

In conversation – TRiM

Rick Hughes interviews Dr Neil Greenberg of the King's Centre for Military Health Research

Q *Neil, could you explain what TRiM is, how it evolved and any recent developments?*

A Trauma Risk Management or TRiM is a peer led system which aims to empower organisations to prepare for and manage the aftermath of traumatic events. The system relies on non medical personnel, who are selected and are volunteers, being trained in the basics of trauma psychology and the principles of post incident management. Practitioners are also taught to carry out structured psychological risk assessments which are undertaken in a confidential and non emotive manner to quantify how individuals have psychologically responded to potentially traumatic incidents. They are carried out at least three days after the event is over and again about a month later. By comparing the two risk assessment scores TRiM practitioners can identify personnel who are not psychologically adjusting in order to signpost them to other sources of formal help such as welfare, medical or mental health specialists. Most people do not require referral and TRiM practitioners are encouraged to provide practical support, advice and mentorship to aid recovery. However those in need of specialist help are encouraged to seek it. The system evolved from the workings of Norman Jones, Peter Roberts and Cameron March who set out in 1997 to help the Royal Marines find ways of dealing with potentially traumatic events; TRiM is the evolution of their original ideas. It has been adopted by a number of other organisations including ambulance services, police forces, diplomatic staff as well as the military. Currently a randomised controlled trial is underway to fully evaluate the system. However there is already plenty of encouraging preliminary evidence to suggest it may be a useful procedure for organisations that predictably put their personnel in harms way.

Q *With formal debriefing under the spotlight, how does TRiM fit alongside the NICE guidelines and other post trauma interventions such as 'Psychological First Aid'?*

A TRiM was born out of the need for organisations to fulfil their duty of care to employees with the knowledge that good man management

also makes for good business. In that sense it aims to keep people 'in the front line' wherever possible. TRiM practitioners are encouraged to avoid using the word 'victim'. We don't assume that everyone will become ill and indeed this is born out by the literature which is explicit that in almost all traumatic events, illness is the exception rather than the rule. One could say TRiM is a form of psychological first aid, however TRiM practitioners are most definitely not counsellors or therapists. They are, though, encouraged to provide practical advice, support and mentoring to personnel who appear to need it.

The NICE guidelines clearly and concisely consider the management of PTSD. However, PTSD is not the only adverse psychological outcome after traumatic events. All variety of psychiatric conditions may result including phobic disorders, depression and substance misuse to name but a few. TRiM risk assessments aim to evaluate an individual's post incident functioning, not just the presence, or not, of PTSD. With that in mind though, the TRiM system is really a way of organisational watchful waiting; where people are considered to be at risk of developing a psychiatric disorder two risk assessments a month apart are standard TRiM policy. The NICE guidelines also support the concept of some sort of formal check being carried out after a month or so; once again TRiM protocols are in keeping with NICE. Finally should a TRiM practitioner find that someone is not coping even with support, advice and mentoring then signposting to an appropriate source of help, able to provide or organise NICE compliant therapies should they be required, is standard TRiM practice.

Q *If TRiM practitioners are not counsellors, what does their training involve, how is this validated and quality-controlled and what support do they derive in terms of supervision?*

A TRiM training involves anywhere between two and five days of training in the first instance. The length of training depends on the role the practitioner will adopt, most importantly whether they will work under the supervision of a more experienced practitioner or whether they will have to work in relatively isolated conditions. The course has a strong educational component covering the

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basic psychological theory behind psychological trauma, active listening skills, legal aspects and details of the TRiM protocols including risk assessment. In total this amounts to just less than a day of lectures. The rest of the course is very role-play heavy. We believe that the only way that people really learn skills is to practice them. We try and ensure that there are enough trainers to provide good feedback to those who attend.

Quality assurance is through two processes. Firstly the trainers on the course have the final say whether someone is TRiM ready. If not, then most people will be offered the opportunity to undergo further training. Secondly the course, within the military, has BTEC accreditation, which is an external validation process. The course was also assessed some time ago by Cranfield University who were very positive about the teaching methods and course content.

