Trauma Risk Management: Evaluation of the RNLI pilot

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Key Findings

This report presents the findings of an evaluation of the Trauma Risk Management (TRiM) programme piloted by the RNLI. The evaluation involved a literature review, a survey of RNLI staff and qualitative case studies. It aimed to explore how far the TRiM pilot had provided the structure needed to deliver effective support for staff and volunteers and what influenced the degree to which it delivered effective support.

TRiM achievements and potential

- Research participants felt that the programme had **delivered real benefits** for those who took part and that TRiM, or an equivalent service, was **definitely needed** within the RNLI.
- Both survey respondents and case study participants felt that **support services were more likely to be available** since TRiM’s introduction.

The success of the pilot was underpinned by the following factors:

- the **dedication of TRiM managers**, who were described as being “always on the end of the phone” and there to provide support whenever it was needed;
- the **connections created** by TRiM practitioners, which made it easier for people to open up and share their feelings;
- the provision of **peer support**, which built on traditionally strong and supportive relationships in RNLI teams to provide a **confidential** source of help from **people who understood** the RNLI experience; and
- the **thoroughness of the training** provided to TRiM practitioners, which helped people feel confident in their skills and techniques.

Policy Recommendations

Research participants felt that TRiM should be rolled out across the RNLI. The following recommendations are based on participants’ feedback.

**Organisation and coverage of TRiM support**

- More paid time for internal TRiM practitioners and managers could be used to boost the resources offered by the pool of volunteer practitioners, in order to provide on-call cover and to deal with the fact that there are unpredictable spikes in demand for support.

Regional organisation of TRiM teams would reduce travel time and costs and help to ensure a quick response.

**Integrating TRiM into standard RNLI procedures**

- Local managers should be trained so that they understand the TRiM process and can:
- identify when TRiM is the appropriate response and form of support
- provide details of how volunteers/staff can self-refer to TRiM as well as the other wellbeing services offered by the RNLI.

- TRiM practitioners should be called in routinely after potentially traumatic events to brief those exposed about the benefits of TRiM and to arrange assessments. In the pilot, it appeared that this was difficult due to wide geographical distances but it would be more feasible if regional TRiM teams were set up.
- TRiM briefings should be integrated within the RNLI’s normal operational debriefing process, replacing any existing use of formal group psychological debriefing.

Providing high quality support

- High quality training and professional development opportunities for TRiM practitioners provided the basis for delivery of high quality support. March on Stress courses were valued, but the RNLI could explore possibilities for in-house delivery of further professional development and TRiM awareness training.
- Some trained TRiM practitioners lacked hands on experience and could benefit from opportunities to pair up with more experienced colleagues.
- There is a need to review the effectiveness of services provided by occupational health to ensure that those referred on from TRiM continue to receive the support they need.

Raising awareness of TRiM

- RNLI staff and volunteers need be aware of what TRiM can offer them before they are involved in a traumatic incident. ‘Real-life examples’ could help draw attention to the potential benefits of TRiM.

Facilitating access to TRiM support

- It is important that TRiM support can be accessed by all who experience post-traumatic stress, including RNLI managers, senior staff and volunteers, and people in non-operational roles.
- Offering direct access to TRiM online and by phone would help meet the needs of those who were anxious about requesting support via local managers, but managers should also be able to request TRiM support for their teams.
Executive summary

Background

- The types of search and rescue activities undertaken by RNLI staff and volunteers can expose them to traumatic incidents and physical danger.
- The RNLI uses post-incident team debriefing as a way of processing such experiences as well as providing a confidential counselling phone line and occupational health support.
- Recent years have brought growing awareness of mental health issues generally, and post-traumatic stress in particular. Research has focused on the difficulty of asking for support for coping with stress, particularly when people see themselves as responsible for “rescuing” others.

The TRiM pilot at the RNLI

- Trauma Risk Management (TRiM) is a peer support programme developed in response to such issues. It has been widely used in military, emergency service and search and rescue organisations.
- The programme is based on the expectation that people who share similar working experiences will be better able to connect with those who have been through traumatic events, and better able to encourage them to open up and discuss their feelings about these.
- Peer supporters, or “TRiM practitioners”, are trained in methods for recognising symptoms of post-traumatic stress, providing initial support and identifying those who need further support.
- The RNLI has been running a pilot of the TRiM programme since August 2016, and NatCen was been commissioned to evaluate this. The aims of the evaluation were to understand the outcomes of TRiM support for RNLI crew and lifeguards; to assess TRiM implementation; and to review the interaction between TRiM and other sources of support.

Evaluation methods

The research approach included three main strands:

- a review of relevant literature and RNLI management information;
- case studies involving 15 depth interviews with RNLI local managers, TRiM practitioners, lifeguards and lifeboat crew in four areas where TRiM had been used; and
- an online survey, sent out to all RNLI staff and volunteers across the UK and Republic of Ireland, asking about their experience of potentially traumatic events and their views on how best to provide support. Only a small proportion of staff completed the survey, and therefore the findings do not necessarily reflect the views and experiences of all staff.

Experiences of traumatic incidents at the RNLI

- Most respondents who completed the survey had experienced potentially traumatic incidents in the course of their RNLI work. Case study participants described other factors that could make incidents traumatic for those
involved, including unpredictability, personal relevance and outside scrutiny. These are also factors that have been identified in the research literature.

- The accounts of case study participants supported the findings of previous research suggesting that people’s ability to cope with post-traumatic stress is improved when they feel that they are supported.
- Although there was evidence of cultural change within the RNLI, the evaluation still encountered cases where people were wary of asking for support from their immediate line managers and team members, for fear that they might be judged as less able to cope with their role.

TRiM pilot implementation

- RNLI research participants were generally positive about their experiences of the TRiM pilot, praising, in particular, the sense of connection they felt when talking to a TRiM practitioner and the ways in which the structured approach and training of TRiM practitioners had helped them to provide a different level of support to that offered by everyday colleagues.
- The TRiM team appeared highly committed to the provision of better trauma support for RNLI staff and volunteers and they gave freely of their own time in order to achieve this.
- The key implementation challenges were the need to raise awareness of what the programme offered, achieving buy-in from local managers and staff, and the need to ensure that everyone who might benefit from TRiM support could easily access it.

Integrating TRiM and other sources of support

- Case study participants described the importance of debriefing processes in helping people to deal with the aftermath of potentially traumatic events at the RNLI. Team members were encouraged to support each other informally after such events and there was evidence of a supportive culture in the RNLI teams that we spoke with.
- Though valued, debriefing and informal support were described as having limitations. These related to the unwillingness of people to burden their colleagues by asking them for support; to fears that being seen to need additional support might reflect adversely on their capacity to do the job; and to the limited knowledge and skills of local colleagues when it came to supporting people who were dealing with post-traumatic stress. TRiM was seen as a form of support that had the advantage of being delivered by peers, with shared experiences and understanding.
- Participants felt that TRiM peers did not know them as well as their close colleagues, who were generally in the best position to spot subtle differences in behaviour that might indicate stress. However, TRiM practitioners had the training required to identify and assess stress symptoms through asking the right questions. They were seen as providing advice and support in a confidential way.
- TRiM practitioners described one of their roles as signposting people to further help when needed. They said that further support would generally be accessed via the RNLI’s occupational health department.
- There were a number of reports of difficulties encountered by people attempting to access support from occupational health, from both survey respondents and case study participants. It was felt that, for people to have
confidence in the TRiM part of the RNLI’s post-trauma support provision, they also needed to have confidence that further professional and practical support would be provided when needed.

TRiM pilot outcomes

- The TRiM pilot set out to:
  - provide a support structure to help the RNLI cope with the aftermath of traumatic incidents;
  - deliver effective support to those who needed it after such incidents; and
  - increase the ability of staff and volunteers to cope with post-traumatic stress.

- There was recognition of the huge effort that had been made to develop and deliver the TRiM pilot for the RNLI, and the high quality of support that had been offered as a result.

- The availability of peer support was seen as one of the major benefits of TRiM. As a result of the pilot, RNLI staff and volunteers now have access to a cohort of dedicated peer supporters who have been thoroughly trained in the best ways to deliver initial post-trauma support and assessment. This is a fantastic resource for the RNLI to build on in the future.

- Our survey showed a substantial increase in the proportion of RNLI staff and volunteers who felt that the organisation provided them with enough support after potentially traumatic events, from 27% before TRiM was introduced (those experiencing their most recent such event in 2015 or earlier), to 65% in 2017, after the introduction of TRiM.

- Case studies showed that TRiM support had helped people to feel less isolated after experiencing traumatic events, and had also helped them to make sense of what they were feeling.

Recommendations

In response to the positive findings of the research, we recommend that the RNLI should roll out TRiM, or an equivalent programme, throughout the organisation’s remit. Findings from the pilot suggest that, in any full rollout, particular attention will need to be given to the areas listed below:

- Providing timely coverage for all those who might need TRiM support, by ensuring that trained practitioners are available in each local region;
- Ensuring that all RNLI staff and volunteers are aware of what TRiM can offer them, through integration of TRiM into normal debriefing processes;
- Facilitating access to TRiM support by making it possible to request this directly as well as via line managers;
- Making sure that high quality professional mental health support from the RNLI’s occupational health department is also accessible when needed, either as an alternative to TRiM or as a follow-up.
Main report

1 Introduction

RNLI staff and volunteers work in a risky environment. The types of search and rescue activities they undertake can expose them to traumatic incidents and physical danger. They also need to deal with the emotional consequences of traumatic incidents, for themselves and for others.

Traditionally, RNLI staff and volunteers have supported each other through the course of such events. A potentially traumatic or “critical” incident would normally be processed via debriefing, after which colleagues would informally continue to share experiences and would assess whether anyone appeared to need further support. The RNLI provides access to professional counsellors via a “24/7” confidential counselling phone line. More specialised support is accessed via the occupational health department.¹

However, the RNLI, like other organisations with high exposure to potentially traumatic incidents, has found that these traditional sources have not always delivered the type and level of support that their staff and volunteers have needed when they have been traumatised by difficult incidents.² Recent years have brought growing awareness of mental health issues generally, and post-traumatic stress in particular, but there can still be stigma attached to the process of asking for and obtaining support (Osorio et al, 2013; Schreiber and McEnany, 2015). Research suggests that those who work in roles where they are responsible for “rescuing” others may find it particularly difficult to put themselves forward as needing help with symptoms of post-traumatic stress (ASR, 2015). One of the key challenges, therefore, concerns how to provide support in a way that is non-stigmatising and easy for people to access.

Trauma Risk Management (TRiM) is one of a number of programmes designed to provide screening for early symptoms of post-traumatic stress and support for those experiencing them. The programme was developed by a team based at Kings College, University of London, which now forms the basis of the psychological health consultancy, “March on Stress”.³ TRiM was initially developed for use in the UK armed forces and has been widely taken up by other organisations, including the emergency services (Whybrow et al, 2015).

TRiM has been recognised as consistent with NICE guidelines for the treatment of post-traumatic stress disorder (PTSD) (Greenberg, 2011). A key feature of these guidelines is the recommendation that group psychological debriefing focusing on emotional responses to a traumatic incident can be unhelpful and “should not be routine practice when delivering services”. (NICE, 2005). The guidelines advise organisations to employ a process of watchful waiting for the

¹ Information drawn from discussions with RNLI managers and case study participants.
² Based on discussions with RNLI research and policy managers.
³ http://www.marchonstress.com/page/p/trim
month after the incident, keeping an eye on all individuals exposed to potential trauma (Dunn et al, 2015).

TRiM has been described as: “a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event”. Peer support programmes are based on the expectation that people who share similar working experiences will be better able to connect with those who have been through traumatic events, and better able to encourage them to open up and discuss their feelings about these (Jones et al, 2003). Peer supporters, or “TRiM practitioners”, are trained in methods for recognising symptoms of post-traumatic stress, providing initial support and identifying those who need further support (Greenberg, 2011).

Based on evidence of its effectiveness in other contexts (Hunt et al, 2013; Whybrow et al, 2015) the RNLI undertook a one-year pilot of the TRiM programme, which started in August 2016 and in finished in August 2017. The RNLI commissioned March on Stress to provide TRiM materials for the pilot and to provide training for its TRiM managers and practitioners. NatCen was commissioned to evaluate the pilot and to produce recommendations about its usefulness as a way of supporting RNLI staff and volunteers.

The evaluation had three key aims:

- to assess TRiM implementation;
- to review the interaction between TRiM and other sources of support; and
- to understand the outcomes of TRiM support for RNLI crew and lifeguards.

1.1 The research approach

Our approach to achieving the research aims involved three elements:

- a brief review of relevant literature;
- case studies, involving depth interviews with RNLI staff and volunteers in areas where TRiM had been used; and
- an online survey, sent out to all RNLI staff and volunteers, asking about their experience of potentially traumatic events and their views on how best to provide support.

The RNLI also provided management information to contextualise the findings.

Literature review

We conducted a literature search of social science and psychological databases to explore recent evidence about support provision for staff and volunteers working in organisations or roles with high exposure to potentially traumatic incidents. The search focused on literature produced in the last five years. The literature review also included sources recommended by the RNLI.

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4 http://www.marchonstress.com/page/p/trim
The search strings used were “trauma risk management” and “trauma* AND 'emergency services' OR 'high risk organi*ation' AND 'peer support'”. A total of 34 sources were fully read and included as evidence for this report. The sources can be categorised under the following headings.

- Studies of the implementation of the TRiM programme in other organisations.
- Studies focusing on other approaches to the provision of trauma support, such as critical incident debriefing and other forms of psychological first aid (PFA).
- Studies focusing on general issues related to the provision of trauma support, including:
  - stigma associated with the experience of mental health problems, and the ways that this could prevent people from asking for support;
  - the various ways in which people process potentially traumatic events and the factors which can help them do so effectively; and
  - the importance of support across a broader context, encompassing organisational relationships more generally, and relationships with family, friends and the wider community.

The literature was analysed by identifying key themes, using a framework approach. Further details of the literature review methodology are provided in Appendix A.

Case studies

The case studies involved qualitative interviews with a range of respondents at sites where a traumatic incident had occurred and the TRiM process was used. A case study approach was chosen to allow us to tap into different perspectives on the way that TRiM was working, from the point of view of those who received support from the programme after a traumatic incident, those who provided the support (TRiM practitioners) and those who were responsible for local operational and personnel management in the areas where incidents had occurred.

Four local areas were selected as case studies. Selection criteria were that:

- someone from the area had been referred to TRiM and been through the full process of assessment;
- different TRiM practitioners had provided support in each area;
- the TRiM practitioners were willing not only to take part in the evaluation themselves but also to approach those who they had supported through the TRiM process;
- areas should represent the diversity of the RNLI in terms of geography, employment roles (lifeguards and lifeboat crew), and types of potentially traumatic incidents encountered; and
- case studies should include areas where local management welcomed the TRiM provision from the outset, and also those where there was a longer process of learning about the programme and what it could offer for staff and volunteers.
Sample selection was conducted with an awareness of the risk of “retraumatisation”, i.e. causing people to re-experience the event when being interviewed. So, while it was important to represent the broadest possible range of views and circumstances, we wanted to avoid putting pressure on people to take part in the interviews. We also wanted to avoid potential participants feeling they had to take part because they felt an obligation to support the TRiM programme, especially where it might affect their wellbeing. We therefore excluded individuals from the case study sample when TRiM practitioners indicated that inclusion could put their mental health at risk. It is likely that people experiencing more severe or entrenched post-traumatic stress symptoms were under-represented as case study participants as a result of this approach.

