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LFSO 3209 (THIRD REVISE)

LAND FORCES

STANDING ORDER NO 3209

by

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Commander Land Forces

LAND POST-OPERATIONAL STRESS MANAGEMENT (POSM)

ANDOVER
APRIL 2014

POC SO2 Health PS4(A)
[redacted]

LAND FORCES STANDING ORDER NO 3209
(THIRD REVISE)

LAND POST-OPERATIONAL STRESS MANAGEMENT (POSM)

References:

A. JSP 375 - MOD Health and Safety Handbook
B. D/DPS(A)/33/64/2/PS4(A) - dated 20 Sep 05: LF POSM
C. Mounting Order, Annex C
D. JSP 770, Pt 2, Ch 3 – Tri-Service Operational and Non-Operational Welfare Policy.

BACKGROUND

1. Operational stress is part of the continuum of occupational stress, for which further guidance is contained in Leaflet 25[1], Vol 2 Ref A. The overarching Review of Operational Stress Management (OROSM)[2] provided the framework for single Service policies on operational stress management, based on 6 steps, beginning with recruitment and ending with the period following discharge from the Armed Forces[3]. This LFSO covers the management of stress from OROSM Step 3 (pre-deployment) through post-operational recovery, to eventual discharge from the Army. This LFSO provides direction to the chain of command (CoC) based on Ref B, the Army POSM policy issued by PS4(A).

2. For the majority of Service personnel an operational deployment is a positive experience, but there will be a number for whom the experience can have negative effects. Commanders at all levels must make every effort to limit the potential for psychological problems being suffered by their personnel and manage those who have been exposed to stressors. The Psychological Welfare of Troops (PWOT) is core business and must be considered by commanders at all levels before, during and after operations. Such action represents a vital part of the Army's enduring obligation to its personnel. POSM is a key element of PWOT.

3. **Definition**. The following has been endorsed[4] as a definition of *Operational Stress*, it recognises that any pressure, challenge, or threat is a stressor on the individual and acknowledges that all people are subject to it:

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

AIM

4. The aim of this LFSO is to direct how Army personnel, Regular and Reserve, deployed on operations are to receive appropriate and coherent POSM in order to minimise the likelihood of, or gain early identification of, Post Traumatic Stress.

PRINCIPLES

5. Prevention and management of operational stress is a command, not a medical responsibility: good leadership and training are vital. Where practicable, commanders are to deliver the same level of support to all personnel, whilst recognising their different circumstances[5].

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[1] Leaflet 25: 'Stress at Work'. Although orientated towards civilian occupational stress guidelines, these are equally applicable to the military non-operational environment.

[2] Phase 1 of which was the Service Personnel Executive Group (SPEG) Paper 19/04 dated 29 Sep 04. Phase 2 - the Training and Communication Strategy - was published 26 Apr 05.

[3] The 6 Steps are: 1 - Pre-service entry beliefs and attitudes; 2 - In service training and promotion courses for career development; 3 - Pre-deployment; 4 - Operational deployment; 5 - Post operational recovery; and 6 - following discharge from the Armed Forces.

[4] SPEG 19/04 OROSM – 29 Sep 04

[5] Differences may include the terms and conditions of service under which individuals have been deployed, levels of training or experience or expectations. The principle however, is that the same level of support should be available whether Regular or Reserve.

Commanders may utilise all or elements of this policy outside of operations, as they deem appropriate. For ADOC directed operations and commitments, specific POSM guidance should be provided in the Personnel Instruction or G1 Annex; guidance can also be sought through the CoC to Pers Ops Army HQ where necessary.

6. If a commander has concerns about any individuals' wellbeing, they are to be referred to the Medical Officer at the earliest opportunity. When implementing POSM measures commanders play a vital role in reducing any stigma associated with post-operational stress[6]. Families, and where applicable employers of Reservists, must be aware and support the POSM process from pre-deployment through R&R to post operation.

STAGES

7. A summary of the POSM process is at ANNEX A. The five stages of POSM are as follows:

a. **Stage 0 – Pre-Tour**. Prior to a deployment commanders should engage with POSM and issue their initial policy (an example is at ANNEX B). This period will also include briefs on POSM to deploying personnel (normally captured during OPTAG), Rear Operations Groups (ROGs) and families in order to manage expectations regarding end of tour dates and the POSM process and raise awareness of stress and support available for Service Personnel (SP) and their families. See ANNEX C.

b. **Stage 1 – Decompression**. Decompression (DcN) must occur in a formal, structured and monitored environment, away from the area of operations immediately before recovery to the home base. Here, personnel are provided with a location in which to **rest, relax and reflect** before returning to a normal, routine, home environment. It should normally take place with those with whom they have served. Decompression is mandatory for all personnel who serve a minimum of 31 consecutive days in a theatre of operations for which DcN has been deemed necessary[7]. CJO is responsible for the implementation of DcN policy in consultation with the in-theatre chain of command. The Front Line Commanders who retain Full Command of their personnel whilst they are deployed on operations are responsible for its delivery. See ANNEX D.

c. **Stage 2 – Normalisation**. Normalisation is the action to be taken on return to the home base until the completion of Post-Operational Leave (POL)[8]. Responsibility rests with Commanding Officers be that of the donor, in-theatre or receiving unit, or the Reserve Training and Mobilisation Centre (RTMC). As with other elements of the POSM process, some individuals may need tailored arrangements to ensure their Normalisation requirements are met, typically normalisation will be 2-5 days in barracks conducting useful and necessary post operational administration. See ANNEX E.

d. **Stage 3 – In Service Support**. This stage begins on return from POL and applies for the remainder of time in Service. It includes the 6-12 week mandatory brief and should include a routine CoC (not Welfare) interview. See ANNEX F.

e. **Stage 4 – Aftercare**. The final stage begins on completion of Regular or Reserve service and is delivered by external organisations such as SPVA or the NHS. See ANNEX G.

8. **Supporting documentation**. A table of appropriate briefings and supporting presentations for SP and Families is shown at ANNEX H.

IDENTIFICATION OF GROUPS

9. **General**. The contemporary operating environment renders a 'one size fits all' approach impossible. Some Army personnel will come from or return to units within the Joint environment,

[6] It is accepted that reducing stigma is difficult; part of that process is the implementation and raising awareness of the POSM process.
[7] Requirement for DcN is a decision of a J1 PJHQ panel, based on an evaluation of risk and rigour.
[8] JSP 760 refers.

these units must follow the direction in this policy. Similarly, if you have personnel from other services under Army command then they should follow this LFSO[9]. Details of the different groups are given below and the subtle differences in their POSM processes are explained in the relevant annexes for each stage. The in-Theatre Commander must produce a POSM plan for each of these subgroups taking into account their specific requirements, it may require close liaison with for example; ROGs, RTMC and a soldier's parent unit.

10. **Regular and Reserve**. Though the Reserves bring their own challenges due to different TACOS[10], geographic dispersal and expectation management, the procedures to be followed are directly comparable to their counterparts.

a. **Aeromed Patients who are classified 'Discharge Airhead to Return to Unit MO'**. The DcN of these patients remains the responsibility of the CO. Their POSM plan is to be incorporated into their Individual Recovery Plan (IRP)[11].

b. **Aeromed Patients admitted to RCDM for less than 48 hours**. Although SJC Medical Staff are unable to start formal DcN at RCDM, Sick Leave policy ensures these patients are given no more than 2 weeks leave prior to returning to the Unit Primary Health Care provider. At this point, dependent on the circumstances (and who has command of the SP) the CO or the Personal Recovery Unit (through IRP) assumes responsibility for formal POSM. Once POSM forms (ANNEX J) are completed, they should be sent through for action to the parent unit HR staff.

c. **Aeromed patients admitted to RCDM for more than 48 hours**. In-patients at RCDM will be of varying degrees of injury severity, and as such their length of stay and clinical pathways will differ. For the purposes of this POSM policy they will be split into two groups:

(1) **48 hours to 14 days**. For these individuals POSM briefs and modified DcN will be delivered by the deployed ROG staffs, normally the Bde LO's, in conjunction with the Community Mental Health Staff at RCDM. ANNEX I will be completed and sent through to the parent unit HR staff for JPA action.