Training is usually provided for groups from a particular organisation; we have found that it is useful for groups who work together to discuss how TRiM applies to their organisation during the course. TRiM protocols need to be tweaked a little to take account of the differences between organisations. Occasionally if people have forces links or work in governmental departments they can attend a military course. If not then usually organisations get in touch and something specific is worked out to suit them.

Q *The 'role-play heavy' element of training will resonate with our readers. But I get a sense this is essentially a Psychological First Aid (PFA) model i.e. 'watchful waiting', 'do no harm', focusing on 'critical incident processing' and 'normalizing reactions' etc. What is the crux of TRiM and how is this differentiated from other PFA models? Can this really transcend the military environment to UK PLC?*

A TRiM is not actually about 'critical incident processing'. Risk assessments seek to identify the potential risk of future mental health problems not to provide therapy or an intervention per se. The majority of individuals recover from traumatic events without needing formal interventions; social support from family, friends and work colleagues does the job for most. The risk assessment part of TRiM is about spotting those who are not adjusting whilst leaving the rest to go on their merry way, sometimes aided with some timely advice, support or mentoring.

It is well known that many people with psychological problems do not seek help because of stigma. We also know that, in the main, people prefer informal support rather than formal interventions

which might imply they are unwell or not coping. We hope that having TRiM practitioners available, at a similar organisational level to those who may be distressed, will provide the best opportunity for those who otherwise would not seek help to do so. Most people are content to talk to people who listen and are not a threat, as line managers can sometimes appear to be. TRiM practitioners, if trusted and observant, may well become a conduit to enable those who need help to access it.

TRiM practitioners also do more than simply risk assess. Their training covers other aspects of trauma management including the provision of appropriate briefings and a basic understanding of how to manage the aftermath of a traumatic incident. For instance if an unpleasant tasks such as body handling are required, it's best to mix experienced staff with less experienced ones.

TRiM is not really an ideal system to help distressed shipwreck victims as they walk off the gangway. It's designed for organisations where identified risks can be managed through workplace adjustments or referral onwards, depending on what is required. It seems to fit well with media organisations, emergency services and diplomatic staff, so the translation from military to the 'real world' appears to have already happened!

Q *You say that TRiM practitioners ideally come from a similar organizational level to sufferers, (i.e. non-clinical peer support), yet the 'Before, During & After' narrative process of TRiM (BDA Grid) – which echoes several debriefing models – will generate both cognitive and emotive responses. How can essentially lay TRiM practitioners, with only one day of lecture training, effectively contain or accommodate the more vulnerable sufferers who may exhibit potential symptoms of acute stress or PTSD?*

A One needs to remember what the point of a TRiM assessment is! Mental health practitioners do not need to undertake a formal risk assessment on someone who is about to step off a high platform declaring themselves to have no interest in life. TRiM training concerns itself with the difficult issue of how to identify someone who has problems even if superficially they appear to be fine. Only good listening skills, an appearance of confidence, confidentiality and competence is likely to encourage such people to divulge that they are not adjusting to the aftermath of difficult situation. The grandmother test applies to those who exhibit extreme or obvious symptoms of stress, PTSD or other mental health problems. You don't need a specialist to tell you that such individuals need pro-



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‘ TRiM practitioners can identify personnel who are not psychologically adjusting in order to signpost them to other sources of formal help ’

professional help, your grandmother could tell you! Highly traumatised individuals may be in need of more specific assistance than can be provided by a TRiM practitioner. Remember however such individuals are the exception not the rule; initial distress may well be normal and is not necessarily an indicator of the need for professional intervention.

TRiM training is explicit in enabling practitioners to spot those requiring assistance when others, having had a more cursory conversation, would not reach the same conclusion. Training also emphasises where single session debriefing models may have caused harm. Risk assessment is not about enforced catharsis. Rather it is a formalised method of scoring a structured conversation that aims to identify the potential to develop post incident mental health disorders. Trainees are told that they should not be left ‘holding the baby.’ Where they have serious concerns, these should be shared with more senior practitioners or medical, welfare or mental health staff.

