by appropriately skilled and trained peers, wherever possible.

d. **Voluntary.** The TRiM Risk Assessment is voluntary.

e. **Immediacy**. TRiM Practitioner assistance should be in place in the immediate aftermath of any event. TRiM practitioners will provide advice and assistance following a traumatic incident that is deemed to require a TRiM response. Formal individual or group risk assessments should not be initiated until at least 3 days after such an event;[11] earlier intervention is not recommended as it could induce the individual to 'relive the event' which might prove detrimental to psychological wellbeing.

f. **Expectation.** Personnel should be made aware that they may be expected to continue their normal duties, regardless of the nature of their traumatic experience, however, when personnel are unable to function due to overwhelming distress, temporary removal and/ or employment in a different role may be appropriate. Providing TRiM assistance at the unit level reinforces the expectation that most people's responses are manageable and will resolve spontaneously. Such responses are not a sign of weakness, neither are they an indication that formal medical attention needs to be sought or that medical evacuation may be required.

g. **De-Stigmatising.** The provision of early, simple and peer-delivered support for the mental well-being of personnel who have experienced traumatic event(s) should contribute to the de-stigmatisation of mental health issues.

Participation in the TRiM Programme

23. Participation in the TRiM Process is voluntary; therefore, personnel can decline a TRiM intervention if they so wish. In this case, the TRiM Practitioner is to annotate the TRiM Incident Log Book accordingly, clearly stating that the individual has declined TRiM support. The TRiM Practitioner is to inform the TRiM Team Leader of this situation in order that further offers of support / TRiM can be made to the individual, in the future.

TRiM Code of Practice

24. TRiM interventions are only to be undertaken by appropriately trained personnel; they must have an in date TRiM qualification, having undertaken an officially recognised TRiM course. The qualification must have been recorded on JPA, and they must have been directed to perform the intervention at the request of the chain of command.

[10] Healthcare Force Elements may have healthcare professionals who are TRiM practitioners, but the duty is not a healthcare duty.
[11] This is not a 'do nothing' option, but good management practice whereby the individual is *encouraged* to follow their normal routine. Whilst some individuals will be more susceptible following any particular traumatic incident, it is normally better to allow this *state* to subside naturally before any more formal intervention is undertaken.

25. All TRiM interventions should be conducted strictly i.a.w the protocols taught on the TRiM Practitioners' Course and all practitioners are to observe the following ethical statements:

a. Maintain confidentiality unless indicated by law not to do so.

b. Obtain informed consent.

c. Avoid any re-traumatising actions to the greatest extent possible.

d. Operate within personal levels of training, expertise, education & experience.

e. Use the TRiM protocol in an empathetic, sensitive and respectful manner.

f. Self-monitor personal capacity to do 'the work'.

g. Do no harm.

h. Promote human welfare.

i. Be fair.

j. Fulfil commitments to clients.

Benefit to Commanders

26. The greatest benefit of TRiM is perceived to be derived by those units deploying on *war-fighting* operations, or those serving within the front-line commands (and therefore more likely to be exposed to high-threat environments). However, the benefits of TRiM are equally applicable to Combat Support and Combat Service Support units. Moreover, through the use of an appropriate management strategy following any traumatic event, examination and possible intervention must be afforded to <u>all</u> those likely to have been involved in the incident.

27. TRiM can also be of great value in most other situations, notably, non-operational traumatic incidents, training accidents and other challenging events encountered within a wider Service context. Therefore, irrespective of the raison d'être of any particular formation or unit, exposure to traumatic events is an unavoidable part of military operations and it therefore must be considered an occupational hazard for all UK Armed Forces personnel. TRiM lies at the centre of command and executive functions for all units, and it is therefore in the interests of all 3 Services to ensure that the application of Tri-Service TRiM policy is implemented and managed through appropriately accurate, robust and sustainable single-Service publications.

Unit TRiM Plan

28. As previously stated it is expected OC PMS / OC PSF or equivalents will be that unit's focal point for TRiM, responsible for producing, reviewing and implementing the unit's TRiM Plan.

29. As a minimum the Unit Trim Plan should contain:

a. Principles of TRiM.

b. Unit TRiM Management Structure including any Satellite Units, Auxiliary, Reserve or Parented Sections.

c. Training requirements detailing the requisite numerical TRiM Instructors, Team Leaders and Practitioners required per section to meet their unit's demographics.

N.B:- Certain sections, e.g. Trade Group 8, are at greater risk of exposure to traumatic incidents and should have a greater proportion of trained TRiM personnel.

d. Terms of Reference for TRiM personnel detailed in the plan.

e. How the TRiM process is to be implemented.

f. Annual Review.

30. Assistance in the development and review of the Unit TRiM Plan can be obtained through the unit's TRiM Instructors, Team Leaders and Practitioners as well as from the SMARTT at RAF Halton on 95237 ext 6901/6882. A unit TRiM plan template can be found on the SMARTT Moss web page.