(2) **Greater than 14 days or/and ongoing recovery at Defence Medical Rehabilitation Centre (DMRC)**. In this case, the patients' recovery pathway may be complicated both physically and mentally. As such, a POSM style brief may be inappropriate. These patients will be in receipt of continuing clinical care following evacuation form theatre, and will have the opportunity to take part on the Battle Injured Mental Health Programme. This exemption from the formal POSM briefs must be recorded as a letter and form (ANNEX J) completed and sent from RCDM through the patient administration cell to the parent unit HR staff for JPA action.

d. **Formed Unit o Full Tour/Deployment & Elements of a Formed Unit on a Sustained Roulement**. The operational CoC applies the POSM implementation plan.

e. **Individuals in a Formed Unit but on a Planned Short Tour**. Individuals who are assigned to a new unit or are attending career courses must be identified once their assignment is confirmed. They should follow the same plan as for Individual Augmentees (IAs). A plan must then be put in place to ensure they participate in all mandated activities. This is likely to involve the ROG and relevant receiving unit.

f. **Individual Augmentees (IAs)**. Personnel assigned to an operational tour away from their parent unit ands returning to that unit, or those assigned to an operational tour and then re-assigned to a new unit, require a detailed POSM plan. They will follow the same plan as for a normal formed unit, however, elements will be completed by their parent unit on return

[9] This has been briefed and supported by the other Services.
[10] Regulations currently limit Reserve mobilised service to a maximum of 12 months.
[11] AGAI 99 refers.

from operations. It is essential therefore, that there is close liaison with the in theatre Comd and their parent unit to ensure that all stages of POSM are completed.

11. **Reservists**. Particular attention must be paid to Reservists who, unlike their Regular counterparts, do not return to a military environment focussed on their mental wellbeing. The application of the POSM policy for those on the Regular Reserve list (i.e. with no parent unit) is compounded further. Responsibility falls to the RTMC and in-Theatre recipient unit.

12. **High Risk Groups**. Some personnel, due to the nature of their employment, will be at higher risk than others of developing the symptoms of stress. The CoC must attempt to pro-actively identify and manage those groups or individuals who are likely to be at exposed risk. These will include certain specific CEGs, such as C-IED, Search or Medical Trauma personnel as well as members of the CoC themselves, who by dint of their role are more likely to succumb to increased levels of responsibility related stress but less likely to recognise it in themselves.

13. **Exceptional Circumstances**. Regular or Reserve SP may under exceptional circumstances circumnavigate the formal POSM regime, such as Compassionate or Disciplinary cases. On these occasions active POSM is to be managed by the appropriate Support Units & ROGs, similarly to Aeromed patients as per para 9b.

14. **Families**. When a soldier returns form the operational environment either on R&R or at the end of a tour, close contact with the unit deployed on operations may diminish or cease entirely. It is the soldier's family that is likely to notice any changes and therefore it is vital that family members are fully supportive and engaged in the POSM process where possible. Units both Regular and Reserve are to ensure that families ate informed of POSM prior to and during any deployment. They are to be fully appraised of the difficulties for both the soldier and family upon return to 'normality', including the signs for which the must look for. Advice and help can be sought from a variety of staffs and organisations, such as Welfare Officers[12] (UWO) and the Army Welfare Service (AWS). Specific information will be outlined within the relevant Mounting instructions.

15. **Trauma Risk Management (TRiM)**. TRiM trained personnel may play a key role in the POSM process, by helping to ensure that this process is as psychologically beneficial as possible. This may include presenting POSM briefs, advising the CoC about psychologically healthy outlines for normalising personnel and by providing informal support to those identified during the POSM process as being at increased risk of mental ill-health. Whilst POSM and TRiM are separate processes they work synergistically to support the psychological well being of personnel.

Recording. Recording POSM activity on JPA is mandatory and auditable. The unit HR staffs are responsible for data input onto JPA. See ANNEX I. Additionally, a hard copy of ANNEX J is to be retained in the individuals AFB9999. This can be referred to during 'move and track' as part of the stress management process.

Original signed on Dii

T R Urch CBE
Maj Gen
for CLF

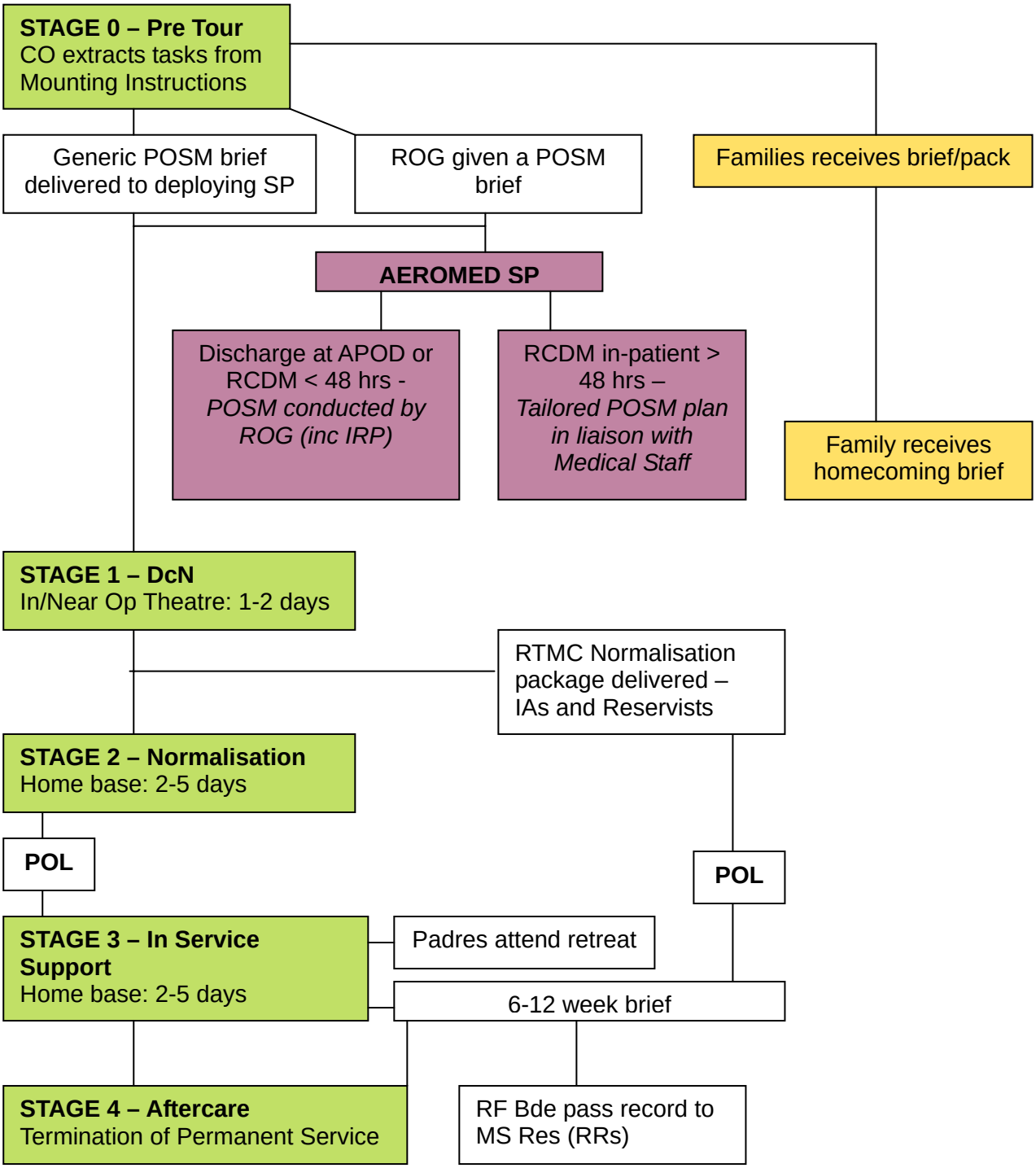
[12] Within Reserve units the ROSO holds this function, supported by the PSAOs.

Annexes:

A. A Summary of the POSM Process.
B. An Example of CO's POSM Policy.
C. POSM Stage 0 – Pre Tour.
D. POSM Stage 1 – Decompression.
E. POSM Stage 2 – Normalisation.
F. POSM Stage 3 – In-Service Support.
G. POSM Stage 4 – Immediate Aftercare.
H. POSM/Decompression Briefings
I. Guidance on Using JPA for the Recording of POSM Activity.
J. Record of Operational Stress Management (OSM) Support Received
K. DCMH Agreed POSM Exemption Form.

Annex A to
LFSO 3209
Dated Apr 14

A SUMMARY OF THE POSM PROCESS



Annex B to
LFSO 3209
Dated Apr 14

AN EXAMPLE OF CO'S POSM POLICY

Reference:

A. Land Post Operational Stress Management (POSM) LANDSO 3209 (Third Revise) dated Dec 2013.
B. Mounting Instruction.

GENERAL

1. For the majority of Service personnel an operational deployment is a positive experience, but there will be a number who have some negative effects. Commanders at all levels must make every effort to limit the potential for psychological problems being suffered by their personnel and manage those who have been exposed to stressors.

2. The Chain of Command (CoC) is key in the implementation of the Post Operational Stress Management (POSM) Policy as directed in Ref A.

AIM

3. This document directs how this unit will deliver POSM. The CoC MUST get it right as it is essential to the Regiments future effectiveness and is key to meeting our duty of care.