Characteristics of the case studies
The RNLI TRiM pilot was initially intended to focus on four areas: Ireland, South Wales, London and the South of England. However, those involved in implementing it felt that it would be wrong to prevent staff and volunteers in other areas from accessing TRiM, in circumstances where there was no equivalent alternative support available. Our case studies were therefore drawn from four geographically different areas, two of which were originally designated as being covered by the pilot and two of which were not. They included two lifeboat stations and two lifeguard units. Table 1:1 below provides information about the roles and gender of the 15 participants who were interviewed in depth.

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<td>2</td>
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<td>Lifeboat crew/lifeguards</td>
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N=15

The incidents that participants had been involved in were diverse. As first responders, RNLI staff and volunteers can be called on to provide support at sea, on the beach or on any occasion when they are present at a scene where their first aid and casualty care skills can be used. Our four case studies were fully representative of this diversity. Providing further details of incidents is not possible since it would make case study participants potentially identifiable.

The interviews undertaken with case study participants provided a wealth of information about the RNLI as an organisation, the types of people working there and their different motivations, skills and roles. This rich contextual information has helped to shape the recommendations made as a result of this research, by providing understanding of the way that the organisation works.
Further details of case study sampling, recruitment and analysis processes are provided in Appendix A.

The online survey
An online survey of RNLI staff and volunteers was conducted in order to gain further evidence about experiences of potentially traumatic events, consequent symptoms of post-traumatic stress, and the support which people had received, across the full remit of the organisation.

Survey questions covered:
• basic background information such as gender, age, RNLI role, and length of service;
• experience of potentially traumatic incidents during the course of RNLI work and the year of the most recent such incident experienced;
• experience of post-traumatic stress symptoms in the months after the most recent incident;
• whether TRiM support was offered and taken up;
• an assessment of whether the RNLI was felt to have offered enough support following the most recent potentially traumatic incident;
• views on helpfulness of various sources of support, including family members, friends, RNLI colleagues; and
• factors that were considered important when providing initial trauma support.

Although the survey was sent out to all RNLI staff and volunteers there were only 269 responses to the survey. Therefore it is important to note that survey responses cannot be considered statistically representative of all RNLI staff and volunteers. However, respondents represented the full diversity of RNLI staff and volunteers, in terms of gender, age, RNLI roles, and length of service and all regions of RNLI operation were represented, covering both Britain and Ireland. But we did not have the information on non-respondents that would allow us to determine whether they were systematically different in any way from those who responded.

Results were analysed using STATA and have been integrated into the relevant sections of this report. Further information about survey measures, methods of delivery, response, and the characteristics of those who responded are provided in Appendix A and a list of the questions used is provided as Appendix B.

1.2 Reading the report
In order to avoid potentially identifying participants, in this report we have not provided details of the incidents to which participants had been exposed. Anonymised excerpts from survey responses and case study interviews have been included in order to provide the richness of detail and nuance. Quotes from different online survey responses are presented without any further
identifying information. Excerpts from case study interviews are identified by number and case study role.\textsuperscript{5}

The report refers to RNLI ‘staff and volunteers’, recognising the importance of volunteer workers within the organisation as well as the fact that some people combine both roles. The term ‘managers’ is used to cover all those with a senior role, including Area Lifesaving Managers (ALMs), Local Operations Managers (LOMs), Lifeguard managers and supervisors, helms and coxswains. The neutral gender ‘them’ is sometimes used in preference to ‘he’ or ‘she’ to avoid making case study participants identifiable.

Chapter 2 of the report draws on the research literature and RNLI research findings to provide an overview of the issues involved in supporting wellbeing after trauma. Chapters 3, 4 and 5 address the three key aims of this evaluation. They draw on synthesised analysis of findings from the literature review, case studies and online survey to provide accounts of the way that TRiM was implemented for the RNLI pilot, the interaction of TRiM and other sources of support, and the outcomes that can be attributed to the programme. Finally, Chapter 6 presents our conclusions and our recommendations for further development of trauma support at the RNLI.

\textsuperscript{5} ‘M’ for local managers, ‘P’ for TRiM practitioners, and ‘R’ for people referred to the programme who had completed TRiM assessments.
2 Supporting wellbeing in trauma-exposed organisations

This chapter draws on the RNLI case studies and on recent research literature considering how best to support workers who are exposed to potentially traumatic events. It examines:

- how potentially traumatic events are defined;
- evidence of trauma exposure among RNLI staff and volunteers;
- effects of trauma exposure on wellbeing;
- the range of factors that affect wellbeing after exposure to traumatic events; and
- the barriers which can sometimes prevent people from accessing trauma support.

2.1 Defining potentially traumatic events

Many different situations can potentially be traumatic for staff and volunteers involved in dealing with them, and it can be challenging to identify which incidents are likely to be traumatic for which individuals. Research undertaken as part of the development of the RNLI’s TRiM programme\(^6\) produced the following list of six “trauma risk factors”.

1. Serious injury to self and others, particularly colleagues.
2. When personnel have been disabled or disfigured.
3. Trauma that involves death, particularly grotesque death.
4. When the trauma is complex, long lasting or multiple.
5. When personnel have been involved in a ‘near miss’.
6. When personnel experience overwhelming distress after an event.

The research literature suggests a number of additional factors that could contribute to making incidents traumatic, including:

- incidents that are unpredictable or caused deliberately (Pulido, 2012);
- incidents that have a personal relevance for the responder (Armstrong et al, 2014; Adams et al, 2015; Evans et al, 2013);
- losing control of the situation or lacking control (Brooks et al, 2015; Adams et al, 2015);

\(^6\) Cited in the ITT for this research
situations attracting a lot of media attention or where the actions of responders are questioned (ASR, 2015); and

- loss of life after a prolonged search and rescue effort (ASR, 2015).

RNLI case study participants also identified some of these factors as responsible for increasing the trauma potential of certain incidents. Personal relevance was a trauma factor in a number of the incidents discussed, when those involved were known to the RNLI lifesavers but also in less direct ways:

> *She told me the age and I remember it because he was the same age as my dad… obviously I felt guilty … that I’d got to go home to my dad and that girl didn’t.* (R4)

It was common for critical incidents to be the subject of scrutiny, and several case study participants described how this was stressful:

> *It was a potential crime scene… they went down to the police station to give statements, and that was quite traumatic… the line of police questioning made them feel they were very much under the spotlight of what had happened.* (M1)

The unpredictability of traumatic situations at the RNLI was also a theme which arose in the interviews, with one TRiM practitioner commenting that it was a common issue in their practice:

> *A lot of the TRiM things I’ve done have often been around that, the shock that it wasn’t expected.* (P1)

### 2.2 Trauma exposure among RNLI staff and volunteers

RNLI is aware of the risk of trauma exposure for staff and volunteers, though there is currently limited information available to quantify the extent this across the organisation. The main piece of quantitative research conducted prior to this evaluation was an RNLI analysis of “Return of Service” records from lifeboat launches, identifying an average of 219 launches per year that could potentially meet one or more of the six key trauma risk factors listed above. It did not provide information on how many individual members of lifeboat crew might be exposed to potential trauma in any year and it only covered potentially traumatic incidents that involved the launch of a lifeboat. So far, there has been no equivalent research on potentially traumatic incidents encountered by RNLI lifeguards or by other staff groups such as call-handlers.

The web survey conducted for this research provided information about individual experiences of potentially traumatic incidents among RNLI staff and volunteers. As noted in the introduction, the figures are not statistically representative of the experiences of all RNLI staff and volunteers. People who had experienced traumatic incidents may have found the survey more salient, and therefore have been more likely to respond. The results do provide further

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7 The RNLI return of service information provided proxies for the 6 factors used to define incidents as potentially traumatic, such as incidents involving fatalities or major first aid.
indication that dealing with the effects of trauma is an important issue for the RNLI, as it is for other first-responding and trauma-exposed organisations.

As Table 2:1 shows, the majority of respondents to the web survey had experienced incidents involving at least one of the six trauma risk factors listed above. This was the case for:

- 74% of all respondents;
- 91% of lifeboat crew;
- 62% of lifeguards; and
- Half of the non-operational staff and volunteers who responded.

As expected from the results of other research (Shakespeare-Finch and Daley, 2017), Table B:1 shows that the longer RNLI staff and volunteers had served, the more likely they were to have experienced a potentially traumatic event (42% among those serving for 1 year or less rising to 93% among those serving for 10 years or more). We also found variation by gender, age and role:

- women respondents were less likely than men to report such experiences (53% vs 81%);
- younger respondents aged 16 to 24 were less likely to than those in older age groups to report them (61% vs 80% of 25 to 49 year olds and 74% of those aged 50 or over); and
- lifeboat crew were more likely to do so than lifeguards and non-operational staff (91% vs 62% and 50% respectively).

While we would expect these factors to be related, it would be useful to do further research to understand them more fully.

2.3 Effects of trauma exposure on wellbeing

While the types of incidents described above are “potentially traumatic”, evidence suggests that the level of stress experienced by those involved may vary widely. Post-traumatic stress can be mitigated or compounded by a range of factors, including individual resilience and susceptibility, and the supportiveness of the environment within which people live and work (Fjeldheim et al, 2014; Setti et al, 2016; Prati and Pietrantoni, 2010).

Research underpinning the TRiM programme indicates that it is normal to experience a range of post-traumatic stress symptoms after potentially traumatic incidents but that most of those who experience them do not get ill (Greenberg, 2011). Post-traumatic stress disorder (PTSD) is only diagnosed when symptoms are considered severe or when they become entrenched and do not improve with time. Estimates of likely PTSD prevalence vary widely in different circumstances. For example, community studies undertaken by the American Psychiatric Association (Scully, 2011; APA, 2000) have shown lifetime prevalence rates of PTSD ranging between 1% and 14% for the general population, rising to 58% among at-risk populations such as combat veterans. A study of London Ambulance Service personnel who responded to the London bombings in 2005 suggested that approximately 4% experienced PTSD afterwards (Greenberg, 2011).
The RNLI online survey used a measure of post-traumatic stress which covered experiences of the following symptoms in the months after a potentially traumatic incident:

- repeated, disturbing memories, thoughts or images of it;
- feeling very upset when reminded of it;
- avoiding activities or situations which reminded them of it;
- feeling distant or cut off from other people; and
- feeling irritable or having angry outbursts.

Table B:2 shows that experience of such symptoms was normal among RNLI survey respondents who had experienced potentially traumatic incidents:

- 84% had experienced some post-traumatic stress symptoms after the most recent potentially traumatic incident; and
- nearly a quarter (23%) had experienced symptoms severe enough to be indicative of PTSD.

It is important to treat these figures with caution. RNLI staff and volunteers who had experienced severe post-traumatic stress might have been more likely to respond to the survey, and this could be an explanation for the fact that 44% of respondents in non-operational roles reported experiencing high levels of post-traumatic stress.

However, responses to the survey do provide an indication of the varying levels of post-traumatic stress experienced by different groups of RNLI staff and volunteers in the following ways.

- While there were no clear differences by gender, respondents who were older were more likely to have experienced more severe post-traumatic stress (13% of 16 to 24 year olds, rising to 33% of those aged 50 or over).
- The likelihood of having experienced severe stress also rose with length of service (from 11% among those who had served in the RNLI for 1 year or less to 28% among those who had served for 10 years or more).
- Lifeboat crew were more likely to have experienced severe stress than lifeguards were (25% vs 11%) a finding that could have been related to their older age profile and longer average length of service.
- Those who had experienced potentially traumatic events in 2015 or earlier (before the introduction of the TRiM pilot) were more likely to report severe stress symptoms than those who done so more recently (31% of those experiencing such events in 2015 or earlier, vs 20% of those who had experienced them in 2017).

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8 The measure used was the shortened version of the PTSD Checklist – Civilian version (PCL-C), developed for use in primary care or similar general medical settings (Lang and Stein, 2005; Lang et al, 2012; Weathers et al, 1993). Appendix A describes how these items were scored in order to screen for PTSD. It is also important to be aware that the level of symptoms defined as indicative of PTSD may vary depending on the measure used.
Post-traumatic growth

Participants in a number of studies have described experiences of “post-traumatic growth”, involving the development of an increased sense of effectiveness and motivation for the work that they are doing after coping with a traumatic event (Armstrong et al, 2014; Sattler et al, 2014; Adams, 2015). However, it is not yet clear whether such outcomes are related to support received (Armstrong et al, 2014).

Participants in this evaluation also discussed positive effects on motivation for RNLI staff and volunteers involved in traumatic experiences. For example, they described an enhanced realisation of how much the RNLI was needed, and how they personally were able to make a difference:

*I just do it to help people… So, that’s what you’re there to do… So, yeah, definitely [the incident] made me want to keep working for the RNLI.* (R5)

Such realisations could have complex consequences for those involved. Another young lifeguard described the sense of responsibility that came with being considered a first responder to potentially traumatic events:

*It opened my eyes a bit into I have an obligation to help out, if I'm outside of work as well, like, I can quite easily be driving and see a car crash or something, and I might have to help out… It would be really tricky; I'd hate to ever have to do that sort of thing ever again, but yeah, if I had to, I'd have to take it on the chin and just do it as best as I could.* (R2)

2.4 Factors affecting wellbeing after potentially traumatic events

Research suggests that both individual and organisational factors affect people’s responses to trauma and the likelihood that they will experience the debilitating symptoms of PTSD. On an individual level, those with previous experience of stress, anxiety and depression are thought to be more susceptible to PTSD (Pulido, 2012; Fjeldheim et al, 2014), as are people experiencing concurrent stress in other areas of their lives (Sattler et al, 2014). At the organisational level, general workplace conflict and stress can make employees more susceptible to symptoms of trauma (Pulido, 2012) and trauma reactions can be heightened or prolonged when workers do not feel supported by their organisation (Adams et al, 2015). Conversely, feelings of camaraderie and experiences of organisational supportiveness can mitigate trauma responses and bolster individual resilience (Shakespeare-Finch et al, 2017; Setti et al, 2016; Adams et al, 2015; Sattler et al, 2014).

Prior understanding

Other research among search and rescue workers has shown how prior education about signs and symptoms of acute stress reactions can help prevent the progression to PTSD (ASR, 2015). The provision of such information, or “psycho-education”, forms the basis of a number of programmes designed to bolster resilience among workers facing the prospect of involvement in potentially traumatic situations (Mind, 2017; Scully, 2011).
RNLI case study participants described various ways in which the organisation trained people to prepare for potentially traumatic events, including through:

- scenario-based training,
- operational management, and
- casualty care courses.

However, they also described how it was impossible to prepare for all eventualities, and how it was often the unexpected events that were most traumatic for those involved.

Post-trauma support

To the extent that it is not possible to fully prepare staff and volunteers for the effects of trauma, the support that is available to them afterwards is likely to be of key importance for their longer term wellbeing (Greenberg et al, 2015).