31. Exercise the TRiM Plan annually to ensure it continues to meet the needs of that Station.

32. The consideration of utilising TRiM should be included in other unit policies such as the Disaster and Crash Plans.

33. The Unit TRiM Plan forms part of the portfolio of evidence during A1 Assurance's Governance Audits. Units are required to submit a copy of their unit TRiM plan along with their pre- completed A1 questionnaire one month prior to their units audit by AI Assurance. This TRiM plan will be passed to SMARTT for any comments prior to a units actual audit visit.

SECTION 3

TRiM ACTIVATION

Action Checklist

34. When responding to a specific incident, a decision must be made to activate the Unit TRiM Plan. OC PMS (or nominated deputy) will make this decision in consultation with the CoC. Once the decision is made to deploy TRiM, the CO usually through OC PMS is to:

a. Activate Unit TRiM Plan, nominating x2 TRiM Team Leaders to run the incident.

b. Hold a Planning meeting within 24hrs, if possible, with key unit A1 personnel and welfare staff, including the x2 TRiM Team Leaders.

c. TRiM Team Leaders are to identify from those at the planning meeting those involved using the Filtering process.

d. One of the Team Leaders will liaise with SMARTT to obtain an incident number and to request any additional TRiM documentation or support as required.

e. Hold an offer of TRiM Brief:-

(1) Depending on the size of the incident and those involved the TRiM Team Leader will decide how many TRiM Briefs will be required.

(2) The CoC representative gives a short brief on the incident and deals with all questions arising regarding the incident. The CoC then introduces the Team Leader.

(3) TRiM Team Leader to conduct a TRiM brief to give an overview of the possible psychological response experienced by individuals. The briefing is to be delivered by a TRiM Team Leader.

f. If anyone accepts the offer of TRiM the Team Leader identifies suitable Practitioners.

g. The Practitioners undergo refresher training and are briefed ready to carry out the intervention.

h. Only after a minimum of 72 hour / 3 day's should the first TRiM Intervention be conducted (either individually or in groups).

i. A second 1 month intervention must be carried out unless at the 3 Day intervention the individual is referred or the individual declines TRiM.

j. A third intervention 3 months after the one month intervention is optional and only normally used in extenuating circumstances to monitor an individual.

k. If the Practitioner decides to refer at the 3 day, 1 month or 3 month intervention then either the individual or group would be signposted to 2nd Line Support.

l. Throughout the 3 day, 1 month and 3 month interventions the TRiM Team Leader is on hand to support, advise and supervise interventions and the compilation of the requisite documentation.

m. The Team Leader holds all documentation between interventions.

n. The 2 Team Leaders monitor each other and their practitioner's welfare; specifically monitoring personnel for Vicarious Trauma throughout the TRiM process.

o. Team Leader also acts as an information conduit to the CoC and support networks within the bounds of confidentiality during that TRiM Incident.

p. Team Leader closes the incident on the Unit and forwards the required documentation to the SMARTT.

35. These actions remain the same when applied to a minor or major incident. In the event of a major incident then more than 2 TRiM Team Leaders may be required. It may be necessary to seek additional help via the SMARTT if the numbers of personnel are significant.

Incident Recording

36. Post planning phase, the TRiM Team Leader is to contact the SMARTT to obtain an incident number and provide general details of the incident.

37. On notification of a unit activating its TRiM Plan the SMARTT will:

a. Enter the incident on the RAF incident log and create an incident folder.

b. E-mail the Team Leader:

(1) Diary of Events[12] - Used to record a timeline of decisions and actions.

(2) Filtering Sheet[13] - Used to record those identified directly and indirectly in the incident by name, rank and service number. In addition it enables the Team Leader to record that individual's progress through the TRiM process.

(3) Confirm the incident number.

38. Team Leader annotates the Incident number on all the incident documentation (primarily the Incident Log Book, Diary of Events and Filtering Sheet); this will enable the SMARTT to track the progress of the Incident.

39. It is the responsibility of the Team Leaders (whether at home or deployed) to ensure that the incident is properly recorded in the Diary of Events, Filtering Sheet and Incident Log Book. It is vital that complete and accurate details are recorded in order that the TRiM incident and interventions can be followed up in the future, as necessary. This could involve RAF personnel not engaged with the original intervention, possibly from another unit (units are to handover / takeover TRiM documentation / cases through OC PMS's). If interventions are conducted on Army / RN personnel, all the TRiM documentation is to be passed to Section 40 to ensure that the incident is handed over to the appropriate RN or Army TRiM teams.

40. Once initiated, TRiM Log Books are not to be destroyed but must be retained and archived in accordance with standard operating procedures[14]. The TRiM Incident Log Books are held throughout the incident by the TRiM Team Leaders and it is recognised that this places a heavy reliance on the TRiM Team Leader and the Deputy Team Leader to carefully manage the TRiM documentation.

[12] Annex B
[13] Annex C
[14] JSP 441 Defence Records Management Manual.

41. The completed TRiM Incident Log Book is to be placed inside a suitable envelope and sealed by the Team Leader and handed to OC PMS (or designated deputy). The envelope is to be annotated with the date of the incident, incident number, individuals name and service number and the correct handling caveat i.a.w JSP 440 protocols. The Team Leader should seal the envelope in the presence of OC PMS or authorised deputy and the seal is to be signed and dated by the TRiM Team Leader. The Log Book should then be filed on the individual's F445A. The TRiM Team Leader is to enter in the Diary of Events the name, service number and obtain an F591 receipt from HR staff who takes charge of the Log Book to file it with the appropriate F445A. This should ensure that the documentation will be safely stored, limited access to the information will be guaranteed and provide an auditable trail.