POSM STAGES

4. **Stage 0 – Pre-Tour**. Once in receipt of this direction all OCs, Unit Welfare Officer (UWO) and medical staff are to ensure that they are familiar with Ref A.

a. **Unit Brief**. The Adjt will lead on a G1 brief which will incorporate details of stress management (signs, symptoms and signposting), as highlighted in MATT 6, emphasising the responsibility we have to look out for each others welfare. In addition to this, all deploying personnel will receive a standard brief on the POSM process during OPTAG. Attendance at this brief is to be added to the individuals Operational Stress Management (OSM) record on JPA and the paper record (Ref A, Annex I).

b. **Rear Operations Group (ROG) Brief**. OC ROG is to brief the ROG. The important role they may play in supporting those who return early cannot be underestimated. They are to be fully conversant in the stages of POSM, aware of the signs and symptoms of stress and who to signpost the individuals to, should someone require extra support. The leave plot for the ROG should be articulated ensuring that leave is managed during the tour as they will be required to cover the Regiments POL.

c. **Families Brief - 1**. The UWO is responsible for co-ordinating a families (including where feasible the families of attached personnel (IAs, Regular or Reserve) brief which will highlight to the families the POSM process. This must be with the soldiers consent and therefore must begin at least 2 months prior to our deployment. Early engagement will ensure that where families cannot attend the brief, their contact details can be collated and briefing packs distributed. It must cover all elements laid out in Ref B, providing the necessary contacts, issuing the Families guide and briefing them on how to access the Regimental Web page. This will also serve to manage expectation regarding leave timings and the POSM process. During deployment the UWO is to ensure regular contact with families is made.

5. **During Tour.**

a. **Families Brief – 2**. The UWO is responsible for a 2nd brief ensuring the families (including families of Reservists) are made aware of the homecoming section in the families deployment guide and explaining to them the POSM process, including Decompression (its benefits), Normalisation and TRiM. It should also include contact numbers for them to use should they require extra support post deployment. See ANNEX H, Appx 4.

b. **Deployed Personnel Brief**. Towards the end of the tour, the Adjt will re-iterate the importance of Decompression and Normalisation to OCs, this information is to be cascaded to all deployed personnel.

c. **Letter to Aeromed Soldiers**. OCs are to write a letter of thanks to each aeromed soldier who will not return to theatre, the timing will depend on the nature of the injury.

6. **Stage 1 – Decompression**. Decompression must occur in a formal, structured and monitored environment, away from the area of operations immediately before recovery to the home base. Here, personnel are provided with a location to relax in a controlled environment before returning to a normal, routine, peace-time environment. It should normally take place with those with whom they have served. Decompression is mandatory for all personnel who serve a minimum of 31 consecutive days in theatre.

a. **Recording of POSM Action**. The POSM Forms (Ref A, Annex J) are to be couriered back to Barracks by the Chalk Commander of each RiP flight or the individual soldier. The POSM Forms are to be handed over to the Duty HR Staff or the WISMIS Manager during RMCCP and the data is to be added to the individuals Operational Stress management (OSM) record on JPA. The Duty HR Staff or the WISMIS Manager is to organise the POSM Forms into Sub-Unit folders. CSM ROG and the WISMIS Manager are responsible for completing the relevant POSM Forms for those soldiers who end of tour early.

7. **Stage 2 – Normalisation**.

a. We will undergo 5 days of Normalisation. This time is to be used for personnel to clear their personal administration as well as complete any urgent unit work. This may include returning equipment, JPA claims, personal banking, amending insurance policies etc.

b. All personnel are to be in receipt of FMed 1019 and 1020 and a list of support contacts (See Ref A and include Unit Out of Hours contacts) this is to be co-ordinated by OC ROG.

c. OCs are to ensure that letters of thanks are written to attached personnel. You are to ensure that details of the individuals POSM plan are clearly articulated (OC ROG will provide the details).

d. The WISMIS Manager is responsible for the handover of all POSM forms to the Sub-Units.

e. The unit will then depart on POL (approx 20 days). Dates will be confirmed towards the end of the operational tour.

f. The completion of Normalisation is to be submitted onto JPA and the POSM form.

8. **Stage 3 – In Service Support**. This stage begins on return from POL and applies for the remainder of time in Service.

a. **6-12 wk Brief.** The 6-12 week brief is to be given to the Regiment by The CSM (TRiM Trained). Attendance at the brief is to be submitted onto JPA and placed on the POSM Form. The JPA record may then be closed. Where a record was opened prior to the publication of the second revise (Jun 2011), and remains unclosed the following should apply:

- Record closed with Date and Location written next to missing serials.
- The in free text – 'No records could be found to confirm that this activity was completed' should be added.
- The individual should be given a letter from the CoC, in the form at Ref A, Annex B, Appendix 1.
- The individual should be given a copy of the 'Coming Home' booklet.

b. **Routine Interview**. Routine interviews are to be conducted following the tour, this provides an opportunity for all commanders to informally monitor and where necessary signpost their personnel to ensure they receive the support they need following what may be a very demanding tour.

c. **Families Brief – 3** – The UWO is to arrange a follow up brief to remind families of the sources of support available to them should they have any concerns about any member of their family as a result of the deployment.

d. **Part 1 Orders**. 6 months following the tour, a note is to be added to Part 1 Orders in accordance with Ref A, Annex F. Adjt to action.

9. **Stage 4 – Aftercare**. The final stage begins on completion of Regular or Reserve service and is primarily delivered by the NHS.

10. It is expected that for the majority this process will be relatively straightforward, what is key is how we also support those that return early, the Reserves and IAs etc. OC ROG is to ensure that POSM activity for these individuals is planned for, implemented and that the necessary recording activity is completed. This will involve close liaison with their OC and parent unit. A flow chart of the POSM process is at Ref A, Annex A.

TRACKING OF PERSONNEL

11. Recording Operational Stress Management activity on JPA is now mandatory and auditable (through the SPS Inspection). Unit HR staffs are responsible for data input (Ref A, Annex H) onto JPA. This record is a management tool showing which stages of the TRiM process have been completed. Once the record is closed it is to be the hard copy is to be retained in the individuals AFB9999. Four months after the tour the R2IC is to conduct a 100% inspection of the OSM records to ensure all are complete.

SUMMARY

12. The implementation of POSM will not only minimise the likelihood of our soldiers suffering from psychological problems but most importantly enable effective and timely management of those soldiers who have been exposed to traumatic or stressful events. This is core business which is to be understood and applied by all commanders at all levels during and after operations. This is critical to our remit to sustain the welfare of those under our command but

equally also enables us to sustain the key capability that is our soldiers in both the immediate and the long term as we retain our campaign footing. The CO places particular emphasis on getting this right.

Appendix 1 to
Annex B to
LFSO 3209
Dated Apr 14

TEMPLATE LETTER FOR INDIVIDUAL P-FILE TO CLOSE POSM JPA REPORT.

From: Maj AN Other

2nd Battalion
The Blankshire Regiment
Watreloo Barracks
Tidworth
SP1 OT1

Sgt AN Other
23 Gaza Close
Waterloo Barracks
Tidworth
SP1 OT1
Month #### (as per JPA entry[13])

Dear Sgt Other,

1. It is noted that you have no record of a 6 to 12 week POSM brief following your last operational tour. Following our interview today[14], there will be a number of individuals you may wish to approach, should you have any unresolved issues.

2. The Coming Home booklet, highlights areas of coping, and how these may be played out in your behavioural characteristics or those of others, especially family members around you. If you think these are affecting you in any way, you are strongly encouraged to speak to either your CoC, UWO, unit TRiM co-ordinator, or RMO[15]. They will be best placed to signpost you to specific help and guidance, you may require.

3. This letter will appear in your P-FILE for record keeping purposes only, your POSM JPA episode closed.

Yours sincerely,

AN Other

Copy to:

Recipients Signature:

Date: Rank: Name:

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[13] Para 8.a. refers.
[14] Use ANNEX H Appendix 2 for this interview.
[15] Place names as appropriate.

POSM STAGE 1 – PRE-TOUR

1. A POSM policy is to be written by the CO prior to the deployment and COs are to consider the health of each individual prior to deployment. This should include a robust plan for all deploying personnel including IAs, Reservists[16] and those returning early (i.e. courses) to ensure the entire process is captured (this may require close liaison with any receiving unit). The deploying CO is responsible for the POSM plan until they handover command of the individual to either RTMC or their receiving unit.

2. **Briefs**.

a. **POSM Awareness**. It is essential that all personnel, be they deploying, ROG or families of those deploying are briefed on what to expect during the POSM process. For those deploying a generic brief may be given during OPTAG. This (similar to the families brief) will detail the stages of POSM so that individuals are aware of what to expect during each stage and are made aware that they will not immediately go on leave on return. The ROG should be briefed within unit lines, this should include stress signs and symptoms (available at ANNEX H, Appendix 1), so that they can support SP returning early from tour, as well as each other, and are aware of when they may get their own leave.

b. **Families**. Families are a key part of the POSM process. They should be informed prior to the tour at unit level, in accordance with the Mounting Instructions. A families' guide[17] should be issued to families of deploying Regular Army Personnel; Reservists will receive an Army Families Deployment Support Pack from RTMC. It is good practice for this process to begin at lest 2 months prior to deployment. Early engagement will ensure that where families cannot attend the brief, their contact details can be collated and briefing packs distributed.