Q *Whilst my grandmother is pleased about potential involvement, I agree that risk assess-*

ment is not about enforced catharsis. However, I’m still left wondering that a ‘Before, During & After’ structured narrative (teasing out facts and feelings) can cause extreme stress for the sufferer, with prospects of secondary traumatisation (especially in group-work) hence my previous question about using ‘lay’, non-clinical practitioners.

A Leaving your grandmother aside for a moment, TRiM assessments are not about ‘teasing out feelings’. The Risk Assessment checklist is a mixture of cognitive, historical and functional items all of which aim to give a measure of the risk of developing formal psychological disorders. Whilst feelings can, and do, flow during assessments they are not the focus of the interview. Practitioners are taught active listening skills and given guidance about how to avoid re-traumatising potentially distressed individuals. Should someone decompensate to such a degree to be suffering ‘extreme stress’ during a TRiM interview that would be a definite indicator for referral. We emphasise that TRiM practitioners should discuss more difficult cases with their supervisors.

The caution about group work is most valid. Much effort is placed upon TRiM practitioners planning what, if anything, needs to be done after a potentially traumatic event. Trainees are taught that great efforts should be made to ensure that group risk assessments are carried out with supportive groups which both respect the organisational hierarchy and avoid the potential for blame between those undergoing risk assessments. The potential for intra-group blame to cause difficulties for both the assessors and those being assessed is substantial and the training emphasises this point. However remember TRiM is not just about BDA risk assessment, it also attempts to ensure that practitioners can look at all aspects of the psychological management of trauma including the provision of psycho-educational briefings and active management of those who are mildly distressed but not in need of formal intervention.

Q *And finally, what do you see as the challenges and the opportunities for TRiM in the future?*

A The main challenge for any intervention is to ideally show that it makes some useful difference and even if the difference is hard to measure, given the controversy around psychological debriefing, that also it does no harm! Thus the results of the TRiM research that is currently underway will provide the main challenge or opportunity in the near future.

However I believe that however organisations

fulfil their duty of care towards employees it is essential to make sure that the system is primarily owned by the organisation. Whilst there is clearly a place for expert advice to set up, facilitate and supervise the running of organisational support systems the primary source of both support and conflict for those in the aftermath of difficult circumstances will be their peers and line managers. Both need to be attentive to the needs of the potentially distressed individual without disempowering them by intervening too early or passing the buck to 'an external provider'. To do so may appear to provide short term relief but detrimental to all in the longer term. There is, of course, also a role for experts in dealing with the limited number of formally unwell individuals when organisational assistance has been ineffective.

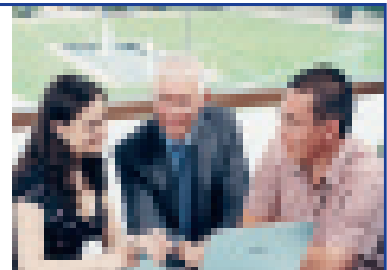
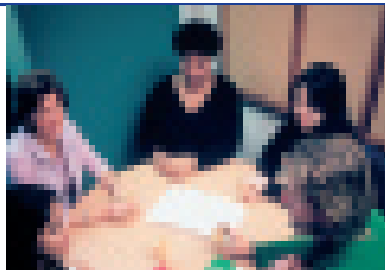
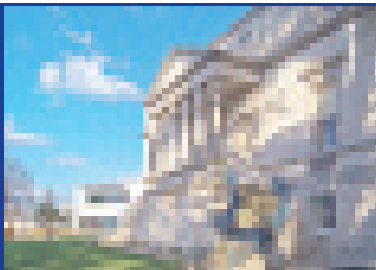
Effective support systems require senior management and line management 'buy in' and all employees to be aware that there are support systems in place. It's important too that a clear message is given to all that accessing support will not be dam-

aging to someone's career or a reason for discrimination. There's no point in having numerous support mechanisms enshrined in company policy if no one is going to use them.

TRiM in its current form may not be a solution for all organisations, however the principles of local support, effective and timely post incident personnel management and early referral are all sound. Quick fix solutions which rely on external experts to discharge moral and legal duties are unlikely to be successful and in most cases are short sighted. Organisations need to provide appropriately for their staff and trying to trim services to save money may leave those in charge feeling de-briefed!

Many thanks Neil for the interview! ■

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