42. When the Log Book is signed for by OC PMS (or authorised deputy) the responsibility passes to them for storing and keeping the TRiM Incident Log Book with that individual's F445A which will follow them through all future assignments until such point as it is officially archived.

43. The Team Leader is to contact the SMARTT and send the Diary of Events, Filtering Sheet and any other pertinent Incident paperwork to enable the SMARTT to enter the relevant data onto the 'Exposure to Hazards' system on JPA.

44. The SMARTT are to close the incident and archive the paperwork in the incident folder.

45. The SMARTT are to hold the incident folder for 3 years before sending for official archiving.

Incident hastening

46. Throughout the Incident the Team Leader is to keep SMARTT informed of the TRiM Incidents progression.

47. After a month of initial contact the SMARTT will contact the Team Leader for a progress report. If no further TRiM Interventions are required SMARTT will request completion of the Incident by e-mail. This will be the deemed the first hastening

48. A month after the SMARTT hastener a second hastening e-mail will be sent by Section 40 to the Team Leader.

49. A month after Section 40 hastener a third hastening e-mail will be sent by Section 40 to the Team Leader and requisite CoC.

TRiM Documentation

50. TRiM documentation is available from the SMARTT. No changes are to be made to the TRiM booklets and associated TRiM documentation without the permission of the Joint Stress and Resilience Centre (JSARC).

Resources

51. In order to successfully implement TRiM there will be a requirement for units to provide resources. Some of these resources may include:

a. An office for the Team Leaders.

b. Communications.

c. Transport.

d. Welfare Support.

e. Accommodation.

f. Practitioners.

52. It is a unit's responsibility to ensure that trained TRiM personnel are in place or in extenuating circumstances they can be obtained through the SMARTT. The roles of these personnel, and access to training places, are outlined below.

TRiM Practitioners

53. TRiM practitioners are carefully selected personnel, drawn from across the unit rank structure, who receive a specialist 2 day trg package to enable them to identify psychological risk factors. Trg covers the basics of trauma psychology, including the normal adjustment phase following an abnormal event, planning a TRiM response to a traumatic incident and the conduct of a TRiM risk assessment.

54. The correct selection of TRiM practitioners is pivotal to the success of TRiM. Failure to do so can, unwittingly, cause both psychological damage to those involved and also reduce the reputation of TRiM. Ideally, selection should be based on the following criteria / ability:

a. A volunteer.

b. Available at short notice.

c. Capable of maintaining confidentiality.

d. Respected and trusted by colleagues.

e. Considered as a "natural helper" by colleagues.

f. Mature, sensitive & empathic.

g. Have good communication skills.

h. Capable of learning about psychosocial processes.

i. Adhering to the TRiM Code of Conduct.

j. Team player.

k. Not exposed to a previous trauma for, at least, 2 years.

55. Ideally, newly qualified TRiM Practitioners should undergo a period of mentoring under the tutorage of the Unit's TRiM Team Leader or another experienced TRiM Practitioner prior to working on their own. However, it is accepted that this will not always be feasible. Command judgement should apply based on the resources available.

56. The TRiM practitioner qualification lasts for 3 years and requalification can be done by conducting a live intervention or by undergoing TRiM refresher training[15]. If the qualification lapses, then the full 2 day initial TRiM practitioner course must be undertaken[16].

[15] Can be conducted by a TRiM Team Leader
[16] Further guidance in Annex D.

TRiM Team Leader

57. TRiM Team Leaders are qualified practitioners that receive an additional 1 day training package to enable them to deliver wider management functions to the CoC throughout the TRiM process[17].

58. The Lead TRiM Team Leader should be an Officer, WO, SNCO or, exceptionally, outstanding JNCOs who are experienced TRiM practitioners. SAC TRiM Team Leaders can act as 2 I/C in support of the lead Team Leader.

59. It is the responsibility of the TRiM Team Leader to manage the TRiM Practitioners at his or her unit and also to ensure that TRiM refresher training is conducted, as required.

60. The TRiM Team Leader qualification lasts for 3 years and requalification can be done by being a team leader at a live intervention or by attending the full team leader course. There is no refresher training for TRiM Team leaders.

TRiM Instructor

61. TRiM Instructors are Team Leaders who have proven their commitment to TRiM and been nominated through their Unit CoC to undergo TRiM Instructor trg.

62. To gain the TRiM Instructor competence the Team Leader must undergo work place training and complete the TRiM Instructors portfolio of evidence.

63. The TRiM instructor qualification lasts for 3 years and requalification can be done by instructing on a TRiM practitioners course. SMARTT reserve the right to attend and observe any instructors undertaking a TRiM course for quality assurance purposes.