[16] COs need to incorporate this into the 12 month mobilisation plan.
[17] AC 64404.

POSM STAGE 1 – DECOMPRESSION

1. **Concept of Decompression**. Decompression (DcN) is an enabler for recovery. It is a process by which personnel who deploy together, unwind together. It is designed to place individuals into a formal, structured and monitored environment in which to **rest, relax and reflect** after a period on operations; by doing so individuals will start to re-adjust to a normal and routine peace-time environment. It affords an opportunity for personnel to begin to rationalise their experiences and set them in context.

2. **Method**. DcN should be a minimum of 24hrs duration and conducted in a benign environment; ideally a third location away from the Home Base and the Operational Theatre[18]. A DcN package may be programmed into any operational deployment and recovery period for all personnel involved. The designation of DcN is to be set by CJO following analysis of the risk and rigour associated with any Operation.

3. **Participation**. Decompression is mandatory for all personnel who have served in an overseas operational theatre for 31 consecutive days or more unless a waiver has been granted. Commanders may apply for those whose tour duration is less than 31 days, for them to attend decompression if they feel it would be beneficial, following experiences in theatre.

4. **Rest and Recuperation (R&R)**. Personnel who depart an operational theatre on R&R, either to the Home Base or a Third Location do not undergo any formal element of POSM, particularly Decompression. Whilst the omission of formal intervention in the form of Decompression or Normalisation for personnel on R&R is deliberate[19], it is incumbent on the Chain of Command to continue to ensure their wellbeing. Acknowledging that personnel on R&R may be detached from the unit ROG it remains a responsibility of the Chain of Command to monitor them as best as is possible, whilst not routinely intervening in their private lives or adversely impacting on their period of R&R.

3. **Waivers**. The authority to grant a waiver from DcN is jointly held by PJHQ and ARMY HQ Pers Ops (on behalf of CinC LF). Units should apply for a waiver in line with the procedures outlined by PJHQ J1, for their specific operation. The format and method for staffing the request will be dictated by PJHQ and will seek the opinion of the deployed chain of command. Those initiating the waiver request will wish to highlight exposure to the following during the deployment:

a. Significant, specific and enduring threat to life and limb.

b. Experience of, and close proximity to, traumatic events.

c. Experience of, or worry of, sustaining casualties and/or fatalities within the unit/sub unit or in their immediate vicinity.

d. Regular employment away from the central contingency operating base or camp.

e. Regular interaction with the indigenous, non-LEC, civilian population.

f. Morale, resilience and robustness of the units and individuals.

Waivers will be granted by exception and only on grounds of maintaining operational capability.

[18] Where a Third Country is not possible, DcN may be undertaken within a benign area of the country of Operations, or within but away from the country of the home base.
[19] Based on Mental Health SME advice.

4. **Passage of Information**. SP and their families will have been briefed during Stage 0 – Pre Tour of the benefits and merits of DcN and why it takes place. The following briefings, prior to Decompression should occur:

a. **Deployed Personnel**. In the month prior to recovery to the Home Base all deployed personnel are to be reminded of the format and benefits of DcN.

b. **Families**. Families should be appraised of the operational environment endured by the family member and be exposed to some of the signs and symptoms of operational stress[20]. Further to this they should be advised on where to go for support if required[21]. This responsibility lies in the main with the donor unit. For Reservists responsibility lies with the Host Unit and for IAs their Support Unit.

5. **Manning**. In order that DcN is effective it is vital that it is facilitated with appropriate and capable manpower.

a. **Large/Medium Scale Main RiP Period**. The Bde ROG will provide a Decompression Support Team whose manpower will cover the full range of activities for the required period of the RiP. The precise requirement and location will be identified by the PJHQ.

b. **Small Scale RiP**. FLCs have a responsibility to man specific posts on an enduring basis for those Operations assigned a DcN responsibility. This is likely include a Padre, CPN and TRiM co-ord.

6. **Format of Decompression**. A DcN package can be broken down into a series of packages that provide particular benefits. Further detail will be disseminated during J1 Force Preparation packages but in summary:

a. **Pre-Departure from the Operational Theatre**. All personnel are to be shown the Coming Home DVD and advised as to how they might seek support upon return to the Home Base. Additionally, for large/medium scale operational RiPs, activities such as Drumhead services are often incorporated where time and settings permit.

b. **Briefings**. A short series of briefings are provided to all personnel attending DcN[22] these will include:

(1) Driving awareness: the Grim Reaper DVD.

(2) A padre's Home Coming brief concerning the management of expectations with regard to personal relationships.

(3) A Mental Health brief from a CPN.

c. **Activities**. In order to provide the opportunity to rationalise their experiences and place them in context, alongside those who experienced similar incidents, a series of social activities are the main focal point of DcN for larger groups.

7. **Command Duty of Care**. During Decompression the Command must monitor and identify, based on operational activity and knowledge of individuals, those who may be particularly vulnerable to developing stress related conditions. Following clinical advice where appropriate, if it is deemed that an individual is particularly at risk his details are to be recorded in accordance with the Suicide Vulnerability Risk Management Policy[23]. Case conferences involving the chain of

[20] They may wish to consider written and or web based information in order to capture all.
[21] The families Homecoming presentation can be found at ANNEX H, Appx 4 and : Operational
[22] For small scale operations predominantly manned by IAs, the briefs as outlined in ANNEX H (groups of 5 or less) should be followed.

[23] Reference: AGAI Vol 3 Chapter 110

command, welfare (UWO and AWS personal support) and medical representatives may supplement this activity.

8. **Those Not Attending formal DcN**. A number of circumstances may conspire that prevent some personnel from attending formal DcN. These may include individuals in the following categories, who subsequently do not return to theatre and thus do not conduct DcN as originally planned:

a. Personnel evacuated from the operational theatre by aero-medical evacuation directly to UK hospitals.

b. Individuals who depart theatre under Compassionate arrangements.

9. In all circumstances individuals who depart theatre after more than 31 days service, but do not attend formal DcN, must have a comprehensive DcN package designed for them and implemented at the Home Base. Most normally their DcN will be incorporated into their POSM Stage 2 Normalisation package (See ANNEX H).

10. **Tracking**. It is vital that Decompression, alongside all POSM serials, is recorded accurately on JPA. This is particularly important when personnel will move away from the unit or chain of command with whom they deployed. Individual plans must be tailored for all circumstances to ensure that the chain of command and individuals are left clear as to who will be responsible for delivering each stage of POSM.

POSM STAGE 2 – NORMALISATION

1. The normalisation stage of POSM is mandatory for all Army personnel on return from operations. Post Operational Leave (POL) is not to be modified in any form, unless exceptional circumstances have been approved by Army Headquarters.

2. As with other elements of the POSM process, some individuals may need tailored arrangements to ensure their Normalisation requirements are met. However, common to all must be the receipt of FMed 1019, FMed 1020 and the list of contact details for support organisations[24]. SJC (Med) is to provide normalisation for all in-patients at Role 4 facilities in accordance with the IRP. It is essential that this stage is recorded on JPA (Annex I) and hard copy (Annex J), as this provides the tracking mechanisms to ensure personnel receive all stages of POSM.

REGULAR FORCES

3. **Formed Units**. Formed units will return to their home bases to conduct normalisation: typically 2-5 days in barracks conducting post operational administration. The exact duration is at the CO's discretion but it must be long enough to permit non operational activity and reintegration of all personnel (those deployed, those on the ROG and the families of all involved). COs may extend the period following consultation with the higher Chain of Command. For personnel returning early from the tour there must be a rolling normalisation programme organised by the ROG in order to permit individuals to undergo this stage of the process.

4. **IAs**. IAs may return to their parent unit or be posted to a new unit. The in theatre unit must contact the receiving unit to appraise the commander of the individual's time in theatre, drawing attention to potentially stress-inducing activities[25]. Normalisation for all personnel (including POL) is the responsibility of the individuals' CO on return from operations.

5. **POL**. Twenty days POL accrues from a 6 month tour or on a pro rata basis for shorter tours (one working day POL for every 9 days in theatre). POL should usually be taken with the deployed unit. Commanders may also consider adding a period of annual leave in order to address the outstanding entitlement created by the deployment.

RESERVES

6. **Formed Reserve Unit (2-5 days in barracks)**. A Reserve unit should conduct its own normalisation period to supplement the demobilisation package. Early engagement with RTMC and the in-theatre unit will be essential to ensuring the most appropriate programme**,** which ideally will take place before the demobilisation package at RTMC.