Recent years have seen a growing recognition that organisations exposing their staff to potential trauma have a duty of care that requires them to provide such support, and TRiM is one of the programmes that has been developed as a way of providing it. The TRiM programme is marketed as offering three main types of benefit for organisations:

- economic – through reducing sickness absence and increasing workforce effectiveness;
- legal – through demonstrating that the organisation meets its duty of care to employees; and
- moral – through supporting the wellbeing of employees and reducing the stigma associated with asking for help.9

RNLI case study participants emphasised the moral imperative over the legal and economic ones. They were particularly wary of any initiative that might be seen as a ‘tick box exercise’, used primarily to demonstrate that the organisation was meeting its legal commitments. For example, a local manager described how a key benefit of TRiM provision was in making people feel that they were supported:

> I think, for the guys involved, it adds the feeling that they’re cared for, you know, there’s people care about what happens to them… that for me as well is great to know, that they feel that way. (M1)

The research literature also highlights the importance of such “perceived support”, in helping people to cope after trauma. For example, a qualitative study of police officers who had experienced traumatic incidents (Evans et al, 2013) concluded that knowing support was available could contribute to recovery, whether or not people chose to take it up.

2.5 Barriers to accessing post-trauma support

The literature describes two main types of problem that people encounter in trying to access support for post-traumatic stress:

- institutional barriers to care, related to the availability or accessibility of support; and
- problems related to stigma associated with mental health issues, which can result in unwillingness to ask for help.

Institutional barriers to care can include a lack of available services, not knowing where to seek help, and not being able to get time off from work to access care. However, a study of UK military personnel found that stigma exerted a greater influence on help-seeking behaviour than did these types of barriers (Osorio et al, 2013). We examine the accessibility of TRiM and other RNLI support in the sections that follow.

A number of studies have tried to unpack the particular issues around stigma within the specific types of culture that tend to prevail in trauma-exposed organisations. They have shown that people who are dealing with trauma regularly as part of their day-to-day work typically feel that it is a part of their role to be able to cope with this (Evans et al, 2013). A study of stigmatisation among serving military personnel (Ben Zeev et al, 2012) describes how this type of expectation can lead to responsibility for mental health problems being placed on the individuals who suffer them.

In addition to the issues relating to stigma and negative stereotypes of mental illness, recent research (Kranke et al, 2017) has also pointed to gaps in knowledge – about the signs and symptoms of mental illness, and about the nature of treatment – as playing a part in discouraging people from asking for support. The TRiM programme aims both to provide people with information about signs and symptoms of post-traumatic stress, and to assess their need for further support.

Traditionally, people undertaking military, emergency service and rescue roles have tended to be male, and some studies have found that women working within these organisations also tend to take on elements of “masculine” identities (Pasciak and Kelley, 2013) which might affect their feelings about asking for support. Although, in the RNLI as elsewhere, more women are gradually moving into trauma-exposed roles, case study participants still felt that the traditional image of a “lifeboat man” exerted a continuing influence in parts of the organisation:

Crust old seadogs with a beard that don't accept females on the lifeboat station, and God forbid you're going to complain that you’re upset by seeing a traumatic incident. (M2)

10 The RNLI survey (Table B:2) showed that 26% of women and 22% of men working in RNLI roles had experienced severe stress symptoms after being involved in a potentially traumatic event, a finding which was not statistically significant due to small numbers in each category.
While a number of participants described how RNLI culture was changing, evaluation participants in managerial and other roles discussed the ways that concerns about being judged by colleagues and managers might prevent people from asking for support with mental health issues. In the following excerpt, a local manager described how people would find it easier to access such support if they did not have to go through their line managers:

*We find it perhaps tricky to go through our management… There’s that perception that… ‘Oh, he’s obviously not handling his workload, or not being able to deal with things.’ So perhaps a level of anonymity… So they don’t necessarily ask me for that… but I think perhaps if … they’re able to do it for themselves or go to somebody without having to come through me or one of the other supervisors.* (M1)

In the sections that follow, we describe in more detail the way that TRiM was implemented for the purposes of the RNLI pilot, and the extent to which the programme was successful in overcoming people’s reluctance to ask for support.
This chapter describes how the TRiM programme was implemented for the RNLI pilot. It looks at resourcing of the programme, focusing on how TRiM practitioners were recruited and trained, and at delivery of the programme, focusing on how people were made aware of it, and on how support was provided.

3.1 Recruitment of TRiM practitioners

One of the key features of the TRiM programme is that support is provided by “peers”, defined as people who are themselves involved in similar operational work. RNLI staff and volunteers were invited to apply to become TRiM practitioners on the organisation’s volunteer recruitment website, and case study participants also described how RNLI TRiM managers used their own networks to identify people with particular skills to offer. During the pilot, all TRiM practitioners undertook their TRiM roles on a volunteer basis, whether or not they were a volunteer or paid member of RNLI staff. Their expenses were paid but they committed their own time to undertake the role.

TRiM practitioners who participated in our case studies described the following motivations for applying:

- having seen colleagues suffer post-traumatic stress after being exposed to traumatic incidents, at the RNLI and elsewhere;
- becoming aware of gaps in support for colleagues experiencing post-traumatic stress;
- feeling passionately that they wanted to help provide better support;
- wanting to reduce or remove the stigma around mental health issues; and
- feeling that they had skills that could be used.

TRiM practitioners described how their own experiences of RNLI operational work and traumatic situations made it easier to connect with those they were supporting. They also mentioned other skills, experiences and qualities that they brought to the programme, including:

- medical expertise and interest in mental health issues;
- previous involvement in delivering post-trauma support; and
- personal qualities, such as having a caring nature, being good at listening and being willing to put themselves out for other people.

Practitioners described the sense of responsibility they felt in taking on the role, emphasised that they had volunteered to take it on because they believed in it, and said how important it was that they were able to offer support to their own colleagues as well as the general public:

*It’s just nice knowing that you’re there to support someone who’s struggling, do you know what I mean? It’s kind of what we’re all about anyway; supporting other people … so if you could be there for your own crews I think that’s a good thing.* (P5)
3.2 Training of TRiM practitioners

TRiM practitioners are not professional counsellors or therapists but they do undergo specific training allowing them to understand the effects that traumatic events can have upon people. Their training covers ethical procedures, listening techniques, ways of offering advice and assistance, the processes to be followed when carrying out TRiM briefings and assessments, and methods of scoring levels of post-traumatic stress to identify people needing onward referral to professional support.

All of the RNLI TRiM practitioners involved in the pilot had undertaken the two-day TRiM practitioner course run by March on Stress, and some of them had opted to complete the BTEC qualification offered alongside this.

The training presented challenges for some:

- it could be difficult to get two days off from day jobs in order to do the course;
- participating in role plays were felt to be useful but not always comfortable; and
- not everyone wanted to do the academic (BTEC) part of the training.

Overall, however, there was a positive response to the TRiM practitioner training, with participants saying how useful it had been for their TRiM practice. There was specific praise for the information packs and resources provided, which were seen as offering clear information and useful prompts. This was particularly helpful when preparing to conduct TRiM assessments.

The RNLI decided that the BTEC qualification should be optional for those joining as TRiM practitioners during the pilot phase; it was felt that making it compulsory could have dissuaded people from taking on the role. Those who decided to do the qualification found that it was challenging, particularly when they had little recent experience of academic work, and they found it stressful having to complete the course within a limited time. However, they also said that completing it gave them a sense of achievement, offered them transferable skills and helped to consolidate their knowledge and understanding. Others, who decided not to do the BTEC, felt that it would not necessarily have made them into better practitioners, and said that practical experience could be equally valuable. On the basis of these findings, we would recommend that the RNLI continues to offer the BTEC element of TRiM as an option for those who value the deepening of understanding and skills accreditation that it provides. We would not recommend making the BTEC element compulsory, as this could deter some suitable people from applying to become TRiM practitioners.

TRiM practitioners who took part in the case studies felt that continuing professional development was important and they expressed commitment to keeping their own skills fresh and up-to-date. They described the efforts that had been made by RNLI TRiM coordinators to bring practitioners together for meetings and scenario-based training. Participants reported that regular TRiM practitioner meetings had been held during the course of the pilot, which were
interesting, valuable and informative. However, there were a number of challenges to be faced in bring TRiM practitioners together:

- TRiM practitioners were geographically widely dispersed. In one area, with a concentration of TRiM practitioners, professional development had been enhanced by the creation of a local network of TRiM practitioners.

- Most TRiM practitioners were volunteering to take on the role in addition to other work and family responsibilities, and sometimes in addition to other volunteering responsibilities with the RNLI. Those we spoke to used elements of flexibility around their work to fit in the TRiM role but it could be difficult for them to make additional time available to attend meetings and training, especially if this meant travelling long distances.

One issue raised by TRiM practitioners was the difficulty of managing the balance between having enough practitioners available and providing each practitioner with enough hands on experience of doing assessments. The practitioners who took part in the case studies were selected on the basis that they had carried out assessments but they spoke of others who had been trained but who had not actually delivered an assessment during the course of the pilot:

*I know there’ve been a few people that have done the training, a year’s gone on, they haven’t had an incident, and they’ve said, ‘Actually, I don’t think I’m able to do this anymore.’* (P4)

Participants felt that action should be taken to make sure that all trained practitioners gained the hands on experience that would enable them to develop their skills to a point where they were confident in delivering TRiM assessments.

A further issue raised was that of providing support for TRiM practitioners whose own wellbeing could be affected by their responsibility for dealing with responses to traumatic events. There were reports from some participants that this was being set up, with more people being trained as TRiM managers in order to support practitioners.

If TRiM or equivalent provision is rolled out across the RNLI as we recommend, it would be important to have the structures in place to ensure that continued development and support opportunities were available to all practitioners. The evidence suggested that initial training for TRiM practitioners delivered by March on Stress was highly valued and of excellent quality. We would recommend that this should continue to be provided, with the BTEC element being available as an option for those who wished to pursue it.

The RNLI’s internal TRiM team have been responsible for delivering continued professional development opportunities for TRiM practitioners. The evidence suggested that the opportunities provided had been of good quality, but that support provision would need to be extended and developed should TRiM be rolled out across the RNLI. Areas for development include:

- the provision of more opportunities for gaining hands on experience of delivering TRiM, possibly through pairing new or inexperienced practitioners with those who had more experience;
- the development of regional networks of TRiM practitioners who could organise professional development meetings in areas more local to practitioners;

- a clear process through which TRiM practitioners could access support if needed, and a system of TRiM managers ‘checking in’ with practitioners regularly to discuss their experiences and support needs; and

- development of an online network for RNLI TRiM practitioners, offering support and continuous professional development (possibly through video links and recordings) to those who found it difficult to access face-to-face meetings.

### 3.3 Delivering TRiM support

The RNLI have produced process maps showing how local managers can obtain TRiM support for their teams. The three main steps are:

- identifying a potential need for TRiM support;
- briefing those involved about what TRiM offers; and
- conducting TRiM assessments.

#### Identifying the need for TRiM support

Local managers were sent information about the TRiM programme at the start of the pilot, and were made aware that TRiM support was available for people exposed to potentially traumatic incidents. They were given guidance in determining whether incidents might be potentially traumatic for those involved, based on a list of trauma risk factors similar to those we have presented in chapter 2, above. Where local managers identified a need for TRiM support, they were asked to notify a TRiM manager as soon as possible.

Although some organisations refer all potentially traumatic incidents to TRiM, the RNLI pilot allowed local managers to exercise their discretion over when to do this. There was concern that imposing a requirement to use the TRiM programme could be counter-productive in circumstances where its potential benefits might not be fully understood.

Case study participants expressed concern that managers in some areas might avoid using TRiM:

> Some stations may say “We’ll deal with it in-house”. And it’s breaking through that crust of that station ethos … We know best what’s happened in the station. We know our patch. We know our crew. (M2)

Even in the areas where TRiM had been used, managers drew attention to the difficulty of deciding **when** to use it:
I’m hoping that I’m not saying the wrong thing here, but from my understanding I just sort of do it as I see it. You know, if the guys ask for it for something, then, yeah, I would do that. But I think there’s also this perception that it has to be something horrific before it gets brought up, whereas maybe that’s not the case. You know, it may not need to be something really, really bad for people. (M1)

Our discussions highlighted the importance of creating awareness of what TRiM could offer, across all geographical areas and all levels of RNLI staff and volunteers.

Conducting TRiM briefings

After an incident has been identified as one where TRiM support would be helpful, the next step is for local managers to provide those involved with information about TRiM, as part of their post-incident debriefings. Process maps state that TRiM practitioners should be involved in these debriefings if they are able to make themselves available, but the case studies showed that it could be difficult for them to make time within the timescale required. As a result, it was often the responsibility of local managers to provide information about TRiM to members of their teams.

Providing information about TRiM could potentially raise issues if local managers were unwilling to engage with the programme, or if they had limited understanding of what it involved. Some of the case study managers said that they had a limited awareness of how TRiM worked, and expressed the desire to learn more, in particular, about:

- the kinds of things that were spoken about in TRiM assessments;
- what TRiM practitioners were looking for; and
- how TRiM scores were calculated.

Some felt that personal contact with those delivering the programme was important to help them achieve a full understanding of what it could offer:

They could have done a bit more on a personal basis to explain it a bit more to us, rather than just send us a load of paperwork... you can’t deal with trauma by filling out a piece of paper. You’ve got to get face-to-face with someone, find out what it’s all about, and that’s how I feel, they should have done a bit more on that, you know. (M3)

Although they had distributed TRiM materials and presented the information during briefings, managers were unsure how effectively they had been able to communicate what the programme could offer. Local managers described some of the ways that they had disseminated information about TRiM, but they also expressed uncertainty about how far messages had been absorbed by lifeguards and lifeboat crew:

- leaflets and information booklets were put out for people to take, but it was unclear whether or not they had been read;
• PowerPoint presentations about TRiM had been delivered, but managers were not sure if the information had been taken in; and
• some managers felt that lifeboat crew were reluctant to get involved in non-practical forms of training, preferring to “get out on the boat”.

It was therefore not surprising that case study participants who received TRiM assessments typically reported having had little awareness of the programme beforehand:

*We heard the word TRiM and we were all laughing, saying “We’re getting trimmed” and we didn’t really understand it. Yeah, if I’m honest, none of us really had any idea what was happening (R4).*

Building awareness was important, because people were less likely to request support, or accept the support offered, if they did not understand what the programme involved. For those who did decide to go forward with a TRiM assessment, lack of knowledge around what to expect could lead to additional anxiety and stress.

One lifeguard explained this more fully:

*I’ve only encountered it because something bad happened. And I think they have taken it on relatively recently so perhaps that’s why, but guards down on the beach don’t know what it is... usually after an incident it feels like you’re being investigated, especially if there is a negative outcome. So to have people come in that you’ve probably never met before and start asking whatever questions, there’s going to be an element of suspicion there. (R6)*

This view was echoed by other case study participants, who also stressed the importance of raising awareness of the programme so that people would know what to expect. One participant felt that more TRiM training for managers and supervisors would help them to achieve “buy-in” from team members:

*I think having some sort of TRiM awareness and TRiM training would really help with [supervisors’] general welfare conversations...even if they were just running a debrief they’d be equipped to have some TRiM awareness and flavour in there, and perhaps do that triage bit of work... it’s a skillset that really needs to be shared amongst that group... often these are the people that are looked up to and if they’re saying this is good, this is normal, then I think that’s only going to help. (M4)*

Accessing TRiM support

Local managers were generally responsible for raising awareness of TRiM among their teams and, for the duration of the RNLI pilot, they also served as gatekeepers to TRiM support. This meant that their orientation towards the programme played a key role in determining whether or not staff or volunteers in different local areas were able to access it.
Participant interviews suggested that there were different ways that staff and volunteers could request a TRiM assessment. Those who had been given contact details for a TRiM practitioner (for example, at a debriefing session) could request a TRiM assessment from them directly. Those who had been briefed about the availability of TRiM but did not have TRiM practitioner details could ask their manager to put them forward for a TRiM assessment. In other cases, managers took the initiative in requesting a TRiM assessment for team members.