Training

61. All TRiM training courses are to be co-ordinated through the SMARTT. The RAF has, and continues to develop, a pool of internal TRiM Instructors who are qualified to deliver TRiM training. To help maintain their TRiM capability, units should plan to be self-sufficient in initial and refresher training of Practitioners by having access to augmentee TRiM Instructors and Team Leaders.

62. The SMARTT will continue to deliver Team Leader and Instructor Training to maintain governance of TRiM training.

63. Requalification of a Team Leader is by completing the full 1 day TRiM Team Leader course to be conducted by a SMARTT instructor.

64. Instructor requalification is through carrying out Practitioner Training or after 3 years have lapsed completing the initial Instructor training portfolio.

65. Units may wish to appoint a TRiM training coordinator to ensure that the numbers and demographics of trained personnel mandated in the Unit TRiM Plan are maintained.

66. The process to qualify and requalify as a TRiM practitioner, Team Leader and instructor can be found in annex D.

[17] TRiM Team Leader courses can only be conducted by SMARTT instructors.

67. On completion of all initial and refresher TRiM Trg the individuals' Record of Training must be correctly annotated to record that trg.

68. The SMARTT is to be sent the nominal role (containing the name, rank and service number of those trained) and course log books to archive.

69. The SMARTT are to archive the nominal role with the course log books in an A4 buff trg folder. The front of the folder is to be annotated with the courses details as follows:

a. Type – Practitioner or Team Leader

b. Date

c. Number

d. Location,

e. Instructors

f. JPA Actioned.

Recording on JPA

70. The SMARTT will collate TRiM intervention data for the RAF via 'Exposure to Hazards' on JPA. This provides an operational tracking mechanisms (OPLOC) for individuals' exposure to hazards that *might* give rise to future health effects to be recorded and tracked on JPA;[18] TRiM provides the appropriate *trigger* to identify such potential psychological hazards. It is recognised that recording sensitive details against individuals' records on JPA could undermine the TRiM model, which relies on confidentiality and voluntary engagement to reduce the stigma associated with mental health issues. Therefore, the minimum OPLOC requirement to record the incident details (in the form of a cross-reference to the TRiM Incident Log Book), time and location against the individuals' names is to be applied.[19] 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.

71. On completion of trg the SMARTT are to update an individual's TRiM competencies on JPA by using the following as required:

a. Course Qualified / TRiM Practitioner / Joint.

b. Course Qualified / TRiM Team Leader / Joint.

c. Course Qualified / TRiM Instructor / Joint.

72. All TRiM JPA qualifications are limited to 3 years life. These can be extended through on-going TRiM trg, Live Interventions, refresher trg or completing the requisite TRiM Trg Course(s).

Additional Support

73. TRiM is a sensible approach to managing the aftermath of a traumatic event. For the RAF the implementation of TRiM and its associated policies and procedures are mandatory, both at the home base and on deployment. Further expertise and guidance is available from the SMARTT:

HQ AIR Section 40

Section 40

Section 40 RAF Halton

Section 40 and Answer Phone

Section 40, RAF Halton

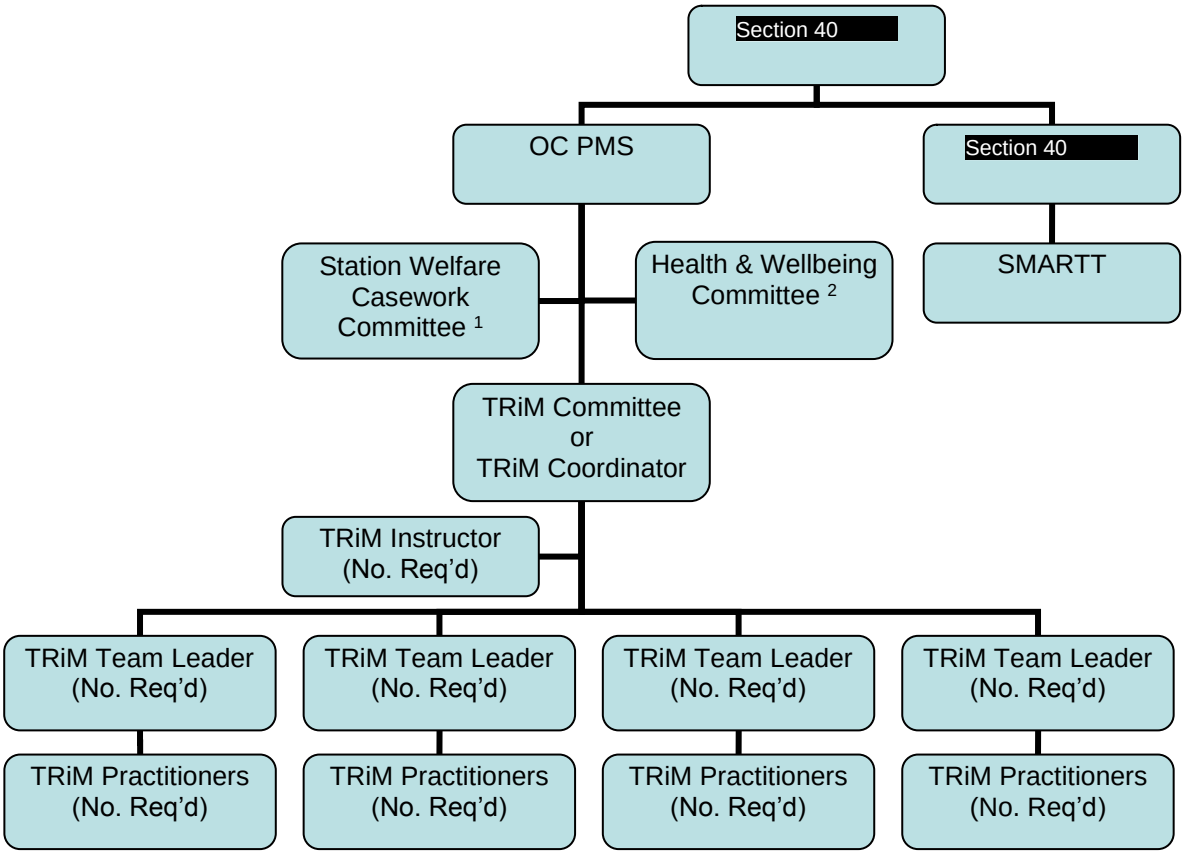
Section 40

Annexes:

A. Suggested unit TRiM Command and Control.
B. Diary of Events.
C. Filtering Sheet.
D. TRiM Training Flow Diagram

[18] JSP 756 - Tri-Service Personnel tracking and Operational Location Policy: Part 2 (Operational Tracking).
[19] JPA (Release 8) provides a suitable functionality known as 'Recording Exposure to Hazards' (E2H) to meet this requirement.

SUGGESTED UNIT TRIM COMMAND AND CONTROL



Notes

1. The activation of TRiM is likely to be in conjunction with the use of other welfare agencies. This should be a point of discussion for Station Welfare Casework Committees.

2. TRiM plays a major role in the RAF's Stress Management and Resilience policy and will be reported on by the unit's Health and Wellbeing Committee to the RAF Health Executive Committee.

3. Larger units may wish to utilise a TRiM Committee where smaller units may choose to appoint a TRiM Instructor or senior Team Leader to the role of TRiM Co-ordinator. Under OC PMS remit the TRiM Committee or Co-ordinator will manage that unit's TRiM activities and training.

TRAUMA RISK MANAGEMENT
LIVE INCIDENT – DIARY OF EVENTS

INCIDENT NUMBER - SMARTT / 20 /

	Date	Time	Occurrence	Action taken	Signature
1					
2					
3					
4					
4					
6					
7					
8					
9					
10					
11					
12					
13					
14					