7. **Reservist IAs (2-5 days in barracks).** Regular units should include Reservists in their normalisation programme where practicable. Care must be taken to ensure they are included in day to day activity and are provided with suitable accommodation. Prior agreement must be sought from donor units in order that they have the opportunity to assess the impact on the families of those soldiers delayed from returning Reserve personnel, normalisation in the Regular unit takes priority**,** but the preference of the individual may be taken into account.

8. **Reserves Training and Mounting Centre (RTMC)**. Following normalisation Reservists will move directly to the RTMC for their demobilisation package, which lasts one day. It should be noted that:

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[24] 'Coming Home booklet', AC 64539.
[25] ANNEX H, Appendix 1.

a. The package is designed to enable reintegration in the same way as the in-barracks package for Regular personnel, but over a shortened timeframe. It comprises:

(1) Post-operational administration.

(2) A run up PULHEEMS medical appointment.

(3) Briefings on:

(a) Stress

(b) Return to Work (given by Directorate Reserve Forces and Cadets(DRFC))

(c) Aftercare and Welfare.

b. Establishing communications between the Army, the individual and the employer. Individuals will be asked if they wish a formal letter to be sent to their employer and if there are any specific issues that they wish to resolve in their reintegration to civilian life.

c. The Reservists outstanding POSM requirements are to be captured on the Release Certificate, this is to be copied to the Reservists Regional Bde. The soldier is to be directed to contact their Regional Bde in order to complete their POSM requirements (i.e. 6-12 week brief). The Regional Bde are to contact the Regular Reservist (RR) in order to co-ordinate the POSM brief.

d. It is the aspiration of Reservists are to get home as soon as possible. In the event that further support is required, the individual will be directed to the appropriate agencies in order that assistance can be provided.

9. RTMC will arrange onward movement from the point of demobilisation at Chilwell to unit or individual destinations as required. Following the RTMC package, Reservists go on POL and may take annual leave accrued during mobilisation.

10. **Letter of Thanks**. A letter of thanks and congratulations must be sent by the in-theatre Army chain of command to each individual Reservists soldier (which should include advice on POSM) timed to coincide with the end of the individual's POL. The default responsibility for this lies with the individual's in-theatre sub-unit commander.

AEROMED AND OTHER PERSONNEL

11. Those personnel subject to Aeromed, and other personnel returning from theatre, present the greatest challenge at Stage 2. Such personnel will need to be treated on a case by case basis. It is important to consider family support, unit COs are to ensure that unit plans address family needs.

12. **Aeromed Personnel**. Those returning by aeromed fall into 2 categories:

a. **Aeromed to Role 4**. SJC(Med) are requested to ensure that the mandatory requirements of Stage 2 are met and that further support is provided by the on-site agencies. Patients may be at Role 4 for long periods, which will extend the Normalisation stage. Conversely some personnel will only remain at Role 4 for a very short period of time and on discharge to Hospital Sick Leave, ROGs are to ensure that Stage 2 has been delivered. Units are to note that POL will need to be taken following discharge from hospital and missed elements of the POSM plan are to be incorporated into the Individual Recovery Plan.

b. **Aeromed other than to Role 4**. Personnel who do not proceed to Role 4 are to conduct Normalisation in the same way as other personnel returning early from the operational tour. The POSM plan should be incorporated into the Individual Recovery Plan.

13. **Aeromed Correspondence**. A letter of thanks must be sent by the in theatre commander to each aeromed soldier who will not return to theatre, the timing will depend on the nature of the injury. A senior officer from the chain of command will visit all personnel in Role 4 each month; this is to be supplemented by Regimental visits at an appropriate level.

14. **Other Personnel**. Individuals returning to face disciplinary action, on extended compassionate leave or returning for any other reason also need Normalisation. The CO of the parent unit is to ensure this takes place.

POSM STAGE 3 – IN-SERVICE SUPPORT

1. This stage of POSM underpins psychological resilience and the ability to retain individuals at combat readiness. In-Service Support refers to the period of time after the return from post operational leave rather than the initial weeks following return from operations. The chain of command is responsible for In-Service Support which continues until the individual (whether Regular or Reserve) is discharged from Service; it may therefore continue for decades.

2. During their remaining service, there remains a military and moral imperative to protect the health of personnel. Future service is likely to include further operational deployments and In-Service Support may therefore be concurrent with subsequent post-deployment Decompression or Normalisation. COs are responsible for all POSM In-Service Support. Reservists may proceed direct to Stage 4 (Aftercare) and therefore do not feature in Stage 3, albeit the opportunities to include them in unit briefings should be taken wherever practicable (see below).

3. Commanders of Regional Brigades must remain open to families and employers concerns as they may be the first to recognise mental health issues and they may have no-where else to turn to.

MANDATORY ACTIVITIES

4. **Brief**. Between 6 and 12 weeks following the return from operations, all Regular and Reserve units[26] are to conduct a stress briefing. A standard presentation has been developed. Where possible the presentation is to be delivered either by a Mental Health professional or a TRiM trained individual. Where this is not possible, the presentation may be given by a Padre/UWO/ROSO[27]. Attendance at this briefing is to be recorded on JPA and hard copy by HR staff. On the rare occasion that the individual resides abroad (Reservists) the brief may be posted recorded delivery to the individual (this action should be annotated on the record).

5. **Interview**. Routine Chain of Command interviews should occur during which the interviewee must be mindful of the SPs experiences. If concerns are raised then they should be signposted to, for example the Medical Officer, Padre or a TRiM trained individual (as appropriate).

6. **Reservist Recuperation Day**. Reserve units including those only providing IAs are to include a recuperation training day in their programme for all demobilised personnel. A maximum of 2 non-Bounty earning Man Training Days can be allocated from within existing unit ceilings. As many members of the unit as possible are to be encouraged to attend and the aim is to ensure that an individual's deployment has been properly recognised by the wider Army, and to assist with identifying any welfare needs[28]. This training period is the ideal time for the 6 - 12 week briefing to be delivered.

7. Reserve units are to inform the local Regional Brigade of proposed recuperation training periods. Although Reservists do not pass through Stage 3, the opportunity to attend the briefing, perhaps combined with a social event at a local reserve unit, represents an opportunity for the Reservists to share experiences and reflect on the deployment. Reserve units are to be prepared to accept that Reservists may wish to attend such briefings. Attendance is to be coordinated by the Regional Brigades. Reservists may claim 1 days pay and T&S costs, this is to be co-ordinated by the Reservists Regional Bde with MS Reserves. The recording of Stage 3 and closing of the OSM record will be conducted MS Reserves.

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[26] CVHQs for Specialist Reserves.
[27] They must have confirmed any queries with the presentation with a Mental Health professional or TRiM trained individual.
[28] Further details were promulgated in LAND/PERS/1308 dated 30 Dec 03.

8. **Padres**. Commanders should be aware that Padres may attend a Spiritual Retreat at approximately the 12 week point. This is essential to their own POSM process.

9. **Part 1 Orders**. All units are to remind personnel to consider POSM on a Part 1 Order notice to be published 6 months after return from operations and at quarterly intervals thereafter. The suggested form of words is as follows:

> "*(**Unit name**) returned from Op (**Op Name**) in (**Date: month, year**). All personnel who deployed on this operation are reminded of the common reactions to traumatic events and some do's and don'ts following the return from the operation as follows:*
>
> - *Don't bottle things up. Try to discuss them as they come up.*
> - *Don't try to avoid thinking and talking about experiences from the tour. Your family and friends will almost certainly want to listen.*
> - *Don't isolate yourself. Try to be with people when possible, but also reserve some private time for yourself.*
> - *Don't use alcohol to help you sleep, cope or forget. Small amounts are OK, but frequent heavy drinking is destructive in the end and risks additional accidents and medical and social problems.*
> - *Do take time to be with your family and friends. Plan events together even if you do not feel like it now; they are a good source of support.*
> - *Do look after yourself by eating and sleeping well and try to maintain a reasonable level of fitness.*
>
> If you are concerned about problems that you may be experiencing contact the Unit MO,UWO or AWS in the first instance (**relevant telephone numbers**). Contact details are available from (**relevant location in unit**)."

10. For groups who deploy regularly under a sustained roulement, careful Stage 3 management will be especially crucial to maintaining unit resilience for operations. Commanding Officers will need to determine how their unit's procedures are developed to achieve the necessary effect.

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

POSM STAGE 4 – IMMEDIATE AFTERCARE

1. Formal responsibility for medical care passes from MOD to the National Health Service on discharge/retirement from the Service. Defence Medical Services are responsible for overseeing the transition to civilian mental health care of Service personnel exiting whilst still receiving clinical treatment for psychiatric problems[29]. Mental Health Social Workers in Departments of Community Mental Health will provide follow-up contact with such individuals for12 months post discharge to ensure a smooth transition. In addition, advice can be sought on benefits, war pensions, employment, resettlement and accommodation to aid this process. All this information is available in the Service Leavers Guide provided by the SPVA. Another useful source of information is the Transition to Civilian Life: A Welfare Guide, which should be provided to all individuals leaving the Service.