The RNLI process document highlights that, once an incident has been designated as suitable for TRiM, all of those exposed or involved should be offered TRiM support. Evaluation participants highlighted the importance of ensuring that all those exposed to a potentially traumatic incident were informed about TRiM support and were given access to it. The importance of this was highlighted by a case where someone who was peripherally involved in an incident had not initially been offered TRiM support:

> It would have been nice to maybe see the team all together first of all, because some people I don't think even got “TRiM'ed” and it got to months later and then they said about it…There was one guard… he was in our ops room … and he saw the vehicle go past with the body in the back and I remember him saying months after he couldn’t sleep afterwards, because it was his first season and he was only 17 years old… but no-one actually thought about him. (R4)

Where local managers serve as gatekeepers to TRiM provision, this shows the importance of providing them with training to help them identify all those who might be potentially exposed to trauma. It also highlights the importance of developing awareness of TRiM provision throughout the RNLI so that staff and volunteers can access the programme directly if they feel it would be helpful to talk through their responses to an incident with an external, trained practitioner.

RNLI process instructions also allow for situations where managers might initiate a request for TRiM support for a particular individual, for example, if a member of their team is showing signs of stress after a traumatic incident. Some case study participants welcomed the fact that local managers had requested support on their behalf as they felt that they were unlikely to have asked for it themselves:

> We had a meeting downstairs straight afterwards saying that if anyone needs any support then go and speak to the station and they’d give you support, but me being me I sort of keep it inside me a bit and just sort of bottle it up and just say “Yeah, I’m fine”. But actually I wasn’t really fine and they could see that down here… the coxswain phoned me up the next day and then I think all that week he phoned me…I told him I was getting better and he said “Well, we have got another route we can go down” and that was the TRiM and he talked to me about it. (R3)

However, some people felt uncomfortable at being singled out to receive TRiM support, even when they had found it beneficial. For example, one case study participant described how it would have been better to have let all those involved in the incident know that TRiM support was available:
If there was a talk with the whole station that would be good… kind of, if anyone was to need this, this is available … I think sometimes it’s nicer not to have everyone know that you’re interested in it. (R1)

There was some wariness about having to approach managers or senior staff in order to request TRiM support, based on concern that this could mark people out as in some way “not up to the job”. Our case study participants were not aware of a way for those experiencing post-traumatic stress to contact the TRiM team directly, but they felt that this facility was necessary, in addition to other means of accessing support. Managers and senior staff could feel particularly uncomfortable about asking for support and some felt that support was not available for them. This was an issue raised in both case studies and the web survey.

Conducting TRiM assessments

When an RNLI volunteer or staff member was put forward for a TRiM assessment, brief details of the case would be circulated to TRiM practitioners, who would apply to take it on if they felt able to do so. The allocated TRiM practitioner would contact the person or people they were assessing to introduce themselves and arrange the first assessment meeting. This introduction provided an important opportunity to “break the ice” and help to put people at ease about the TRiM process.

TRiM guidance suggests that assessments should take place approximately three days after the traumatic incident, in order to give time for some processing of initial feelings beforehand. Our case study participants generally agreed that it was best to have time to process feelings before the assessment, but also felt that too long a wait could be difficult, as feelings were left to fester. However, providing support within the ideal time frame could sometimes be difficult, particularly when TRiM practitioners had a long way to travel, or had many other commitments.

The five TRiM practitioners who participated in our case studies had all conducted one or more completed TRiM assessments. They also described how they used TRiM skills to provide more general support to colleagues (for example, when they did not wish to go through a full TRiM assessment). TRiM practitioners described the goals of the programme in a way which closely reflected recommended goals for peer supporters (Creamer, 2012):

• helping people to recognise when someone is struggling;
• offering support;
• helping people to stay well and stopping them from deteriorating;
• making people feel cared about; and
• signposting them to further help.

The structure of TRiM assessments

In order to ensure that they covered everything required for the TRiM assessment, TRiM practitioners made use of materials provided to them as part of their training, and some had also devised their own processes and crib sheets. Those who had received TRiM assessments described how the
practitioners started by covering such issues as confidentiality and disclosure, the voluntary nature of the interview, and how the TRiM scores would be used. They found it reassuring to know that such safeguards were in place.

In order to decide whether or not people needed further support, TRiM practitioners scored the symptoms that they were experiencing at the initial assessment (which usually took place within a week of the incident), and then re-scored them at a follow-up assessment, approximately one month later. They explained to those they were assessing that high scores for stress symptoms soon after the traumatic event were not unusual. If the score decreased between initial and follow-up interviews, this was taken as evidence that the person was going through a normal coping process. TRiM practitioners felt that the simplicity of the process was good for them and also good for those that they were helping. TRiM scores and brief accounts of incidents were sent to the TRiM manager, but any detailed information was shredded in the interests of confidentiality.

Creating a connection
Although TRiM practitioners were trained to use structured processes, they also needed to create encounters that were informal and friendly in nature, in order to encourage people to open up and discuss their feelings. TRiM practitioners tended to ease into assessments by chatting about mutual interests. As the next chapter indicates, the fact that they were “peer supporters”, with similar experiences and interests to those they were supporting, helped them to do this. They then aimed to obtain the information required within the context of an informal chat.

Creating the balance between structure and informality could be a challenge. Where it worked, people felt that they had been:

- in control of the situation:
  
  *It felt like it was run by me although it was structured… I thought that was really good* (R1)

- and they were less likely to feel that their abilities were being investigated:

  *To assess you kind of, but without actually assessing you* (R5).

However, too much informality could leave people feeling that the support lacked structure and rigour:

*They're just the people that volunteered for it. And … they've dealt with stuff, but I don't think they have a TRiM qualification, whether one exists. It's just people that were there and said, 'Yes, okay, I'll do that.'* (R6)

TRiM attempted to combine elements of informal support, such as that which people received from their close colleagues, and “professional” support, such as that which they might receive from a trained counsellor. The next section looks in more depth at the characteristics and benefits of the different types of support available to RNLI staff and volunteers who had experienced traumatic incidents, in order to describe how best to integrate the TRiM programme within this broader context.
4 TRiM and other sources of support

As we have outlined in previous sections, TRiM and similar programmes have been developed over the past decade as a way of filling perceived gaps in the support available for people exposed to potentially traumatic incidents at work. In this section, we explore how TRiM has been used alongside the other sources of support upon which RNLI staff and volunteers have traditionally relied and examine how the TRiM model of peer support combines characteristics of formality and informality, looking at what it adds to existing support provision, and how it can be integrated within this.

4.1 Incident debriefing

Traditionally, first-responding organisations such as the RNLI have dealt with difficult and potentially traumatic incidents through a process of critical incident management and debriefing. There has been some criticism of debriefing methods in the literature around trauma support, leading to a recommendation by the National Institute of Health and Care Excellence that: “brief, single-session interventions (often referred to as psychological debriefing) that focus on the traumatic incident are unlikely to be helpful and should not be routine practice when delivering services”. (NICE, 2005). The core of advice given in the NICE guidelines is “not to make a meal” of normal levels of post-incident distress, but to employ a process of watchful waiting for the month after the incident, keeping an eye on all those individuals who might have been exposed to an event (Dunn et al, 2015).

Discussions of debriefing in the research literature (Pasciak and Kelley, 2013; ASR, 2015) conclude that:

- informal sharing of emotions and memories with colleagues after trauma can help promote recovery, but intensive sharing via the process of a group psychological debriefing might not be helpful;
- there is a risk that a lack of continued support from the organisation after such sharing has taken place can lead to worsening of symptoms;
- although group psychological debriefing is not recommended, operational debriefing should take place;
- organisations should establish relationships with local professional providers of services for psychological stress and should develop rapid referral mechanisms for those who need these services.

A number of different types of debriefing were described as being used in the RNLI, all of which involved groups of staff or volunteers:

- “hot” debriefs generally took place when the team returned to base from an incident;
- full debriefs tended to take place within about three days of an incident and provided the opportunity to go over what had happened in more detail.
Some case study participants had also been involved in multi-agency debriefs, alongside other agencies who had responded to traumatic incidents, such as members of the emergency services and medical staff.

According to case study participants, debriefs tended to contain the following elements.

- They were seen as a way of making sure that everyone was all right before people went home from an incident. Formal debriefs often led into informal continuation sessions, usually in the pub, but sometimes also involving people staying to chat longer over cups of tea or coffee.

- They were a way of ensuring that everyone in the team knew the circumstances of a potentially traumatic incident, and a way of encouraging them to check in on each other afterwards.

- They usually involved putting together people’s various experiences to “tell the story” of what had happened. It was seen as important that everyone had the chance to go through what had happened and tell this from their own perspective.

- They provided an opportunity for people to ask questions and gain information about what had happened.

- They also provided opportunities for people to “vent” and share their feelings after a potentially traumatic event.

- Some participants described how they made sure to praise everyone in debriefing sessions, acknowledging the good work that they had done and reassuring people that they had all done their best.

One case study participant described how there was some discord between the debriefing methods traditionally used and those being developed as part of the TRiM programme. Debriefing processes in that case study area had been adapted to reflect TRiM guidance emphasising the importance of avoiding any implications of “blame and shame”.

4.2 Professional mental health support

When RNLI staff and volunteers felt there was a need for professional mental health support, after trauma or in other circumstances, the two main options offered by the RNLI were access to the “24/7” confidential telephone counselling service, and access to more specialist services via the occupational health department.

The 24/7 counselling helpline

The main characteristics of help provided by the 24/7 service were:

- accessibility – the service could be accessed directly by staff and volunteers, was available for discussion of any issue and, as the title suggests, was available at any time of the day or year;

- confidentiality – no one needed to know when people had accessed the service and no details would be passed on to the RNLI;

- professionalism – the service employed trained counsellors; and
impersonality – the caller did not know the counsellor in any way and did not meet them face-to-face.

As a result of its accessibility, the 24/7 service had traditionally been used as the first port of call for people experiencing post-traumatic stress. Case study participants certainly felt that there was a need for support to be available seven days a week, and that it was helpful to have 24 hour access to some kind of support when needed. Some of those we spoke to had used the 24/7 service after being involved in a traumatic incident and others said that it was a service they might use if they needed to talk to someone about coping with stress more generally.

Details of how to access 24/7 were published widely in RNLI, with people also being made aware of it in induction, training, and debriefing sessions. However, both case study participants and survey participants raised questions about the adequacy of the 24/7 service for providing support after people had experienced traumatic events at work.

Although it was seen as useful to be able to talk to an “external” person, there was also a sense that, as outsiders with no RNLI experience, 24/7 counsellors could not have a real understanding of the types of incidents that people had been through. The impersonality of the 24/7 service meant that it was difficult for counsellors to create a personal connection with callers. It was felt this, in turn, could make it more difficult for people to “open up” about their experiences and needs after traumatic events.

Occupational health

The TRiM programme is designed to provide initial low-level support to people experiencing distress after involvement in potentially traumatic events, and to signpost people to further help when this is required. Where it is clear that an individual’s needs demand more intensive or specialist help than TRiM practitioners are trained to provide, a direct “incident referral” is made to the occupational health department.

Case study participants stressed the importance of knowing that the right level of support would be there for people assessed as needing more specialist post-trauma support. They expressed concerns about the ability of the occupational health department to deliver the level of support that was needed, at the time when it was needed:

There were immediately some issues about referring that person to Occupational Health, and it was a real struggle. I think some of the personalities in Occupational Health have changed since then, but early on, we kind of had some concerns that we’re promising something that perhaps we’re not able to deliver through Occupational Health. (P4)

For example, participants described how the lack of out of hours cover from occupational health meant that people with the greatest support needs had been left without help when they needed it, with the only option being to refer them to the 24/7 counselling service. TRiM practitioners were also concerned
about the RNLI losing touch with people in this situation, as no-one internally knew whether they had been given appropriate support:

*We had one of our lifeguards that had two major incidents and after the second one, he was in pieces really. We didn’t even bother trying to put him through the TRiM process… it was basically an incident referral. This happened at a weekend, so there’s nobody in occupational health… He had the next day or so off which linked up with his two days off, so we didn’t see him for nearly four or five days… I don’t know if he’s getting help, if his wife potentially might need help. So, there’s just that little void afterwards that 24-7 isn’t filling I don’t think.* (P1)

TRiM practitioners also expressed concern about how the quality of care was monitored when people were referred on from TRiM to occupational health for further help:

*One guy… the [TRiM] process worked really well and, like I said, he didn’t want management to know, so I got him to phone occy health basically himself and I basically sat there and made him do it. So, he kind of self-referred which was fine, it worked fine. He then went I think and started counselling but then when I saw him a month later, he said that he’d basically had one session and then he couldn’t get hold of the counsellor again to organise anymore and so that side of things had fallen down.* (P2)

4.3 Informal support from family, friends and colleagues

Research has shown that people with more access to various forms of support tend to be better protected from the detrimental effects of stressful situations (Setti et al, 2016; Sattler et al, 2014; Greenberg et al, 2015). Table B:3 shows how the RNLI survey respondents felt about support from family members, friends and colleagues. Overall, respondents who had experienced potentially traumatic events were most likely to feel that family members had been very supportive (63%), with just under half (45%) reporting that colleagues had been very supportive and slightly fewer (38%) reporting that friends had been very supportive. A similar pattern was evident for men, older respondents, those with longer service and those involved in incidents less recently. For women, there was a different pattern, with just over half feeling that family members, friends and colleagues had been very supportive.

Support from family and friends

Case study participants described family support as having the following characteristics, which reflected those described more generally in the literature (Evans et al, 2013; Brunsden et al, 2013).

- Family members tended to be available to offer support, particularly emotional support, when this was not forthcoming from other sources.
• People felt most comfortable about showing emotion with family members. For example, one participant described how people did not have to hide anything from family members because “they know you inside out and backwards” (R5).

• Unless family members had been through similar traumatic incidents themselves, there was concern that they would not really understand the experience, either of the event itself, or the feelings afterwards.

• People did not want to upset family members by sharing details of incidents that they also might find traumatic. Some participants said that they preferred to receive support from people who were less likely to become emotionally involved.

Relationships with friends tend to be less intimate than those with family members and people did not want to jeopardise friendships by sharing too much about experiences that they had found difficult. This was partly about avoiding placing undue burdens on friendships and partly about protecting the “self-image” that people wanted to project to their friends. However, the greater degree of emotional distance in friend relationships could be helpful when people wanted to share experiences without going too deeply into the feelings involved:

> When I told my mum it was almost like she even started crying before I was. So, you know, got me in that state. And that’s what I said to the team this time… if you want positive vibes, you know, and quite a tough reaction and get through it, speak to your mates. But if you want to just break down and cry… I’d recommend doing it to both and see how you react. (R5)

Support from colleagues at work

After incident debriefing, informal forms of social support based on colleagues’ looking out for each other have traditionally been the main ways in which people have supported each other after experiencing difficult or traumatic events at the RNLI. In this section, we consider two types of colleague relationship:

• those between colleagues of a similar level; and

• those between team members and local managers (used here to include all in a position of responsibility within a team).