15					

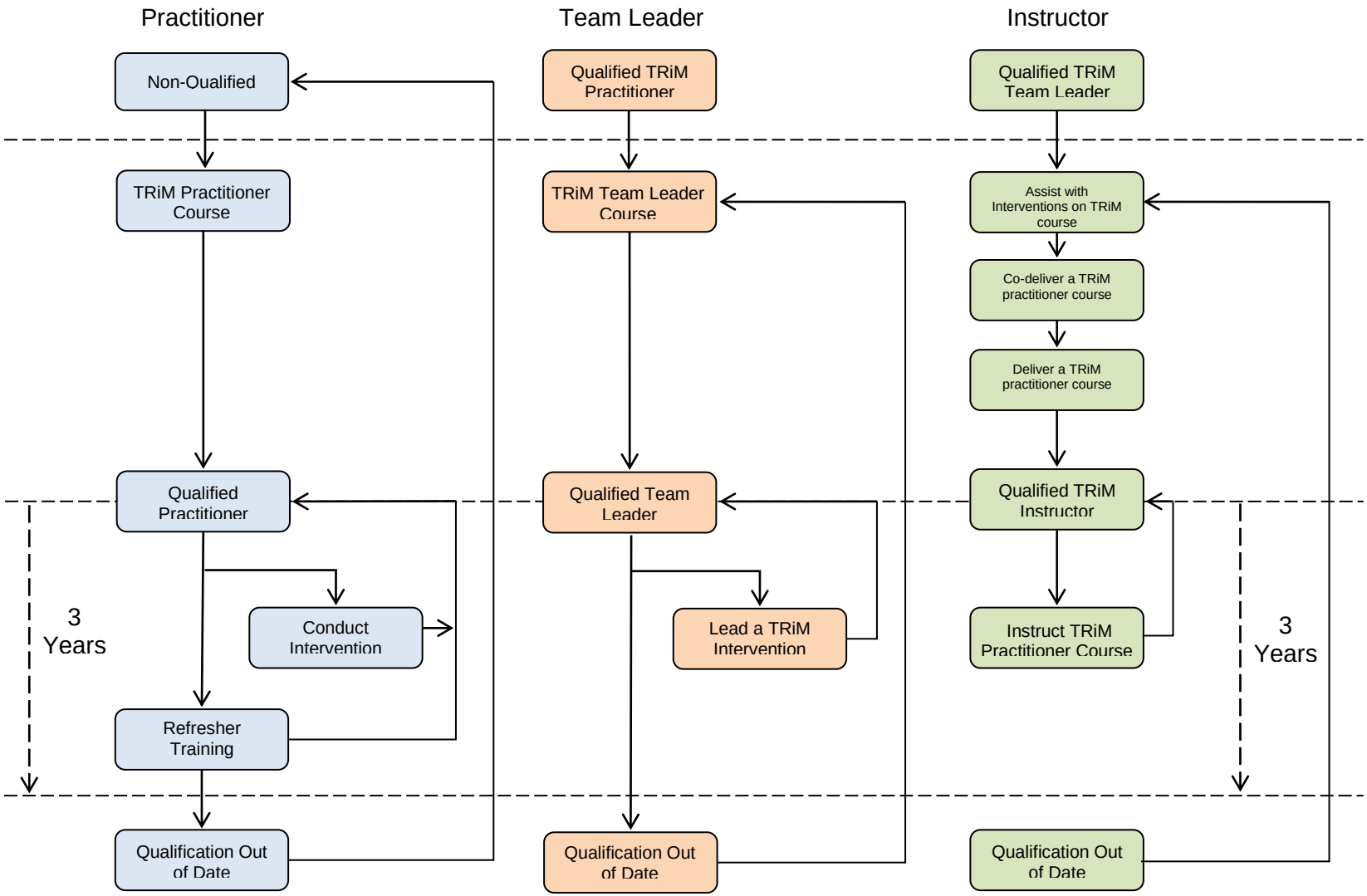
TRAUMA RISK MANAGEMENT
LIVE INCIDENT – FILTER SHEET

INCIDENT NUMBER - SMARTT / 20 /

	Name	Rank	Sevice No	Age	Role	Filter Group	Accept Y/N	Practitioner	3 Day Assessment	M/R	28 Day Assessment	M/R/N
1												
2												
3												
4												
4												
6												
7												
8												
9												
10												
11												
12												
13												
14												

15												

TRIM TRAINING FLOW DIAGRAM



AP9012, Chapter 11

Governance and Assurance

Why should I read this??

'The review firmly re-enforced that a robust governance and assurance system was needed to ensure that the CO and the individual's chain of command provide the best possible support for their people '.

RAF Community Support Letter 14/2016

Sponsor: Section 42

Governance and Assurance

1. The RAF's Stress Management and Resilience policy (AP9012) formalises the management of stress throughout the RAF in order to hone collective and individual resilience. The introduction of a set of Governance protocols was directed in the COS Pers' Business Plan 12/13[1]and the RAF People Campaign Plan (PCP)[2] with details advised to units by ACOS Pers Pol[3].

2. The Stress Management Governance Protocol (SMGP) was developed by the Stress Management and Resilience Training Team (SMARTT) in liaison with representative Stn SMEs. HQ Air Cmd A1 Specialist Support staffs will conduct the 'checks' as part of their A1 Assurance[4] and Welfare Assurance Team[5] (WAT) unit visits. The SMGP is based upon a series of questions designed to help Stn Cdrs assess the stress management preparedness of their establishments.

3. The SMGP covers the following themes:

Stress Management and Resilience Policy

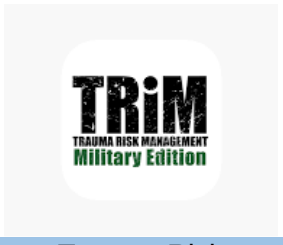
Stressors and Mental Wellbeing for individuals - Ch 3

Operational Stress Management - Ch 4

Occupational Stress Management - Local issues - Ch 5

Suicide and Self-Harm - Ch 6

Stress Management Training - Ch 7



Trauma Risk Management (TRiM) Capability - Ch 10

[1] Chief of Staff Personnel & Air Secretary Business Plan 2012/13 (page 5, 7th bullet point).
[2] PCP Serial 5.3.
[3] 20130128-SMRGovernanceLetter-U dated 29 Jan 13.
[4] AP9012 Ch 4 is assured by the HQ Air Cmd A1 Assurance Team due to the HR processes that are required – AP3392 Vol 2 Lflt 202.
[5] All other protocols are assured by the HQ Air Cmd DACOS Com Spt WAT iaw AP3392 Vol 2 Lflt 301.

4. Units should expect to receive a routine governance and assurance visit annually. HQ Air may direct an assurance visit is undertaken on an exceptional basis. Units may request a visit outside of the routine programme if there are specific concerns for consideration as resources allow. All requests for such visits should be forwarded to Section 42 [redacted] Policy or Section 40 [redacted] in the first instance.

AP9012, Chapter 12

Spiritual Resilience

RAF Chaplains: Serving the Royal Air Force Community through Prayer, Presence and Proclamation

Ministrare Non Ministrari

Sponsor: Deputy Chaplain in Chief Ops

Contents

Overview

1. This chapter identifies what spiritual resilience is, and why it matters in the military environment. It is not simply an issue of private religious practice, but is a key component of human existence. Leaders need to be aware of the need to develop spiritual resilience amongst personnel, which contributes not only to individual well-being but also to the health of the organisation. The chapter will identify ways in which spiritual resilience may be enhanced and developed.