2. The Veterans and Reserves Mental Health Programme provides mental health assessments for veterans and reservists who have concerns about their mental health as a result of service. The Medical Assessment Programme, for veterans, has moved from St Thomas' Hospital, London to Chilwell, Nottingham, bringing closer links to the Department of Community Mental Health based there. The service will be co-located with Reservist Mental Health Programme and renamed the **Veterans' and Reserves Mental Health Programme (VRMHP)**[30].

3. The VRMHP is available to veterans who have deployed since 1982 and are experiencing mental health challenges as a result of military service. The service will remain the same; a full mental health assessment by a Consultant Psychiatrist with accompanying guidance on care and treatment for the veteran's local clinical team. Referrals to the VRMHP will preferably be made by the individual's GP, however self referrals will be accepted for this service. The VRMHP investigates patients' mental health concerns and, so far as possible, it provides a diagnosis if the veteran has a mental health disorder, and recommends appropriate management through the NHS, if required. Advice will also be provided on the extensive support network that is available to veterans and their families in the UK.

4. The Service Personnel and Veterans Agency (SPVA)[31] acts as a point of contact to provide advice for serving military personnel, ex-service personnel and their dependents. The SPVA is responsible for the War Pensions Scheme and Armed Forces Compensation Scheme. These schemes provide compensation to personnel for illness that arises as a result of service prior to 6 Apr 05 and on/after 6 Apr 05 respectively. Outside the NHS, the charity Combat Stress[32] provides specialist advice and inpatient and outpatient mental health care for veterans.

5. Should a Service Leaver have an enduring welfare requirement[33] then the Veterans Welfare Agency (VWS) can give advice, guidance and practical help. It will also assist with any welfare related problem their family or dependants may have. The problem does not have to be directly related to disablement or service in HM Armed Forces.

6. For individuals with a Transitional Welfare Requirement referrals should ideally be made to the Veterans Welfare Service 8 weeks prior to discharge. Referrals could be made for any type of discharge including Administrative, Medical or on normal discharge. Further information regarding this and how to refer SP can be found at: http://www.veterans-uk.info/welfare/trans.html

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[29] DCMH care can be maintained for upto 6 months post discharge in order to facilitate this transition.
[30] DCMH Chilwell, Chetwynd Barracks, Chilwell, Nottingham, NG9 5HA. Freephone Helpline: 0800 0326258 Email: aphcsedcmhchl-vrmhp@mod.uk
[31] http://www.veterans-uk.info/veteranscommunity.htm 0808 1914218.
[32] 01372 841600
[33] This may be debt, drug or alcohol issues or that they are illiterate.

7. For those seriously injured, referral may be made to the VWS from Service Welfare staff which addresses the Welfare needs of Seriously Injured Leavers. Further information may be found at: http://www.veterans-uk.info/welfare/protocol.html

8. Outside the MOD's responsibilities, the Army Regimental families and Service charities can greatly assist in Stage 4.

TRANSITION INTO AFTERCARE

9. For Regulars on discharge/retirement, a similar recorded chain of command advice interview is to be conducted. A POSM advice leaflet is included in the Officers' and Soldiers' Leavers Pack. In the short term Resettlement Officers, UWOs and Regimental Operations and Support Officers, Regimental Recruiting Retention and Welfare Officers should be briefed on POSM advice and make it available to those leaving the service or demobilizing.

10. For Reserves, on termination of permanent service, the CO of the SPs final unit is responsible for ensuring an interview takes place to explain that should the individual experience difficulties associated with operational service, he should contact his/her nominated focal point – this must be agreed prior to termination and may be a local Regular unit or the local Reserve Forces and Cadet Association (RFCA). If relocating, the Reservists should be directed to contact the nearest Regional Brigade HQ.

ACTIVITIES

11. As well as the Department of Health, there is a key role for Regimental Associations, the Directorate of Reserve Forces and Cadets (DRFC), Service Personnel and Veterans Agency (SPVA), the Soldiers, Sailors, Airmen and Families Association Forces Help (SSAFA-FH), Combat Stress and the wider body of Service charitable organisations in addressing individual cases. A regimental association, headquarters or charity might be the most suitable point of contact for ex-Service personnel, to provide moral or material support and direct individuals to the most appropriate support agency to address their needs.

POSM/DECOMPRESSION BREIFINGS

For all of these resources use the following link: Operational

	Groups of 5 or less	Groups of 5 – 25	Groups of 25 or more
Individual	**Immediately Post-deployment**. To be issued with: • **Coming Home Booklet** (AC64539) To undertake: • **'Going Home'** DVD (C5153/08) *or* an Initial **CoC / Stress Management Co-ord Interview** • **'Grim Reaper'** DVD (D042/07) *or* **'Army Road Safety Campaign'** DVD (D048/08) **At 6-12 weeks.** Undertake: • **A CoC follow-up Interview** (not UWO)	**Immediately Post-deployment**. To be issued with: • **Coming Home Booklet** (AC64539) To undertake: • **'Coming Home and Mental Health'** power-point presentation • **'Going Home'** DVD(C5153/08) • **'Grim Reaper'** DVD (D042/07) *or* **'Army Road Safety Campaign'** DVD (D048/08) **At 6-12 weeks.** Undertake: • **A CoC Interview** (not UWO)	**Immediately Post-deployment**. To be issued with: • **Coming Home Booklet** (AC64539) To undertake: • **'Grim Reaper'** DVD (D042/07) *or* **'Army Road Safety Campaign'** DVD (D048/08) **At 6-12 weeks.** Undertake: • **'Coming Home and Mental Health'** power-point presentation • A **CoC Interview** (not UWO)
Chain of Command	**Immediate**. Presenting the **'Going Home'** DVD will be done with a working knowledge of the script of 5-25 power-point brief, **'Coming Home and Mental Health'**. Interviewers should follow the prescribed template and be aware of: • Any significant tour events • Any TRiM interventions • The generic list of immediate risk	**Immediate**. Presenting the **'Coming Home and Mental Health'** power-point brief with accompanying script. The CoC should ensure the awareness of all relevant SMEs for those involved: o TRiM Co-ord o Padre o UWO	**Immediate**. The CoC should ensure the awareness of all relevant SMEs for those involved: o TRiM Co-ord o Padre o UWO **6/12 weeks**. Presenting the **'Coming Home and Mental Health'** power-point brief with accompanying

	indicators • Awareness of all relevant SMEs of those involved: o TRiM Co-ord o Padre o Master Driver o UWO **6/12 weeks**. An interview with the CoC / Stress Management Co-ord. *By now, any significant issues and stress indicators should be making themselves apparent.* Ensure ANNEX I (JPA Recording) and ANNEX J (OSM Record) are followed / completed appropriately.	**6/12 weeks**. An interview with the CoC / Stress Management Co-ord. *By now, any significant issues and stress indicators should be making themselves apparent.* Interviewers should follow the prescribed template and be aware of: • Any significant tour events • Any TRiM interventions • The generic list of delayed risk indicators Ensure ANNEX I (JPA Recording) and ANNEX J (OSM Record) are followed / completed appropriately.	script. An interview with the CoC / Stress Management Co-ord. *By now, any significant issues and stress indicators should be making themselves apparent.* Interviewers should follow the prescribed template and be aware of: • Any significant tour events • Any TRiM interventions • The generic list of delayed risk indicators Ensure ANNEX I (JPA Recording) and ANNEX J (OSM Record) are followed / completed appropriately.
Families	Routinely supported by UWO. There are x2 DVDs which can to be presented: • **Prior to deployment**: 'Deployment – Families Guide' (C5228/11) • **Upto one month before return**: 'Homecoming – A Families Guide' (C5229/11) <u>*or*</u> the 'British Army Family Homecoming Brief'. • **Script**. The script for the PowerPoint brief is suitable for use with both the presentation and DVD. To be issued with: • **Coming Home Booklet** (AC64539)	Routinely supported by UWO. There are x2 DVDs which can to be presented: • **Prior to deployment**: 'Deployment – Families Guide' (C5228/11) • **Upto one month before return**: 'Homecoming – A Families Guide' (C5229/11) <u>*or*</u> the 'British Army Family Homecoming Brief'. • **Script**. The script for the PowerPoint brief is suitable for use with both the presentation and DVD. To be issued with: • **Coming Home Booklet** (AC64539)	Routinely supported by UWO. There are x2 DVDs which can to be presented: • **Prior to deployment**: 'Deployment – Families Guide' (C5228/11) • **Upto one month before return**: 'Homecoming – A Families Guide' (C5229/11) <u>*or*</u> the 'British Army Family Homecoming Brief'. • **Script**. The script for the PowerPoint brief is suitable for use with both the presentation and DVD. To be issued with: • **Coming Home Booklet** (AC64539)

Appendix 1 to
Annex H to
LFSO 3209
Dated Apr 14

POSSIBLE RISK AND STRESS INDICATORS

Risk Factors. These will be most relevant to the immediate post-operational period of DcN and Normalisation where an individual has experienced:

- High Intensity of Operations.
- Unpleasant role (e.g. body part recovery).
- Working outside their normal military role whilst deployed.
- Previous trauma.
- TRiM intervention in Theatre.
- Death of Colleague (particularly if seen).
- Threat of injury or death to self.
- Responsibility for delivery of lethal force.
- Error resulting in death or serious injury.
- High frequency of deployments.
- Consistent bombardment when deployed.
- Involuntary isolation.
- Previous mental health difficulties.
- Equally all may not be well at home.