Support from colleagues at a similar level

Many of those we spoke to described how the opportunity to work closely with teams of like-minded and inspirational people was one of the best aspects of RNLI work. Evaluation participants generally gave accounts that emphasised the supportiveness of colleagues within local teams, although some contrasted this with a lack of support from the centre of the organisation. The following comment from a survey respondent provides an example of this:

> Considering we as a crew had no communication or support from any RNLI persons except within our own station i think that would be a good starting point for the RNLI as a whole.
As other studies of people in trauma-exposed roles have found (Sattler et al, 2014; Evans et al, 2013), colleagues supported each other in three main ways.

- Team chat and “banter”, where experiences were shared but anything “too deep” tended to be avoided. Strategies such as humour were used to keep conversations at a comfortable level.
- Indirect opportunities to talk, such as staying on for a cup of tea and chat after a shift, which were generally preferred to direct invitations to share experiences.
- Using knowledge of each other to detect behaviour that was out of character, and subtle signs of distress.

The benefits of such support included:

- sharing of experiences, through which people learned that certain symptoms were normal after traumatic events;
- sharing of information and comparison of alternative perspectives on their experiences; and
- reassurance that people had done a good job and consequent enhancement of their self-belief and self-esteem:

  That’s how it always seems to work… just a couple of pints of whatever and just a chat, basically. And certainly reassure young guards that “Yeah, what you did was fine. Whatever you do is better than nothing anyway and you’re certainly not to blame, that’s for sure”. And I think a lot of people blame themselves when things like that happen, and it maybe takes someone who’s done it before and knows that actually, no, it’s not your fault. (R6)

Case study participants described how shared experience of potentially traumatic events could intensify and strengthen friendship bonds and there were strong friendship bonds existing within many RNLI teams. The advantages of looking for support from colleagues who were also friends related to:

- close knowledge of each other, which made it more likely that something out of character would be noticed;
- confidence that friends who were also colleagues could relate to the experiences that they had encountered; and
- feeling comfortable about sharing experiences with close friends.

The main limitations of support from colleagues related to:

- people being wary of burdening their colleagues by asking them to provide support;
- wariness of being judged as less capable than others; and
- the fact that colleagues did not always know how to support people who were going through more severe stress reactions; in these cases it was felt that the support of trained practitioners was necessary.
Support from local managers

The research literature shows how poor support from leaders can make it more difficult for people to cope after experiencing traumatic incidents, whereas effective support contributes to recovery (Brooks et al, 2015; Lewis et al, 2014). Supportive managers have been described as down-to-earth and approachable, with “old-fashioned” managers being described as less approachable (Evans et al, 2013). Research has also found that supportive managers managed to foster supportive relationships more generally within their teams (Lewis et al, 2014).

Case study managers described the strong bonds that existed within teams, as in the following example:

*Any crew I think takes great pride in their lifeboat because it's theirs. It’s a part of the group. It’s how we run. We're all good friends, we go out for drinks together, we party together, because that's what makes the crew. That’s what keeps them together.* (M3)

Lifeguards and crew members also pointed to different ways in which managers had been supportive, for example: by taking an active interest in them, recognising their abilities, and encouraging them to train. However, even when they made every effort to support more junior colleagues, managers were aware that fears about being adversely judged might mean that colleagues would prefer to go elsewhere to ask for help.

4.4 Integrating TRiM support

In the sections below, we examined how TRiM was integrated with other sources of support at the RNLI, and we also look at differences in the way support might need to be provided for people with different types of roles within the organisation.

Table B:4 shows the proportion of survey respondents who had been offered support from the TRiM programme. The TRiM pilot was operating throughout 2017, and the table shows that 41% of respondents who had experienced potentially traumatic events in that year had been offered TRiM support. There was no difference in the proportion of respondents offered TRiM by gender or RNLI role, but the figures do suggest that older people and those with longer RNLI service were less likely to have been supported by the programme:

- 15% of respondents aged 50 or over had been offered TRiM after experiencing their most recent potentially traumatic event, compared with 36% of those aged 16 to 24
- 22% of those with 10 or more years of RNLI service had been offered TRiM, compared with 33% of those who had served for a year or less.

These findings support the accounts of participants who suggested that managers and senior staff might find it more difficult to access support than those at other levels, seeing TRiM as something that they offer to their team members, rather than something that is there to support them.
I believe there is still a culture within the organisation where managers ought to be able to deal with this type of thing. Recent incidents are brushed over. Because I am involved with TRiM I push it for my staff but my manager is not really interested. (Survey respondent)

TRiM and other sources of support

The TRiM programme is designed to provide a combination of support which is, on the one hand, **structured**, and delivered by people trained in detecting and addressing the symptoms of post-traumatic stress; but, on the other, **informal**, placing an emphasis on relatability and the establishment of genuine connections with those who have experienced traumatic events.

The following five themes emerged concerning the way that TRiM fitted with other forms of RNLI support.

1. TRiM is intended to complement operational debriefing, which is an established part of post-incident procedures at the RNLI. However, TRiM should replace previously used methods of group psychological debriefing after potentially traumatic incidents.

The case studies suggested a number of contrasting ways in which TRiM had been integrated with debriefing processes:

- information about the TRiM programme was provided as part of the standard incident debriefings;
- there were separate TRiM incident briefings, led by TRiM practitioners, with groups of people exposed to potentially traumatic incidents;
- standard operating procedures for debriefings had been adapted to incorporate elements of the TRiM guidelines.

The relationship between TRiM and debriefing was seen as an area that would need consideration in any full rollout of the programme. A number of issues were raised by participants.

- Although it was useful to remind people about the TRiM programme as part of debriefing sessions after critical incidents, people felt that this should not be the first time that people were told about the programme and what it offered.
- If local managers were responsible for telling team members about TRiM, in the context of debriefings, it was important that they had received the necessary training and experience to provide them with a real understanding of what it offered.
- For TRIM to work, it was important for people to be reassured that the content of discussions was completely confidential, and would be protected from use in any subsequent investigations of the incident. This could mean that TRiM discussions needed to be kept separate from other debriefings, but there was some concern about whether people would be willing to go through two sets of discussions about the same incident:

  *People have … only got a certain amount of capacity to talk about something and I wouldn’t want them to go to give their statement for the*
investigation and then I think that would put them off going and sitting for a TRiM process because… they’d probably say, “No, I’ve had enough. I’m going home”. (M4)

2. TRiM is not designed to replace the intensive professional mental health support that should be available via the occupational health department when people are experiencing severe or entrenched symptoms of post-traumatic stress.

TRiM practitioners are trained to provide low-level support for people experiencing post-traumatic stress and to refer them on for professional mental health support when this is needed but those experiencing severe post-traumatic stress symptoms should be directed immediately to the occupational health department as an “incident referral”, rather than being routed through the TRiM programme.

Among the 84 RNLI web survey respondents who experienced a potentially traumatic event in 2017, only one had accessed support from the RNLI’s occupational health department, four had used support from a non-RNLI professional counsellor and seven had been supported by the TRiM programme. Among the seven who reported more severe post-traumatic stress symptoms, none had used support from occupational health, one had used a non-RNLI counsellor and two had been supported by TRiM (Table B:5). Despite the small numbers involved, these findings suggest that it was relatively uncommon for RNLI staff and volunteers to access support from the occupational health department.

Both case study and the web survey respondents described cases where they felt that the support provided by the occupational health department had been inadequate in the past. Key issues raised by TRiM practitioners were the lack of an out of hours service to which people with severe trauma could be referred, and a perception that it was difficult to monitor of the quality of support that people were receiving. Most cases that research participants had dealt with had not needed to be referred to occupational health and there was a feeling that the link between TRiM and occupational health remained untested. This led to concerns that the success of TRiM could be compromised by the lack of effective follow-up support:

> Once you’ve said, ’Right, okay, I’ve done this risk assessment on you and I’ve scored, and I think, actually, yeah, you need some help - these are the options, and we’ll get you into Occupational Health, if nothing then happens, then actually the credibility of the process is questioned, and it’s outside of our control to influence that. (P4)

3. TRiM had potential advantages over the 24/7 helpline, in being delivered by people with more experience and understanding of RNLI work.

However, the scope of support provided by the RNLI’s TRiM pilot was understood to be more limited than that available from 24/7:
TRiM practitioners were volunteers and therefore were not available 24/7, so there was a possibility that people might still need to contact the counselling helpline if they needed immediate support. Our case study participants were generally happy with the timeliness of TRiM support, but they did express some concerns that this could be compromised if too many incidents occurred together and there were not enough TRiM practitioners available to cover them.

TRiM support is currently only available to support those who have experienced traumatic incidents. RNLI staff and volunteers needing mental health support for other reasons would normally be expected to use the 24/7 counselling service. Positive experiences of the TRiM programme, where a personal and face-to-face connection with the supporter made it easier for people to open up, led some case study participants to consider the potential benefits of extending peer support for use in other circumstances.

4. TRiM practitioners are “peer supporters”, in the sense that they generally have experience of RNLI operational work, but they are deliberately selected to be “external” to the teams of people that they are supporting.

This externality of a TRiM practitioner is important in ensuring that the support is both delivered confidentially and perceived as confidential. People could be wary of asking for support from team members and local managers in case this was seen to reflect on their competence. One participant described the benefits of receiving support from someone who was both “part of the same family” and also external, saying that it was:

Nice to speak to someone who has dealt with a lot of these things, but someone I don’t know as well and someone who is part of the same family.. they’re part of the team so, yeah, it’s definitely important. I think if an outsider came and done it … I don’t think they’d understand really.

(R3)

5. The availability of “peer support” was seen as one of the major benefits of TRiM.

Case study participants described a number of specific benefits that they had experienced when talking with peer supporters as part of the TRiM pilot:

- Having a peer supporter with similar interests or experiences made it easier to “break the ice”, so that people could relax and feel comfortable talking to them about sensitive issues.

- Peer supporters were described as people who “were on a level” with those they were supporting, “talking the same language”, and “who’ve actually been there and done the job”.

- Being offered help from a colleague was perceived as less “scary” than being contacted by a mental health professional. Case study participants hinted at the vulnerability they felt after experiencing traumatic events by
saying how being offered professional support could “push someone over the edge” by making them feel that there was something wrong with them.

TRiM support for people with different roles

The RNLI is a large and geographically widely dispersed organisation, employing people in a wide variety of roles. There are a number of aspects of its organisational culture that might be expected to influence responses to trauma, and the ways that support can be best provided. In this section, we examine the differing support needs of volunteer lifeboat crew, seasonally employed lifeguards, and people with different lengths of service and levels of seniority.

Supporting lifeboat volunteers

Within the RNLI, the majority of lifeboat crew and many local operational managers are volunteers. In line with other research among search and rescue workers and firefighters has found (Mind, 2017; Armstrong et al, 2014), our case studies showed that, while RNLI volunteers often formed close-knit communities, they were at risk of being overlooked by support programmes.

Typically, volunteer lifeboat crew would be paged when incidents took place but could choose whether or not to respond, and they could also choose whether or not to take part in other communal activities, such as training. Case study participants described how some volunteers had simply stopped engaging with the RNLI after finding it difficult to deal with the after-effects of traumatic incidents:

I see people bottling stuff up and that worries me, and I try to talk to people who do that, but in some cases you can’t… We had one crew member who was like that. That was a lot of years ago, and he actually stopped, he left the crew… he wouldn’t talk about it. Brought the shutter down on it, which is very, very sad. (M3)

Supporting lifeguards

RNLI lifeguards are generally employed full-time for the course of a “season”.11 Some case study participants described how they were attracted to the role for the opportunities it offered to spend time on the beach, to use surfing skills at work, and to work in other parts of the world during the UK off season. For young people who were still in full-time education, a seasonal lifeguarding role offered well-paid work outside of term time.

As a result of being employed in paid roles with regular shifts, most lifeguards were less likely than lifeboat volunteers to “fall through the cracks” of RNLI support systems. However, they could miss out on support because of the seasonal nature of their work:

Your manager and supervisors should know you reasonably well and be able to tell when something’s bothering you. But then if it’s not during the

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11 A full season generally lasts from March until the end of October, with some lifeguards working a reduced season covering just the summer months.
season, I don’t know what you do because you’re not employed by the RNLI so you’re just out there, kind of… as far as they’re concerned, once you’re off the books, like, it doesn’t really matter. (R6)

There were also other challenges in supporting the mental health of lifeguards including the fact that many were relatively young. In some areas, they could move into supervisory roles while still in their teens, potentially putting them in a position where they would not only be responding to traumatic events themselves, but also managing the responses of others. In addition, the unexpectedness of events was seen as increasing the risk of trauma for lifeguards, who did not have the pre-warning of a pager, but tended to be already present at the scene, responding to events as they happened. One described the challenge of switching from “doing nothing” straight into a critical incident:

We’d go three weeks on end, just sitting there staring at the sea, and you sort of get into a bit of a zombie mode, and then the next day something will happen and it’ll kick off, and you’ve got to be able to switch from doing nothing to remembering all your training, going and doing this thing and dealing with it. That’s a big challenge, a big part of the job as well, sort of being able to change gears. (R2)

Lifeguards, and those who were managing lifeguards, highlighted the importance of providing general mental health checks for people working in this role, an issue that has been highlighted for employers in a recent government review (Stevenson and Farmer, 2017). Although there was an understanding that TRiM was designed to support people in the aftermath of traumatic incidents, people were interested to explore ways in which the peer support model it provided might be extended to the provision of more general mental health support.

Supporting managers and senior staff
Recent research among ambulance officers found that length of service was associated with greater exposure to trauma and more post-traumatic distress (Shakespeare-Finch and Daley, 2017). Our survey results also indicated this, showing that people who had served the RNLI for 10 years or more were more likely than others to have experienced severe stress after the most recent traumatic incident that they had been involved in.

RNLI managers described how their role could be “lonely”:

- they had to enforce policies that people did not always like;
- they had the pressure of being accountable;
- they sometimes struggled under heavy burdens of work; and

12 In order not to identify particular case study participants, we are using the term ‘manager’ to encompass all those in senior roles, including local operations managers (LOMs), area lifesaving managers (ALMs), lifeguard managers and lifeguard supervisors.
• some described a need to keep a social distance from other members of their teams, in case their presence inhibited conversation and adversely affected team bonding:

  The crew will bond very quickly, and... they know the tipping point of various individuals. [As]… the manager, I’m slightly remote for them... I feel that there should be that sort of distance, so they can let off steam. (M2)

Several evaluation participants described the way that managers and senior staff could feel in need of more support than they were currently receiving:

Support was offered to crew yet as helm I was not offered or given any help, far from it. (Survey respondent)

Case study managers spoke in more detail about the kinds of help they felt they needed, which included:
• practical support, such as having someone else available to take on tasks, or make it possible to take time off;
• opportunities for sharing experiences, for example through regular meetings with other local managers; and
• TRiM support from practitioners who had experienced the pressures of senior roles.

The creation of the Area Lifesaving Manager (ALM) role was seen as a step forward in terms of offering more regular support to local managers.

Supporting new recruits
There was recognition that younger and newer recruits to the RNLI could be at particular risk of post-traumatic stress because they often had little previous experience of traumatic incidents and had not built up the coping strategies to deal with the feelings involved. Our survey results indicated that younger respondents were more likely to have been offered TRiM support (Table B:4).