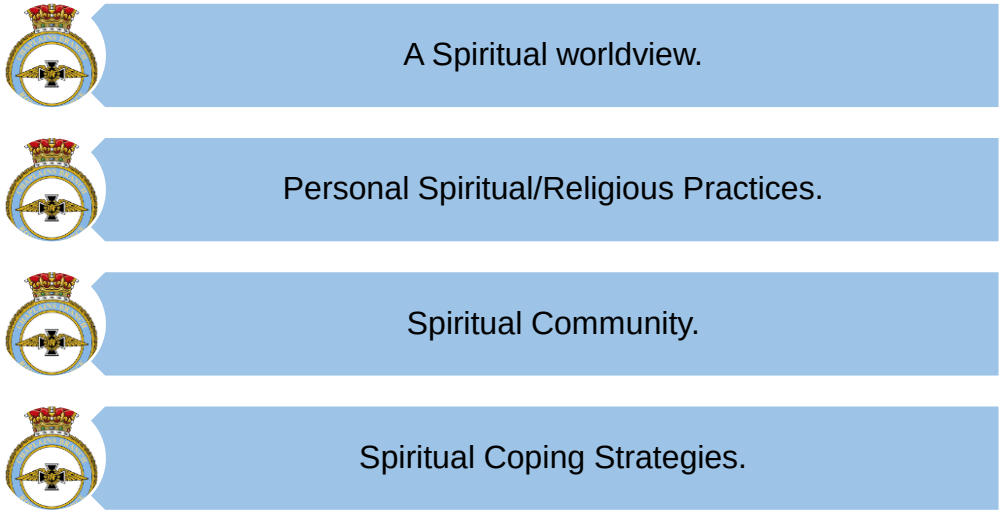
Spiritual Resilience

2. UK joint doctrine defines resilience as ‘an ability to detect, prevent, and, if necessary to withstand, handle and recover from disruptive challenge’1, and the Royal Air Force is keen to develop Whole Force resilience in four areas – physical, mental, social and spiritual. Spirituality refers to the human capacity for reflecting on the nature and purpose of our lives - the meaning of our existence within the universe. Spiritual Resilience can therefore be defined as the ability to withstand, recover, or grow from adversity, stress or change, using resources that are not merely material or psychological; namely, a sense of belonging to something larger than self, deep levels of meaning, moral values, and connectedness to the other. This can be religious, but not necessarily so.

Components of Spiritual Resilience

3. The armed forces have long recognised the importance of transcendence – the sense of belonging to something greater than self - and meaning. Music, ceremonial, colours, mess life and medallic recognition all contribute to spiritual resilience. These things help us to develop common values, a sense of belonging and shared purpose. Their goal is to imbue military personnel with the background awareness that service and sacrifice is an honourable and worthwhile calling.

Attributes of Spiritual Resilience



4. 4 key attributes make up spiritual resilience:

a. **A Spiritual Worldview**. The belief that meaning and purpose have an existence beyond the individual and his or her needs and desires, or immediate community. This is where values/virtues such as hope, altruism, duty, patriotism and forgiveness are rooted, rather than self-centred preferences. For the RAF, our Core Values constitute a valuable starting point for exploring where these values come from, and how they frame meaning, both within and beyond oneself.

b. **Personal Spiritual/Religious Practices**. Spiritual Resilience is most effective where it grows from regular practice, rather than a crisis response; personnel should be encouraged to incorporate spiritual resilience into daily life. For instance, activities such as Mindfulness may be helpful, and smartphone users have access to a wide range of inexpensive apps in this field. There is some evidence that daily exposure to an outdoor natural setting has significant benefits for one's overall health, exposing us to an environment that takes us beyond the routines of daily existence. Similarly, there is also evidence that prayer and spiritual meditation can produce positive outcomes amongst those faced with adversity.

c. **Spiritual Community.** The social support offered by a spiritual community builds resilience. Pastoral care, as provided by chaplains, is an obvious example. Another is the tight-knit military culture, with its primary emphasis on ethos and values rather than specific utilitarian outputs. This is a culture that marks the Royal Air Force's past, and can be engendered at all levels of the RAF for the future.

d. **Spiritual Coping Strategies**. The ability to re-frame stress or adversity as part of something bigger than self has been shown to enable people to make sense of suffering and even use it as a source of growth. Much of the foundational work in this area was carried out by Victor Frankl, a psychiatrist and Auschwitz survivor whose insights remain highly pertinent. Studies in a variety of medical contexts have demonstrated the empirical value of seeing one's life in a broader context of meaning, rather than simply a line of chance occurrences. This can come, for instance, through seeing oneself as part of a community of other human beings.