Stress Indicators. These are most relevant at the 6-12 week point. Whilst many people will have many of these stress indicators initially, it is fair to expect most, if not all, to have dissipated by the 12 point.

- Life being ‘out of control’.
- Blaming others for involvement in traumatic event.
- Displaying shame in own performance.
- Constant dwelling on an episode.
- Inability to cope with day to day activities - poor functioning at work or home.
- Changed behaviour pattern / ’personality’.
- Personnel who have little social support.
- Inability to handle relationships and domestic upheaval.
- Irrational behaviour (anger outbursts).
- Disturbed sleeping patterns.
- Alcohol / Substance / Nicotine misuse or increased use.
- Concern expressed by others.
- Increased reporting to medical staff with unexplained or vague physical complaints – stomach complaints/aches and pains.
- Disciplinary action / sporadic minor incidents e.g. increased lateness for duty.

Individual subjective stress feelings may be expressed by the SP, such as:

- An individual who, in their post deployment interview, reports to have difficulties or:

- Felt out of control at the time.
- Felt their luck would not hold out and that they would not ‘get out of there’.
- Unable to understand why they were placed in that situation / why the decision was made.
- Wishes to leave / PVR from the service immediately on return.

Appendix 2 to
Annex H to
LFSO 3209
Dated Apr 14

INTERVIEW CHECKLIST

This interview checklist provides a template that may be used by the CoC and/or the Stress Management Co-ordinator at either the immediate or 6-12 week interview stages. It should be used in conjunction with the guidance notes containing the post-deployment stress indicators (Appx 1).

The interviewer must be mindful of the SPs recent operational experiences, including any TRiM incidents. If concerns are raised then they should be signposted, as appropriate to: a Medical Officer, a Padre or a TRiM practitioner.

Grey italicised font is guidance for the interviewer that should be deleted prior to the form being issued.

Number:	**Rank:**	**Name:**
Unit:		**Date:**

Deployed location: ……

Deployment dates: ……

Resources:

Has the individual received the following (tick box for Yes):

- Coming Home Booklet (AC64539) ☐
- Going Home DVD (C5153/08) ☐
- Coming Home and Mental Health - power-point presentation ☐
- Grim Reaper DVD (D042/07) *or* Army Road Safety Campaign DVD (D048/08) ☐
- Other: ……
  ……
  ……

Did the individual undertake Decompression? YES ☐ NO ☐

If NO, what was the reason? ……..
……
……

**This should be verified by the Record of OSM received, ANNEX J.*

Topics. The interview should allow the CoC to be persistently, yet unobtrusively interested in the SPs welfare after operations. It is not to be a 'debrief', but an opportunity for the SP to express what they have experienced and any issues they may have.

1. **Immediate** (in lieu of 'Coming Home and Mental Health' - power-point presentation):

   - *Assess what they have experienced and how they perceive it.*

- *Assess what they already know about the POSM process.*
- *Use negative comments to at least show they have experienced / watched / paid attention to the mandatory briefs.*
- *Enforce what we know: the well researched benefits of the POSM process including DcN, Normalisation and TRiM.*

- *Cover the areas of:*
  - *Normalise post-tour reactions.*
    - *Emotional variation is normal.*
    - *It is the prolonged disabling symptoms that require help.*
    - *'Let time pass', 'you are not going crazy' are the key messages at this point.*
    - *Avoid long lists of symptoms, or saying everyone has problems. Simply ensure it is understood that should the interviewee feel they have a problem, they should approach someone they trust, and that you are available to approach at any time.*

  - *Self Help should be promoted:*
    - *Talking to others, with similar experiences. Slowly and in their own time.*
    - *Getting and sticking to a routine, to include PT, eating and sleeping.*
    - *Not to abusing alcohol.*

  - *Other Help:*
    - *Ensure all relevant contact details are annotated within the Coming Home Booklet.*
    - *Highlight and name the:*
      - *Defence Centre for Mental Health Staffs (DCHM).*
      - *Padre.*
      - *UWO/UWWO.*
      - *TRiM practitioners.*
      - *External agencies (see Appendix 1 to Annex E).*

  - *All attempts should be made to reduce any Stigma associated with mental health issues.*

  - *Are there any Family issues for which support is required?*

2. **6/12 weeks** (mandated):

- *Similar in out line to the immediate interview, this should have a less ordered tone. By this point any potential stress indicators should be making themselves apparent. The interviewer should make themselves aware of any issues that have manifested in the time since return. This may be through chatting with the immediate CoC, peers or welfare staffs. For IA's the tour insert report should be read prior to interview.*

- *Did the SP undergo Normalisation, are there any outstanding issues?*
- *Has the SP taken all of their post-operational leave entitlement?*
- *If part of a TRiM intervention, has the 12 week interview been carried out?*
- *Set out the plan for the SPs employment over the next reporting period.*

	Interviewer	Interviewee
Rank & Name:		
Signature:		
Date:		

This record is to be filled in the individual P File and retained or 6 months.

Appendix 3 to
Annex H to
LFSO 3209
Dated Apr 14

SERVICE PERSON'S HOMECOMING BRIEF – SPEAKERS NOTES

1. The purpose of the homecoming brief is to reinforce the messages that personnel should have already received prior to and during deployment. However, for some personnel your presentation may be the first opportunity to highlight the issues within the brief. The brief, in conjunction with the related literature and media is designed to be delivered in both small group (up to 5 SP) and team level (up to 25 SP). It can also be used to guide one to one interviews.

Introduction

2. The essence of POSM from a wellbeing point of view is to encourage both the service person and their line management (particularly the latter) to be *persistently, yet unobtrusively* interested in that service person's welfare after operations. From that flows the more obvious attempts to ease adjustment back to UK life like Decompression, to Normalisation (a return to work interview, Acknowledgement of your work on ops, the 12 week welfare interview).

"This brief to support delivery of the Army's Post Operational Stress Management (POSM) policy and is one of the ways the military recognises that deploying on operations can affect both Service personnel and their families. POSM includes direction on Decompression, Normalisation (Return to normal work) and Aftercare (on leaving the Service). Of course, you may go through the deployment cycle a number of times in your career.

IA's or small groups or teams may not have gone through Decompression, so this brief as part of a short package is replacing that function. Your responsibilities with respect to POSM include being aware of how you are, helping yourself if that is necessary and seeking outside help if that is necessary. To help you with that, I am here to give relevant information and offer you the opportunity to ask any questions."

Preliminary Information

3. It is suggested you now assess what they already know, this not only breaks the ice but allows you to gauge their understanding of the levels and types of stress they may have experienced.

Suggestions:

Start by asking when they returned, have they had POTL (Now called POL), what briefs they have had; Have they seen any Going Home DVDs or driving safety ones?

If they say they thought it was "pants" or patronising – say "Good, at least you listened and will now be aware of the issues!" "We do know from research done recently that receipt of this sort of brief (i.e. a post-operational one) has a beneficial effect on the likelihood of developing MH problems 'down the line".

'You may have also been provided with a booklet of useful information and contacts. Please keep this in a safe place and you may find it useful to refer to this over the next 4-6 weeks'

"Today, I am going to brief you on four areas:
1) What's a normal reaction, what's not?
2) Helping yourself.
3) Getting outside help.
4) Why getting help can be difficult (Stigma etc – Barriers to Care).
Then there will be an opportunity to ask questions?"

Normalisation of symptoms

4. The goal here is to show that emotional variation (labile mood) and experiencing usually strong emotions is normal (in almost all cases) at first. It is the prolonged and disabling symptoms that indicate a need to seek help. Do all you can to reinforce the "let time pass" and "you're not going crazy" messages, appropriate humour is ok here. Avoid giving lengthy lists of symptoms and saying that everyone will have problems – this is not true!

"Swings in your emotional state and experiencing usually strong emotions is normal (in almost all cases) at first. However if these are the prolonged more than 6 weeks or stop you from functioning at work or home then this is a sign to perhaps seek help."