Among those who took part in the case studies, all those who had been through the TRiM process after experiencing trauma were relatively young. The stress symptoms that they experienced after dealing with traumatic incidents could be unexpected and frightening, as one participant described:

  The biggest thing for me after the first shout was I’m not allowed to feel like this. It’s not fair for me to feel like this, but then hearing everybody else felt like that too, it was OK, well, maybe I am allowed. (R1)

The managers and more experienced staff that we spoke to were clearly aware of the potential vulnerability of new recruits and took care to ensure that they and other team members made regular informal checks on how they were coping.

In the light of research evidence showing how particular aspects of events can trigger trauma reactions for some people but not others, it is important to be clear that younger and less experienced RNLI staff and volunteers are not the only people likely to suffer the symptoms of post-traumatic stress. It is for this
reason that the written TRiM processes state that help from the programme should be offered to all those involved in traumatic incidents, in whatever capacity. Indeed, some senior RNLI staff and volunteers participating in the case studies felt that it was particularly difficult for them to ask for support; as a result of their experience they felt that they should be able to cope with difficulty, and there was concern that requests for help could be interpreted as indicating an inability to handle the work.
5 Outcomes of the RNLI TRiM pilot

Previous reviews of the effectiveness of peer support programmes have emphasised the need to link assessments to clearly stated goals (Creamer et al, 2012). As part of the planning for the TRiM pilot, RNLI staff set out some of the key outcomes that they wanted it to deliver:

- having a support mechanism/structure available for those who need it;
- providing support/referrals to effective support;
- increasing people’s/the organisation’s ability to cope with aftermath of potentially traumatic events;
- being prepared in advance for what might happen; and
- achieving reduction in symptoms of post-traumatic stress.

In this section, we consider the extent to which this research provides evidence of what the TRiM pilot achieved in relation to these outcomes. We look at the role of TRiM in:

- providing a support structure for those who need it (and thus being prepared in advance for what might happen);
- delivering effective support;
- increasing people’s ability to cope with trauma; and
- reducing the symptoms of post-traumatic stress.

5.1 Providing a support structure

The RNLI as an organisation has a legal and moral duty of care to its staff and volunteers. There is recognition that potentially traumatic events can have serious negative consequences for the RNLI staff and volunteers exposed to them, and that problems are likely to be compounded where post-trauma support is lacking. Evidence of gaps in support was cited as a key driver for the decision to implement the TRiM pilot.

Our research provided further evidence of the existence of gaps in support before the pilot was introduced. As described in chapter 3, the experience of watching colleagues struggle to cope after traumatic events was one of the factors which motivated people to volunteer their services as TRiM practitioners.

The online survey provided information on the experiences of people who had been through potentially traumatic events in the course of their work for RNLI, and their levels of satisfaction with the support that the organisation had provided.

Results showed a stark difference in such satisfaction levels between those who had experienced potentially traumatic incidents before and after the start of the TRiM pilot in August 2016 (Table B:6):
• only 27% of those who had experienced potentially traumatic events before 2016 felt that they had received enough support from the RNLI; but
• 65% of those who had experienced such events in 2017 felt that they had received enough support.
• Among those who said that they had been offered TRiM, 83% felt that the RNLI had provided enough support.
• Older respondents and those with longer RNLI service were less likely than younger ones and those with shorter lengths of service to feel that the RNLI had provided them with enough support after the most recent potentially traumatic event that they had experienced.

Further information from survey respondents provided more information about reasons for dissatisfaction. Several expressed the feeling that no support had been forthcoming for them, with statements such as: “At least make an inquiry as to my health and wellbeing” and “The RNLI should be more pro-active instead of sitting back waiting for someone to break down or ask for help”.

Some participants praised the support that they received from local colleagues but felt that support from RNLI centrally had been inadequate. They suggested that area managers or staff from HQ should make more efforts to contact crew and lifeguards to check what support was needed after a potentially traumatic incident, especially if there was media attention.

Case study participants expressed interest in the survey results, as they were keen to know more about the response to TRiM in other areas. Survey responses showed that managers in at least one local area had rejected external support from the TRiM programme:

When asked shall we use TRiM we were told “No, don’t bother with that, we will be OK.

Other responses indicated the continuing need for cultural change to overcome the stigma of asking for mental health support. This was still seen a sign of weakness by some managers:

[I need] support from [my] manager when I tell him that I am seriously struggling, not have it thrown back at me and told it will reflect badly on me.

Approximately one in five survey respondents who had been offered support from the TRiM pilot had taken up this offer. Those had not taken up TRiM support said that they did not feel that they needed it, or that they had enough support from other sources, such as family members and local RNLI colleagues. They were, nonetheless, reassured to know that TRiM was there if they did need more support.

At the moment, I haven’t taken up the offer as the incident hasn’t affected me because I have openly spoken about it with my colleague. If feelings change, I’ll be in touch with TRiM.
Managers from case study areas where TRiM had been used also emphasised the importance of knowing that TRiM support was there. They described how the TRiM pilot had reduced the burden on senior staff, by providing trained supporters:

Because often before that it would come down to me and I’ve run lots of debriefs and I’ve personally spoken to people after incidents before and… I’ve not felt confident that it’s been potentially right or I’ve not had the kind of background to do that… So it’s been really good to say, right, this is what we would offer now and it’s our first step to whatever else might come. (M4)

Other case study participants also highlighted the importance of knowing that TRiM support was there, and that people were cared for, echoing the findings of previous research that the perceived availability of support could be as effective as actual receipt of support in helping people to cope after trauma. One participant described how TRiM gave confidence that all necessary support would be provided:

It felt good, because he felt that if he couldn’t help me then someone could. So it’s nice to see that it’s not just, right, you’re going to have TRiM and if it doesn’t work for you then that’s it… they’re not going to give up until you’re right, you know until you’re happy again… which was really nice. (R3)

Another participant indicated how showing that staff and volunteers were supported was important for the external image of the RNLI, suggesting that TRiM could have long term benefits for recruitment:

If you’re finding out that lifeguards are getting post-traumatic stress and it’s not being dealt with or they’re not being handled properly, it doesn’t make it as appealing as the all-time summer job that everyone really wants. So, it’s nice to see that they are taking it seriously. (R5)

5.2 Delivering effective support

As seen in the previous chapter, TRiM was not the only source of support for people who had dealt with potentially traumatic events. Previous studies have shown that informal support from colleagues and managers helps to bolster coping after such events (Scully, 2011; Prati and Pietrantoni, 2010; Setti et al, 2016) and that support from family members can also be helpful.

Results from the RNLI web survey (Table B:7) showed general support for a TRiM-type model for providing initial support after traumatic incidents, although there was also support for other models:

- 58% felt that local, trained peer supporters as provided within the TRiM model were the best people to provide this initial support;
- 15% felt that professional mental health practitioners were the best people to provide initial support; and
17% felt that initial support would be best delivered by a central team of trained RNLI staff.

The survey included a number of questions about the ways that support should be provided, in order to best meet the needs of RNLI staff and volunteers who might be exposed to trauma at any time. Table B:8 shows that:

- 85% said it was very important for support to be provided quickly when needed;
- 74% said it was very important that support was available outside of office hours; and
- 51% felt it was very important that support was provided by someone in the local area.

Case study participants also stressed the importance of providing timely support, but those who had received TRiM appreciated the way that assessments were designed to be scheduled a few days after the experience of a potentially traumatic event:

*For the first three days you do doubt yourself and you do question. So, you speak to your colleagues and you speak to other professional services such as paramedics and it gives you time to reflect as well… No-one really picks into it and asks you the questions that TRiM asks you. So, by the time you get to speak to someone from TRiM, you’ve answered personally those questions that you want to… And then it’s nice to have someone … then ask you what was going on that day… And it makes you think about it more, but you’re not emotional about it because it’s a few days later, and you’ve got past that.* (R5)

Some case study participants stated a preference for TRiM support to be provided locally where possible, in the interests of reducing practitioner travel time, increasing efficiency, and providing a personal connection with the team providing support. However, they stressed the importance of practitioners being based in neighbouring areas, rather than in the same areas as the people they were supporting, in order to preserve the benefits of being able to talk to someone “external”, which was seen as offering a better guarantee of confidentiality and which lowered the risk that people would be reluctant to seek support from someone they knew.

TRiM provides a way of training RNLI staff and volunteers to provide support to their colleagues in a structured way based on research evidence on how best to help people process the effects of post-traumatic stress (Greenberg et al, 2015). Our case studies showed that TRiM training enabled practitioners to build a base of knowledge and skills, which were then further enhanced through hands on experience in conducting TRiM briefings and assessments. Practitioners used their accumulated resources to support specific individuals and groups of people who had been exposed to traumatic events, but they were also in a position to share their knowledge, experience and skills more widely throughout the RNLI. They did this through attending TRiM debriefings and, more informally, by chatting to those they met at the various stations and units that they visited:
I consider myself as an ambassador for TRiM when I go out, so for me it’s about discussing and having the conversation, because if we don’t start the conversation then who will? (P3)

Our case studies suggested that, in order to be as effective as possible, the TRiM programme needed to be integrated with other, more traditional, ways of supporting people in the RNLI, reinforcing and enhancing these rather than replacing them. The TRiM pilot brought together a team of people with a deep understanding of RNLI work, who those in local areas could turn to when they needed additional resources to support staff and volunteers who were dealing with the effects of trauma.

5.3 Increasing people’s ability to cope with trauma

In order to understand how TRiM might have increased people’s ability to cope after trauma, it is helpful to draw on the findings of previous qualitative research looking at the ways in which post-trauma support can effect change (Scully, 2011; Prati and Pietrantoni, 2010; Setti et al, 2016). The following themes, drawn from this literature, were also supported by evidence from the RNLI case studies:

- supporters can help by sharing the burden of coping with post-traumatic stress;
- supporters can help people make sense of what they are feeling after traumatic events; and
- supporters can help reduce feelings of isolation in the aftermath of traumatic events.

Sharing the burden

Research has shown that receiving support from colleagues and, to a lesser extent, family members, can bolster people’s resilience after trauma (Setti et al, 2016). One way in which it has been found to do this is through broadening the pool of resources that people can draw on after experiencing traumatic events, for both emotional and practical support (Prati and Pietrantoni, 2010). As we have seen in the previous section, RNLI staff and volunteers sometimes felt that providing emotional support through listening and talking could be burdensome for family members, friends and colleagues. As a result, they could feel reluctant to approach them to ask for support, and reluctant to share too much when support was offered:

> It was really nice to know that they’re here for me, but at the same time I didn’t want to burden them ‘cause a lot of them have got families themselves and so I don’t want to take up their time as such and sort of waste their time almost. (R3)
The resources provided by TRiM, normally involving a visit from a TRiM practitioner to conduct an assessment, were valuable in allowing people to feel that they could share their experiences with someone who was equipped to deal with them, and who they knew had volunteered to take on the role.

Making sense of feelings

Research with other trauma-exposed groups has shown how support from others can help people adjust their perspective on events in a way that is “adaptive” in helping them cope. Support from colleagues or supervisors can be particularly helpful in countering feelings of self-blame or guilt after an event, for example, through providing reassurance that the person did everything possible to help. Supporters can also help if they have the knowledge and understanding needed to provide advice about how to deal with post-trauma feelings and symptoms (Prati and Pietrantoni, 2010).

TRiM played a number of roles in helping people to make sense of their feelings after trauma.

- TRiM briefings provided people with information about the things that they might expect to feel, and how to deal with them. This information was gradually becoming more widely dispersed throughout the organisation, enabling people to better support each other at local level.

- Although local colleagues and managers did their best to provide reassurance, they did not always feel that they had the skills and resources needed to help people adjust their perspective on events. TRiM training had equipped practitioners to take a structured approach to talking through their responses to traumatic experiences, based on the principles of cognitive behaviour therapy. Case study respondents described how this was helpful:

The training that [the TRiM practitioner] had and the systematic approach to it kind of made it easier to work out why I was feeling or how I was feeling things… the training [the TRiM practitioner] had meant [they] knew slightly more beneficial things to say rather than “Oh, it's all right mate, I had that too”. (R1)

- TRiM practitioners were also trained to understand when people needed more intensive help with the processing of events, ensuring that they were referred for more specialist counselling or therapy:

TRiM teaches us to look for certain markers of when someone is struggling. If we can catch it early enough and we can, if needed, put something in place, be it counselling or whatever, then we can stop them deteriorating and we can get them back into the position where they can go in the sea or go on the boat or whatever it is. That's kind of the idea of it I suppose. (P2)

- Local colleagues were in the best position to discuss the details of what had happened in the course of potentially traumatic events but, as we have seen, people could be reluctant to approach managers and colleagues for help when they felt that this might reveal weakness or expose them to judgement. The availability of confidential help from the TRiM team was
seen as essential in order to ensure that needs were not left unmet because of stigma.

Reducing the sense of isolation

Many studies have pointed to the importance of camaraderie and positive social experiences in helping people to overcome fear, learn that others have felt the way they do, and understand that their feelings are normal responses to trauma which can be expected to get better with time (for example, Prati and Pietrantoni, 2010; Scully, 2010; Evans et al, 2013). Recent research has shown that organisations such as the RNLI, with a high proportion of volunteers, tend to be particularly good at developing camaraderie among teams of workers (Mind, 2017).

However, case study participants described the sense of isolation that could come from thinking that they were the only one who was reacting to events in a certain way. TRiM practitioners were viewed as bringing previous experience of dealing with traumatic events and understanding of the way that people responded to them. Their ability to establish connections with people experiencing post-traumatic stress was seen as valuable and necessary in circumstances where people were felt to be isolating themselves because they did not feel able to open up to colleagues:

5.4 Reducing the symptoms of post-traumatic stress

Evaluations of trauma support programmes have developed various ways of measuring reduction in the symptoms of post-traumatic stress. However, since such symptoms would be expected to reduce anyway, as part of the normal healing process, quantitative evaluations tend to involve comparisons with groups that have not had access to a particular form of trauma support. There are complications involved in the process of evaluating one form of support compared to another (see, for example, Tuckey and Scott, 2014) which have tended to limit the effectiveness of such studies. To date, there have been few randomised control trials of the TRiM programme. The most well-known UK trial was conducted on Royal Navy warships. The study concluded that TRiM “did no harm” and had a positive occupational effect in terms of reduction of disciplinary offences (Whybrow et al, 2015). However, it is difficult to transfer such findings to organisations such as the RNLI, where the “disciplining” of staff and volunteers is likely to play a peripheral role.

Our research does not attempt any quantitative measurement of change in the symptoms of post-traumatic stress as a result of involvement with the TRiM programme.
6 Conclusions and recommendations

The final chapter of this report brings together key findings from the previous sections in order to draw conclusions about the achievements and potential of the TRiM programme for the RNLI. We also provide a number of recommendations for how to roll out trauma support and broader mental health support services within the RNLI.

6.1 Conclusions

TRiM achievements and potential

The RNLI TRiM pilot had started to change perceptions about the availability of support within the organisation:

- Since the pilot started, more of those reporting symptoms of post-traumatic stress said that the RNLI had offered them enough support.

- Survey respondents and case study participants expressed the feeling that support services were more likely to be there, since TRiM had been introduced. Research has shown that knowing that support is available is a factor which promotes better coping in the aftermath of trauma.

- Case study participants, who gave their time to be interviewed in depth about their experience of the programme, strongly expressed the view that the efforts that had gone into developing the TRiM programme should not be wasted, that the programme had delivered real benefits for those who took part and that TRiM, or an equivalent service, was definitely needed within the RNLI.