The need for Spiritual Resilience

5. There are two areas within contemporary RAF life that highlight the need for Spiritual Resilience, namely the mind-set and culture we inhabit and the changing nature of air operations:

a. **Mind-Set and culture.** In the modern world, we lack a sense of group identity – things that bind us together. Most of us focus simply on our own daily lives and personal goals. We tend to look to short-term horizons, and social media often encourages us to engage in online rather than personal interaction2. The demands of life in the Royal Air Force are very different. Although we recognise the importance of the individual, everyone is part of the team, and a great deal of emphasis is placed on living and working with others. The goals we work towards may be costly for individuals and involve great sacrifice. Spiritual resilience is a key tool in helping our people embrace a form of collective life which is seldom found in modern civilian life.

b. **The changing nature of air operations.** Reserves of Spiritual Resilience will better enable our personnel to deal with the specific demands of an increasingly technological battle space, especially in the ISTAR and FJ environments. Often physically separated from the conflict area, they are nonetheless required to assess, operate and use lethal force in high tempo situations which may lack physical danger but carry risk of moral injury through intimate knowledge of combatants and a high degree of involvement in life and death decisions. The full demands of hybrid war may only become clear over time. It is important to note that the RAF will also continue to rely on the historically familiar patterns of air operations involving manned aircraft, which make their own demands on personnel. Further factors causing potential moral and spiritual harm (or, at least, dissonance) include the conduct of operational tours from the home base, and the varying degrees of personal and shared experience brought to the deployed base. Personal resilience within the wide spectrum of contemporary operations calls for a well-founded worldview, if moral and spiritual scars are to be avoided. This may be increasingly important as new patterns of living, working, and training take effect.

Developing Spiritual Resilience within the RAF

6. Given the high degree of operational and community cohesion required within our Service, personnel, commanders, and the organisation itself have a clear responsibility to engage with our people on the spiritual level of meaning and purpose, values and relationship.

Spiritual Resilience and Individuals

7. As with physical fitness, individuals have a responsibility to maintain and develop spiritual resilience. At its most basic level, this requires some reflection on the purpose and meaning of one's life – the tools for which will be introduced in Phase 1 training. For instance, the Beliefs and Values Programme invites personnel to reflect on their own perspectives on subjects such as morality and the meaning of sacrifice; reflecting on the crucial interaction between the Core Values and one's own moral compass is strongly encouraged. Further support and advice is available from Force Development Squadrons and station chaplaincy centres. This can take several forms, such as the Eagles schemes, which facilitate spiritual resilience by helping personnel engage with the service and sacrifice of previous generations, seeking to understand the values and principles which inspired our forebears. A number of retreat opportunities are also available to personnel of all faiths and none, many of them hosted at Amport House.

Spiritual Resilience and Commanders

8. Commanders have a responsibility to develop spiritual resilience amongst their personnel. Important station and unit anniversaries provide an ideal opportunity for doing so – occasions such as Battle of Britain and Remembrance to name but two. Commemoration and celebration can be most helpful in imbuing a sense of meaning and purpose, and each station or unit should be proactive in seeking out such opportunities, in a way which resonates with contemporary personnel. Commanders should also facilitate space and time for personal spiritual practice as the operational tempo permits. This can take a number of forms such as charity work/volunteering, prayer and meditation, time to attend lunchtime study groups and so on. Leadership by example is key, and commanders should not be afraid to demonstrate an awareness that life involves more than deliverables.

Spiritual Resilience & the RAF

9. The RAF draws significantly on spiritual resilience to do its daily work. Practices such as ensign raising, sunset ceremonies and even dining-in nights are of limited obvious utility, but do much to encourage a sense of common purpose and sacrificial service, which are at root spiritual issues. The intense interest aroused by medallic recognition of any operation is another clear example of how spiritual resilience interacts with our world – these small tokens of cloth and metal clearly point to something more than their physical components. Annual celebrations such as the Battle of Britain are not simply optional extras in the Service calendar but are absolutely essential in fostering an awareness of what service and sacrifice may demand. Time spent celebrating the ethos and values of the Air Force is not simply a 'nice to have' but is vital in our on-going identity, as the RAF100 celebrations clearly demonstrated. In the final analysis, RAF personnel are more than contracted employees, having entered into a covenant with the Sovereign. This covenant may demand considerable sacrifices, thereby raising deep questions of human value and significance. In planning and making decisions, the organisation should continue to recognise the continuing importance of such spiritual factors in its assumed worldview, and ensure that they are safeguarded and developed. The organisation can do this by encouraging its personnel to embrace activities which go beyond a mere contractual view of employment, such as volunteer work with the local community.

Delivery

10. A great deal of activity in the sphere of spiritual resilience is already being delivered throughout the Royal Air Force – through acts of commemoration, Eagles schemes and graduation parades. Initial work on developing the concept further will take place through the Beliefs and Values programme, ensuring that new generations of RAF personnel can understand and articulate what it means. The Robson Academy of Resilience will help devise a range of approaches to further develop spiritual resilience at personal, station and organisational level.

Conclusion

11. The Royal Air Force requires its personnel to operate on a sliding scale of sacrifice which may involve anything from minor inconvenience to giving one's life for Queen and Country. Our personnel are asked to shoulder heavy responsibilities in the service of our nation. No matter how attractive an employment contract the RAF may seek to offer, something more than material reward is required to sustain such commitment. The Royal Air Force already has this extra dimension to hand in its ethos, heritage and concern with the development of character – a degree of intentionality in bringing these existing resources to bear under the banner of Spiritual Resilience will bring greater cohesion and focus. The RAF will continue to develop this concept as we seek to shape the Gibsons, Cheshires and Triggs of the future.