TRiM implementation

There was recognition of the huge effort that had been made to develop and deliver the TRiM pilot for the RNLI. There was particular praise for:

- the dedication of TRiM managers, who were described as being “always on the end of the phone” and there to provide support whenever it was needed;

- the quality of support provided by TRiM practitioners, in particular, the way that they managed to make connections with those who had been through traumatic incidents, and created a relaxed atmosphere for discussions, in a way that made it easier for people to open up and share their feelings;

- the thoroughness of the training that had been provided to TRiM practitioners, and the usefulness of the materials packs given as part of this training. Having the knowledge and skills to deliver trauma support in a structured way was seen as being just as important as having the ability to open up connections with people. Those who were supported needed to have confidence that the people assessing their support needs were qualified to do so.
There were also areas where TRiM implementation could be improved, and it will be important to bear these in mind as trauma support services are rolled out more widely within the RNLI.

- It was important to ensure that all those potentially exposed to a traumatic incident were briefed about the availability of TRiM support and made to feel that they could access it if needed, even if they appeared to be less directly involved. On occasions when managers had been more selective about who was offered TRiM support within their teams, there were suggestions that people who potentially could havebenefitted had been missed out.

- People were not always aware of the existence of TRiM or of what the programme could offer them until after they had experienced a traumatic event. They felt that knowing about TRiM beforehand would have made it easier to cope after the event, reducing the anxiety about what was going to happen next. There was evidence that local managers needed to be more fully informed about TRiM and its potential benefits, in order to pass this information on to people in their teams.

- Despite evidence of cultural change within the RNLI, people could still feel uncomfortable about approaching line managers to ask for help coping with stress. They were concerned about being seen as lacking the ability or resilience needed to carry out their role. With this in mind, participants at managerial and other levels felt that there should be well-publicised routes for accessing TRiM without going through line management.

- Although case study participants were generally happy with the timely support that TRiM practitioners had provided, there were instances where people felt that the availability of the TRiM practitioner had had to take priority over the needs and working patterns of staff and volunteers in a local area. There was concern about whether TRiM practitioner resources would be sufficient to cope with spikes in demand once the programme was rolled out across the organisation.

- TRiM practitioners were highly satisfied with the training opportunities that had been provided to them, and were committed to taking part in ongoing professional development activities. However, they had experienced difficulty in organising these at times when everyone could be available.

Integration of TRiM and other RNLI support

There was clear evidence that TRiM-type support was needed within the RNLI, and that it was filling gaps in the services provided by other support sources, principally, those delivered through debriefing and follow-on informal support from colleagues and managers, by the confidential counselling line, ‘24/7’, and, more formally, via the occupational health department.

However, our research highlighted the essential role of all of these sources, and the ways in which the most effective support is likely to be delivered through integration of different methods.

- Incident debriefings are the established way of “making sense” of events at the RNLI, draw together different perspectives on what happened, answering questions, and delivering advice about how to cope after trauma. Within the
TRiM programme, practitioners also had a role in briefing people exposed to trauma about what to expect afterwards and how to deal with symptoms of stress. There was evidence of some differences in approach between TRiM and standard RNLI debriefings, although it appeared to be common for these to be combined, with information about TRiM delivered by local managers as part of incident debriefing.

- Participant accounts described the strong culture of people supporting each other within the RNLI and the many informal ways of fostering close bonds between team members. Closeness between members helped them spot subtle signs of distress in colleagues after traumatic events. As well as offering support themselves, colleagues and managers played important roles in providing information and encouraging people to take up help. A number of people mentioned the importance of having TRiM “spoon fed” to them by managers who had recognised the need and organised it on their behalf. On the other hand, people did not always want colleagues and managers to know about their need for support. Participants stressed the importance of having support available from someone who understood their work but was external to their team, a role that was fulfilled effectively by TRiM practitioners.

- TRiM practitioners are trained to provide initial support after trauma, to assess people’s need for further professional mental health support and to signpost them to sources of professional support where this is needed. This means that the success of TRiM is dependent on the availability of appropriate follow up support to which people can be referred. Participants expressed a lack of confidence in the availability of such support in some areas.

- The scope of the TRiM pilot was limited to the provision of support after people had experienced potentially traumatic events or for those who were showing signs of post-traumatic stress. For other mental health support needs, people were directed to the confidential counselling phone line, ‘24/7’. There were reports that some people had found this service unhelpful, and suggestions that they would prefer to receive peer support from someone within the RNLI who had a better understanding of their experiences.

Measuring outcomes

It is difficult to provide quantitative measurements of the outcomes of TRiM, in terms of reducing the symptoms of post-traumatic stress, because reactions to incidents are highly individualised and recovery is influenced by a wide range of circumstantial factors as well as TRiM support. The RNLI made TRiM available to all stations and units who expressed a need for it, but even if the programme was only being offered in certain areas, the uniqueness of the potentially traumatic events that different people were exposed to, and the multitude of factors that combine to make them more or less traumatic for particular individuals, would mean that very large numbers of cases would be needed for significant differences between TRiM and non-TRiM areas to become evident. This would not have been possible within the one year RNLI pilot.

Post-traumatic stress symptoms generally diminish over time as a natural part of coping, so assessment of any TRiM effect in reducing these would need to compare differences in recovery rates between people who have and have not received support from the programme. Programme managers were reluctant to
withhold support when they felt it could offer benefits to staff and volunteers exposed to trauma.

This research added to the body of evidence that indicates the importance of making people aware that support is available for them after traumatic events. There is evidence that people cope better with trauma when they feel that they are cared about, and when they know that there are ways that they can ask for support without incurring negative judgement from colleagues or managers. Measures of people’s satisfaction with the support available provided an indication that TRiM was helping the RNLI to achieve its objective of having a support structure in place for people to turn to.

6.2 Recommendations

We found that RNLI staff and volunteers who had experienced trauma were, on the whole, highly satisfied with the support that TRiM had delivered, and that the provision of peer support was particularly welcomed. We recommend that the TRiM programme, or an equivalent, should therefore be rolled out throughout the RNLI. More specific recommendations are provided below.

Coverage of TRiM

When trauma support is provided in response to an incident, it is important that all those exposed are covered. As the TRiM pilot is rolled out to provide full coverage of all the areas in which the RNLI operates, we recommend that the RNLI:

- ensures that local units and stations adhere to the protocol that all of those exposed to trauma should be offered TRiM support, rather than this being offered selectively to those who managers feel are most likely to benefit;
- pays particular attention to groups who have previously been at higher risk of being left unsupported, such as senior staff and volunteers, and those involved in more peripheral or non-operational roles;
- ensures that support services for those with symptoms of post-traumatic stress are available to all of those who have experienced trauma while working for the RNLI, whether or not they are current employees or volunteers. It is important to provide support for people who might have dropped out of engagement with the RNLI after finding it difficult to cope with trauma, as well as to provide support for seasonally employed staff that is accessible all year round.

Awareness

For TRiM to operate effectively, it is important that people are aware of what it can provide, and how the processes work. Developing awareness was part of the remit for the TRiM pilot and case study participants described how this had grown during the course of the year. In order to further increase awareness, we recommend that the RNLI:

- encourages the sharing of real-life accounts of the ways in which people have benefitted from TRiM;
• makes sure that people know about the TRiM programme before they need to use it, as it is easier to take in the necessary information when they are not under stress;
• provides TRiM awareness training for managers and supervisors so that they are in a position to be champions of the programme for their local teams; and
• routinely reminds people about symptoms of post-traumatic stress and the way that TRiM can help them deal with these: as part of incident debriefings and training courses.

Access
Case study participants were keen to discuss ways of ensuring that people could access support for post-traumatic stress and other mental health issues when they needed to, without being put off by fears of how they might be judged. Drawing on their suggestions, we recommend that:

• all RNLI staff and volunteers should be provided with contact details for a member of the TRiM team as a matter of course, and not just in response to a potentially traumatic incident;
• people should be to request support from the TRiM team online as well as by phone;
• the confidentiality of TRiM discussions should continue to be protected and all staff should be aware of this, so that fears about the consequences of speaking out do not deter them from seeking support.

Resources
The TRiM pilot was run by a dedicated team of managers and practitioners who gave freely of their own time to make it a success. However, there were concerns about whether a service that relied on volunteers would be able to deliver the quality of support that people needed in the long run, when the programme was more widely rolled out. We recommend that:

• the RNLI should consider carefully whether sufficient coverage can be provided by TRiM practitioners who undertake the role on a voluntary basis, and whether it would be useful to supplement the voluntary workforce with paid TRiM managers in each region or with regular paid shifts for TRiM practitioners;
• there should be on-call rotas to ensure that TRiM support is always available when needed and consideration should also be given to how support from occupational health can be provided promptly when people’s needs are too great for TRiM;
• regional TRiM teams might provide support more efficiently than national ones, but practitioners should still be drawn from outside the immediate area in which an incident has taken place, in order to provide reassurances about confidentiality;
• regional organisation of continued professional development opportunities for TRiM practitioners could help to make these more accessible; and
• the RNLI should provide TRiM awareness training for a broader cross-section of staff and volunteers, especially those with responsibility for management of teams.

The scope of TRiM

Case study participants suggested that it could be useful to extend the provision of internal RNLI peer support to cover mental health issues more generally, pointing out how this could help to create a healthy, motivated and effective workforce. We recommend that:

• the RNLI considers the potential for using peer support more widely to support the mental health of staff and volunteers.

• the RNLI explores some of the bespoke integrated trauma and mental health support programmes that have been developed in other emergency service organisations (Scully, 2011; OHW, 2017) to gain further ideas about how to develop TRiM provision.
References


Appendix A. Methodology

Literature review

The databases searched and parameters used are shown in Table 6:1.

<table>
<thead>
<tr>
<th>Database</th>
<th>Time period</th>
<th>Other parameters</th>
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</thead>
<tbody>
<tr>
<td>EBSCOhost</td>
<td>Jan 2006 to June 2017</td>
<td>Academic search complete, including: periodicals with full text, and peer reviewed articles in English, with pdf full text</td>
</tr>
<tr>
<td>PsycARTICLES</td>
<td>2006 to 2017</td>
<td>Journal articles</td>
</tr>
<tr>
<td>PsycINFO</td>
<td>2006 to 2017</td>
<td>Journal articles in English, from peer reviewed journals, excluding dissertations</td>
</tr>
<tr>
<td>SocINDEX</td>
<td>2006 to 2017</td>
<td>Articles in English, with pdf full text</td>
</tr>
</tbody>
</table>

The search strings used were “trauma risk management” and “trauma* AND ‘emergency services’ OR ‘high risk organi*ation’ AND ‘peer support’”. The combined sources and search strings produced 47 articles that were considered title relevant, and 33 of these were considered relevant after skim-reading. The final number of articles selected for full review was 34, which included some that were recommended by the RNLI.

Case studies

Cases were selected at a meeting between the TRiM manager, RNLI project manager and NatCen project manager. The TRiM manager provided a list of areas which fit the selection criteria described in Section 1. This was divided between areas where the TRiM manager felt there had been a positive reception for the programme from the outset, and areas where more persuasion had been needed to encourage them to use it. The lists were stratified further by whether they covered lifeboat stations or lifeguard units. Cases were then listed randomly and the TRiM manager contacted TRiM practitioners in the order listed, in order to request their participation. Once an area was selected for inclusion as a case study, others in the same region were excluded.

The 4 selected case studies covered:
- 2 lifeboat stations and 2 lifeguard units, and
- 4 different RNLI regions.
In total, 15 depth interviews were carried out within these case study areas. Lengths of interview ranged from 35 minutes to 105 minutes. Interviewees included:

- 4 women and 11 men
- 4 local managers, 5 TRiM practitioners, 2 members of lifeboat crew who had been through TRiM assessments, and 4 lifeguards who had been through TRiM assessments.

Interviews were conducted using a topic guide to ensure that all relevant areas of interest were covered, in the context of an informal encounter which was responsive to the issues that participants felt were important. Depth interviews were recorded and fully transcribed with the permission of the participants.

Interview data was managed and analysed using the Framework approach developed by NatCen (Spencer et al, 2014) which is embedded in Nvivo 10 software for qualitative analysis. Key topics which emerged from the narratives were identified through familiarisation with the transcripts. An analytical framework was then drawn up and a series of matrices set-up, each relating to a different thematic issue. The columns in each matrix represented the key topics and the rows represented individual participants. Data from each interview was summarised in the appropriate cell, so that the data were ordered systematically and grounded in participants’ accounts. The final analytic stage involved working through the data, drawing out the range of experiences and views, identifying similarities and differences and seeking to explain emergent patterns and findings.

Web survey

A link to the online survey (Appendix B) was sent out to RNLI staff and volunteers using a number of platforms, in order to achieve the broadest possible coverage. Follow-up reminders were also sent (see summary of RNLI internal communications activity, Appendix C).

There were 269 respondents to the survey, representing a broad diversity of characteristics, levels of experience, and roles, as described below. Since we do not have access to equivalent information about the sample who received communications about the survey, it is not possible to calculate the extent to which our sample was statistically representative of all RNLI staff and volunteers.

Appendix table A:2, below, presents more information on the characteristics of survey respondents.

Due to small numbers of respondents in many categories, results of cross-tabulations were generally not statistically significant, even where differences between groups were substantial. For this reason, we have not provided indications of statistical significance, and results should be viewed as indicative of likely patterns rather than as providing conclusive evidence of systematic differences between groups.
<table>
<thead>
<tr>
<th>Table A:2</th>
<th>Survey respondents by gender, age, length of RNLI service, RNLI role, and RNLI region</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Base: all respondents)</td>
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<tr>
<td><strong>Gender</strong></td>
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</tr>
<tr>
<td>Lifeboat crew (some also had other roles)</td>
<td>48</td>
</tr>
<tr>
<td>Lifeguard</td>
<td>31</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
</tr>
<tr>
<td>Operational management mentioned</td>
<td>4</td>
</tr>
<tr>
<td>Base</td>
<td>269</td>
</tr>
<tr>
<td><strong>RNLI region</strong></td>
<td>%</td>
</tr>
<tr>
<td>Channel Islands and Islands</td>
<td>1</td>
</tr>
<tr>
<td>East Coast</td>
<td>16</td>
</tr>
<tr>
<td>Ireland</td>
<td>11</td>
</tr>
<tr>
<td>North West England</td>
<td>5</td>
</tr>
<tr>
<td>Poole HQ</td>
<td>12</td>
</tr>
<tr>
<td>Scotland</td>
<td>11</td>
</tr>
<tr>
<td>South East England</td>
<td>9</td>
</tr>
<tr>
<td>South West England</td>
<td>22</td>
</tr>
<tr>
<td>Thames</td>
<td>2</td>
</tr>
<tr>
<td>Wales</td>
<td>10</td>
</tr>
<tr>
<td>Base</td>
<td>263</td>
</tr>
</tbody>
</table>

*percentages add up to more than 100% because some respondents worked as both lifeboat crew and lifeguard, or as both crew and in a managerial role.
Screening for PTSD
Post-traumatic stress symptoms were measured by questions derived from the shortened version of the PCL-C (PTSD Checklist – Civilian version). Respondents were asked to describe how much they had experienced each symptom in the month following the most recent potentially traumatic event, with scores going from 1: not at all, to 5: Extremely. Respondents who scored 4 or more on the two items: Q9a (flashbacks) and Q9b (upset) were considered to have screened positive for PTSD (2-item version), as were those who scored 14 or more on all five items (this is a conservative estimate as we omitted a sixth item asking about difficulty concentrating). Anyone who screened positive for PTSD via one of these methods was considered as having screened positive for the purposes of our analysis.
### Appendix B. Tables

#### Table B:1 Whether experienced a post-traumatic event in the course of RNLI work by gender, age, length of RNLI service, RNLI role, and RNLI region (Base: all respondents)

<table>
<thead>
<tr>
<th></th>
<th>Experienced PTE</th>
<th>Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>All respondents</td>
<td>74%</td>
<td>268</td>
</tr>
<tr>
<td>Female</td>
<td>53%</td>
<td>64</td>
</tr>
<tr>
<td>Male</td>
<td>81%</td>
<td>203</td>
</tr>
<tr>
<td>Aged 16 to 24</td>
<td>61%</td>
<td>62</td>
</tr>
<tr>
<td>Aged 25 to 49</td>
<td>80%</td>
<td>145</td>
</tr>
<tr>
<td>Aged 50 or over</td>
<td>74%</td>
<td>58</td>
</tr>
<tr>
<td>Served 1 year or less</td>
<td>42%</td>
<td>65</td>
</tr>
<tr>
<td>Served 2 to 9 years</td>
<td>77%</td>
<td>101</td>
</tr>
<tr>
<td>Served 10 years or more</td>
<td>93%</td>
<td>92</td>
</tr>
<tr>
<td>Lifeboat crew</td>
<td>91%</td>
<td>128</td>
</tr>
<tr>
<td>Lifeguard</td>
<td>62%</td>
<td>84</td>
</tr>
<tr>
<td>Non-operational</td>
<td>50%</td>
<td>36</td>
</tr>
<tr>
<td>Table B:2</td>
<td>Experience of post-traumatic stress by gender, age, length of RNLI service, RNLI role, and date of potentially traumatic event</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Base: Respondents who experienced a potentially traumatic event</strong></td>
<td><strong>No stress symptoms %</strong></td>
<td><strong>Stress symptoms below PTSD level %</strong></td>
</tr>
<tr>
<td>All experiencing potentially traumatic event</td>
<td>16</td>
<td>61</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>62</td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
<td>61</td>
</tr>
<tr>
<td>Aged 16 to 24</td>
<td>21</td>
<td>66</td>
</tr>
<tr>
<td>Aged 25 to 49</td>
<td>15</td>
<td>64</td>
</tr>
<tr>
<td>Aged 50 or over</td>
<td>16</td>
<td>51</td>
</tr>
<tr>
<td>Served 1 year or less</td>
<td>33</td>
<td>56</td>
</tr>
<tr>
<td>Served 2 to 9 years</td>
<td>14</td>
<td>68</td>
</tr>
<tr>
<td>Served 10 years or more</td>
<td>13</td>
<td>59</td>
</tr>
<tr>
<td>Lifeboat crew</td>
<td>13</td>
<td>62</td>
</tr>
<tr>
<td>Lifeguard</td>
<td>25</td>
<td>63</td>
</tr>
<tr>
<td>Non-operational</td>
<td>17</td>
<td>39</td>
</tr>
<tr>
<td>2017</td>
<td>19</td>
<td>61</td>
</tr>
<tr>
<td>2016</td>
<td>10</td>
<td>75</td>
</tr>
<tr>
<td>2015 or earlier</td>
<td>13</td>
<td>56</td>
</tr>
</tbody>
</table>
### Table B:3 People who were very supportive after potentially traumatic event, by gender, age, length of RNLI service and date of event

<table>
<thead>
<tr>
<th></th>
<th>% Colleagues very supportive</th>
<th>% Family very supportive</th>
<th>% Friends very supportive</th>
<th>Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>All experiencing potentially traumatic event</td>
<td>45</td>
<td>63</td>
<td>38</td>
<td>195</td>
</tr>
<tr>
<td>Female</td>
<td>56</td>
<td>53</td>
<td>52</td>
<td>34</td>
</tr>
<tr>
<td>Male</td>
<td>43</td>
<td>65</td>
<td>36</td>
<td>161</td>
</tr>
<tr>
<td>Aged 16 to 24</td>
<td>51</td>
<td>66</td>
<td>50</td>
<td>37</td>
</tr>
<tr>
<td>Aged 25 to 49</td>
<td>47</td>
<td>59</td>
<td>35</td>
<td>115</td>
</tr>
<tr>
<td>Aged 50 or over</td>
<td>34</td>
<td>66</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td>Served 1 year or less</td>
<td>48</td>
<td>67</td>
<td>56</td>
<td>27</td>
</tr>
<tr>
<td>Served 2 to 9 years</td>
<td>53</td>
<td>63</td>
<td>39</td>
<td>76</td>
</tr>
<tr>
<td>Served 10 years or more</td>
<td>38</td>
<td>61</td>
<td>32</td>
<td>81</td>
</tr>
<tr>
<td>2017</td>
<td>46</td>
<td>64</td>
<td>35</td>
<td>82</td>
</tr>
<tr>
<td>2016</td>
<td>54</td>
<td>60</td>
<td>50</td>
<td>46</td>
</tr>
<tr>
<td>2015 or earlier</td>
<td>38</td>
<td>60</td>
<td>33</td>
<td>54</td>
</tr>
<tr>
<td>Table B:4</td>
<td>Whether offered TRiM support by gender, age, length of RNLI service, RNLI role and date of potentially traumatic event</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offered TRiM support %</td>
<td>Base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All experiencing potentially traumatic event</td>
<td>26</td>
<td>190</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>27</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
<td>157</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged 16 to 24</td>
<td>36</td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged 25 to 49</td>
<td>27</td>
<td>113</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged 50 or over</td>
<td>15</td>
<td>39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Served 1 year or less</td>
<td>33</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Served 2 to 9 years</td>
<td>29</td>
<td>76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Served 10 years or more</td>
<td>22</td>
<td>81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifeboat crew</td>
<td>27</td>
<td>111</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifeguard</td>
<td>28</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-operational</td>
<td>29</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>41</td>
<td>82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>30</td>
<td>46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015 or earlier</td>
<td>2</td>
<td>54</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table B:5</th>
<th>Whether used support from RNLI occupational health, non-RNLI counselling or TRiM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base: 84 respondents experiencing potentially traumatic event in 2017</td>
<td>Used this type of support %</td>
</tr>
<tr>
<td>RNLI occupational health</td>
<td>1</td>
</tr>
<tr>
<td>Non-RNLI counselling</td>
<td>5</td>
</tr>
<tr>
<td>RNLI TRiM</td>
<td>8</td>
</tr>
</tbody>
</table>
### Table B:6  Whether received enough support from the RNLI after a potentially traumatic event by gender, age, length of RNLI service, RNLI role, date of potentially traumatic event and whether received support from TRiM

<table>
<thead>
<tr>
<th></th>
<th>% Received enough support</th>
<th>Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>All experiencing potentially traumatic event</td>
<td>51</td>
<td>192</td>
</tr>
<tr>
<td>Female</td>
<td>59</td>
<td>32</td>
</tr>
<tr>
<td>Male</td>
<td>49</td>
<td>160</td>
</tr>
<tr>
<td>Aged 16 to 24</td>
<td>70</td>
<td>37</td>
</tr>
<tr>
<td>Aged 25 to 49</td>
<td>50</td>
<td>112</td>
</tr>
<tr>
<td>Aged 50 or over</td>
<td>32</td>
<td>41</td>
</tr>
<tr>
<td>Served 1 year or less</td>
<td>74</td>
<td>27</td>
</tr>
<tr>
<td>Served 2 to 9 years</td>
<td>62</td>
<td>78</td>
</tr>
<tr>
<td>Served 10 years or more</td>
<td>34</td>
<td>82</td>
</tr>
<tr>
<td>Lifeboat crew</td>
<td>42</td>
<td>112</td>
</tr>
<tr>
<td>Lifeguard</td>
<td>65</td>
<td>52</td>
</tr>
<tr>
<td>Non-operational</td>
<td>63</td>
<td>16</td>
</tr>
<tr>
<td>2017</td>
<td>65</td>
<td>81</td>
</tr>
<tr>
<td>2016</td>
<td>56</td>
<td>48</td>
</tr>
<tr>
<td>2015 or earlier</td>
<td>27</td>
<td>55</td>
</tr>
<tr>
<td>Offered TRiM support</td>
<td>83</td>
<td>48</td>
</tr>
<tr>
<td>Not offered TRiM support</td>
<td>37</td>
<td>108</td>
</tr>
</tbody>
</table>

### Table B:7  Best people to provide initial support after RNLI trauma

(Base: all respondents)

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional mental health practitioner</td>
<td>15</td>
</tr>
<tr>
<td>Local trained peer supporters</td>
<td>58</td>
</tr>
<tr>
<td>Central team of trained RNLI staff</td>
<td>17</td>
</tr>
<tr>
<td>Other/don’t know</td>
<td>10</td>
</tr>
<tr>
<td>Base</td>
<td>252</td>
</tr>
<tr>
<td><strong>Table B:8</strong> ‘Very important’ factors in support provision</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><em>(Base: all respondents)</em></td>
<td></td>
</tr>
<tr>
<td>Support available out of office hours</td>
<td>74</td>
</tr>
<tr>
<td>Support available from someone in local area</td>
<td>51</td>
</tr>
<tr>
<td>Support provided quickly when needed</td>
<td>85</td>
</tr>
</tbody>
</table>
Appendix C. Web survey questionnaire

Supporting RNLI staff who deal with traumatic events

(Only questions and answer categories are reproduced here, not introductory text or instructions.)

Q1: What is your current role with RNLI?
(Lifeboat crew, Lifeguard, Non-operational staff, Other)

Q2: Is your role paid or unpaid?
(Paid, Unpaid, Partly paid and partly unpaid, Other)

Q3: Where are you currently based for your RNLI work?
(Channel Islands and Islands, East Coast, Ireland, North West England, Poole HQ, Scotland, South East England, South West England, Thames, Wales, Other)

Q4: In which year did you first start working or volunteering with the RNLI?

Q5: What is your gender?
(Female, Male, Other, Prefer not to say)

Q6: What age group are you in?
(16-24 years, 25-49 years, 50 years or over, Prefer not to say)

Q7: As part of your work for the RNLI, have you encountered situations involving any of the following?
(Somebody died; Somebody was seriously injured, disabled, or disfigured; A 'near miss'; A distressing or traumatic experience for you or your colleagues; No, none of these)

Q8: Thinking about the most recent situation like this, please indicate approximately when this happened.
(2017, 2016, 2015 or earlier, Don't know/don't remember, Prefer not to say)

Q9: The next questions are about problems that people sometimes have in response to stressful life experiences. Please tell us how much you experienced each problem in the months after the most recent difficult or traumatic situation.
(Not at all, A little bit, Moderately, Quite a bit, Extremely, Don't recall)

Q9a: How much did you experience repeated, disturbing memories, thoughts or images of the stressful situation?

Q9b: How much did you experience feeling very upset when something reminded you of the stressful situation?
Q9c: How much did you experience avoiding activities or situations because they reminded you of the stressful situation?

Q9d: How much did you experience feeling distant or cut off from other people?

Q9e: How much did you experience feeling irritable or having angry outbursts?

Q10: The next questions ask about how much support you felt you had from various sources after this stressful situation encountered during your work for RNLI.

(Very supportive, Somewhat supportive, Not that supportive, Not at all supportive, Other, Don't recall)

Q10a: How supportive were your colleagues at RNLI?

Q10b: How supportive were your family?

Q10c: How supportive were your friends?

Q11: Were you offered any support from the RNLI's Trauma Risk Management (TRiM) programme?

(Yes, No, Don't know/Don't recall)

Q12: Did you take up the offer of TRiM support?

(Yes, No, Don't know/Don't recall)

Q13: How helpful was the support from the TRiM programme?

(Very helpful, Somewhat helpful, Neither helpful nor unhelpful, Somewhat unhelpful, Very unhelpful, Other, Don't know/Don't recall)

Q14: Please use the box to tell us briefly about your reasons for not taking up the offer of TRiM support.

Q15: Did you use any of the following types of support?

(RNLI Occupational health; Support from a specialist counsellor or adviser outside RNLI; Other; No, none of these; Don't recall)

Q16: Do you feel you had enough support from the RNLI following the stressful situation you experienced?

(Yes, No, Don't know, Prefer not to say)

Q17: Please use the box to tell us more about the ways that the RNLI could have supported you more.

Q18: The next few questions ask about the importance of different types of support for RNLI staff and volunteers who might encounter stressful or difficult experiences in the course of their lifesaving work.

(Very important, Somewhat important, Not that important, Not at all important, Don't know)
Q18a: How important is it that support is available out of office hours?

Q18b: How important is it that support is available from someone based in your own local area?

Q18c: How important is it that support can be provided quickly when needed?

Q19: Who do you feel would be the best people to provide the initial support after a stressful or traumatic incident encountered during work for the RNLI?

(Professional mental health practitioners; Local RNLI staff or volunteers trained in how to help colleagues after traumatic events; A central team of trained RNLI staff who can travel to where support is needed; Other; Don’t know)
Appendix D. Internal TRiM survey communications

InBRIEF

August edition sent out on 28 July and a reminder in September edition sent out 1 September

Goes out to around 400 line managers who are encouraged to cascade to their teams.

Porthole

<table>
<thead>
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<th>Date published</th>
<th>Article</th>
<th>Unique Reads</th>
<th>Total Reads</th>
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<td>The TRiM survey: help us to improve the support we offer</td>
<td>104</td>
<td>111</td>
</tr>
<tr>
<td>11/09/2017</td>
<td>The TRiM survey closes on Friday</td>
<td>No stats through</td>
<td>No stats through</td>
</tr>
</tbody>
</table>

(Quite a low read count for a Porthole article)

Volunteer Zone

<table>
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<th>Article</th>
<th>Unique Reads</th>
<th>Total Reads</th>
</tr>
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<td>The TRiM survey: help us to improve the support we offer</td>
<td>90</td>
<td>101</td>
</tr>
<tr>
<td>11/09/2017</td>
<td>The TRiM survey closes on Friday</td>
<td>52</td>
<td>55</td>
</tr>
</tbody>
</table>

(this number is high for a Volunteer Zone story)

Horizon

Sent to operational staff.

Friday 28 July and Monday 11th September
Yammer

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<th>Date</th>
<th>Likes</th>
<th>Comments</th>
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<td>0</td>
</tr>
<tr>
<td>08/08/2017</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15/09/2017</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

1,100 staff members are on Yammer

Volunteer Facebook Group

<table>
<thead>
<tr>
<th>Date</th>
<th>Likes</th>
<th>Comments</th>
<th>Shares</th>
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<tbody>
<tr>
<td>09/08/2017</td>
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<td>1</td>
</tr>
<tr>
<td>13/09/2017</td>
<td>10</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

3,000 volunteers are in the group

Volunteer e-newsletter

Sent to 12,613 volunteers, open rate of 43.63% (4,921 unique openers)

Click throughs to survey = 68

Total clicks to survey = 74

% of Total clicks in the email = 6.33%

Daily Comms Digest – Friday 28 July

An all RNLI email – sent out to all staff with an RNLI email address