"If any of you feel you are already at this point please come and discuss it with me, or someone they trust, over the next day or so – don't leave it."

Self help

5. There are a variety of methods of self help. Getting personnel to talk to others, to get back to and to stick to a routine and not using alcohol as a crutch are key messages here. Helping personnel to access social support will be useful. Remember personnel usually speak to each other about all manner of things and you encouraging them to share thoughts with colleagues will be useful. They should do so slowly, at their own pace an also talk to their family and friends outside of their unit.

"There are several ways you can help yourself.

- ***Get back to a routine and stick to it for a bit before any significant changes – [Important to recognise if you are posted or sent away after your deployment this may be difficult]***
- ***Not using alcohol as a crutch is also very important.***
- ***Sharing your thoughts and concerns with others who you care about and who care about you will be useful***

However, the key message is, getting back to normal for you takes time and you should do so slowly, at their own pace and also talk to their family and friends outside of their unit."

Other sources of help

6. “Accessing other sources of help varies depending on the unit and location. Remember many people do not even know that the military has a mental health service or imagine it’s not confidential or that it is staffed by people who have simply done a 2 week “mental health” course.

“There are several avenues of support both within the unit”
[Provide details for UWO, TRiM lead and Padre]

“You can also speak to the medical centre/RMO who can support you in accessing more comprehensive help from the Mental Health Service if required”

“Remember this is confidential and that it is staffed by people (Drs/Nurses/Psychologists) who have a great deal of knowledge and experience in dealing with deployment related problems.”

Stigma

7. We know that a large number of those with problems will not come forward for help. This section attempts to dispel the myths and hopefully empower individuals and leaders to help their colleagues. The messages you give here can be reinforced in subsequent briefs and interviews and as you talk to people after this brief. In particular you should ask junior leaders to reinforce these messages. In particular let them know…

Myth 1. Only weak people have mental health problems

Fact: Anyone can be affected by operations

Myth 2. If someone has a problem, they will get help.

Fact: Most people do not get help because of stigma

Myth 3. My buddy/colleague’s mental health problems are none of my business

Fact: Buddies are best placed to spot the distress and encourage help-seeking

Myth 4. The military doesn’t support personnel who have mental health problems

Fact: There are multiple ways to get help

Myth 5. No one can help me if I have a mental health problem

Fact: Professional treatment helps, the earlier the better

“It’s actually clever to ask for help if you need it and you are more likely not to get promoted because your mind is full of operational nonsense and you don’t do you job well than if you get help and get sorted”

8. The last reason for the mental health brief is to show that the Army, its leaders and the medical/mental health practitioners appreciate the stress a deployment can place on *some* SP and the audience should leave thinking ‘if I had to seek some professional help…then I could talk to someone like him/her’. Once again, make a firm offer to give advice there and then to anyone who needs it. Finally, do remember not to make any promises you *or colleagues* may have difficulty in keeping.

- Should you want any further information contact a senior colleague or you local DCMH via the DII link below or by calling SO2 Mental Health - Lt Cdr Ian Kennedy | Tel: 94422 4741 | Email: SG-DPHC MH SO2

http://defenceintranet.diif.r.mil.uk/Organisations/Orgs/JFC/Organisations/Orgs/SG/DefencePrimaryHealthcare/DPHCClinicalServices/Pages/DPHCMentalHealth.aspx

Appendix 4 to
Annex H to
LFSO 3209
Dated Apr 14

FAMILIES HOMECOMING BRIEF – SPEAKERS NOTES

Introduction

1. These notes are designed to be used by Unit Rear Operations Group welfare staff to families prior to their soldiers return in accordance with LFSO 3209 (Post Operational Stress Management) The LFSO should be read and understood by the presenter prior to delivering this presentation. It can be used either in conjunction with the 'Homecoming – a families Guide' DVD (C5229/11), or to support the 'British Army Family Homecoming Brief'. If using the brief, Units may wish to put their own appropriate unit pictures on the slide.

2. **Preliminary Information**. Units should also consider including two additional sections tailored to their own circumstances prior to giving this homecoming presentation.

a. An introductory section delivered by an appropriate member of the unit who has just returned from theatre who can give the audience a balanced flavour of what the tour has been like for their soldiers covering: the highlights, the difficult times and the successes.

b. A section briefly explaining the decompression process followed by the unit as it returns from theatre. A brief explanation of TRiM is useful so that families are aware of the structured and supported journey that there soldiers goes through during their return from theatre through to beginning post operational leave.

Introduction

"I am sure that all, or at least most, of you are looking forward to your loved ones coming home. Whilst I expect that you, and your partner/son/daughter, will have been increasingly looking forward to this moment for a while now, we have found that knowing what to expect, and what not to, can be helpful.

This presentation has been put together using the experience of many families and service personnel who have been through the homecoming experience it also uses what research evidence we have to provide you with the facts."

"It may not come as a shock to you to learn that everything in the newspapers and media is not entirely true for example the Army's PTSD rates are similar than the civilian population.
We also hope you'll leave this presentation knowing some more about what help the military can provide to both yourselves and your loved ones if either of you needs it."

"Today, I am going to brief you on 3 areas:

1. What Homecoming might mean for you & them
2. Possible feelings and behaviours.
3. When and where to get outside help.

At each stage there will be some hints and tips that others have found helpful. Then there will be an opportunity to ask questions"

3. **What does home coming Mean for you and your returning SP?** This section can be

adapted to fit the audience. Almost all service personnel are glad to be home. However many also miss their work on operations. Being away from their loved ones and facing danger and hardship is not for everyone, whilst away many SP feel that they are 'doing the job they trained for' and there is something immensely satisfying about the high level of teamwork and friendship that personnel experience whilst deployed.

4. This does not mean that personnel don't want to come home, but for some a 'bit of them' may wish they were back in theatre, even though it was not the nicest place to be when they are there. It's not that they did not miss their family, their home, lifestyle and friends, just that being on operations can provide people with a feeling of being alive and doing something important which it is not easy to find in everyday life.

5. Prior to deploying they may have spent some time getting themselves physically, mentally and emotionally ready for deployment. Families often report that the person has left before they have actually deployed. They spend months away keeping themselves and their colleagues motivated, often in a highly difficult environment it's not surprising perhaps that they will take a little time to settle down to 'normal' life whatever that may look like.

6. Whilst flight delays and a day or two of decompression to get back from theatre to their home base is part and parcel of coming home, is not the same as homecoming.

7. Homecoming can take days, weeks or even months. In fact for most, it will take 12 weeks to fully readjust to their lives home again and what may both see as normal. It involves the service person relearning what 'normality' is like. Often both sides will have built up a fantasy of what coming home is about. They may have been looking forward to all the comforts they missed including being with their partner. But they may have forgotten about the routine bills, weekly shop, the challenges of parenting and those family disputes that have been brewing.

8. Neither party will be able to undo months of training and experience in a few days. Often trying too hard too quickly brings its own problems. Instead encourage homecoming personnel to pace themselves. The emphasis is to adapt these new behaviours and lessons to the home base.

Some things to Remember

"Whilst flight delays and a day or two of decompression to get back from theatre to their home base is part and parcel of coming home, is not the same as homecoming."

"Most people in relationships spend some time away from each other. Whilst it's likely that service personnel spend more time away from their loved ones than most, there is lots of scientific evidence which shows that healthy relationships are likely to fare fine….well as long as the period of separation is not overly excessive. The Army's guidance is that for most personnel, they should not spend more than 1 year away on operations in every 3. This level of separation has not been found to be detrimental for most. However, relationships that were having serious problems before separations don't necessarily do as well. If you think you fit this category perhaps discussing what was difficult the last time early may help"

"Whilst the majority of both their behaviour and yours will not have changed…some things will have done. Remember that difficulties and irritating elements of the SP's behaviour and habits won't always have been cured on deployment. Although it may be that you have forgotten about them whilst they were away, don't be surprised that they are still there now they are back."

"It's likely that you have changed too, household tasks, financial matters perhaps even your looks. You may need to, slowly, adapt some of the changes you have made, and perhaps now enjoy, to allow 'normality' to happen."

"If you left any difficult decisions on hold whilst your loved ones were gone these will still need to be dealt with. However it is recommended to hold off on dealing with them straight away unless you really have to. Remember that welfare support is there for you throughout the deployment and should be accessed if needed, both before and after. Where you can, it's best to face the adaptations that everyone will have to make together, talk about it."

9. **Possible Emotions and Behaviours**. Families should be mindful that homecoming should be seen as a process where all concerned (SP, Family, Friends, colleagues, particularly the Rear Ops Group) will take time to adapt to. Personnel whilst deployed often have to keep close control over their emotions. When bad things happen, it's important to keep a check on feelings in order to focus on getting the job done. Controlling emotions works and is helpful. Similarly, when in theatre, reacting to a threat such as hitting the deck is often a positive thing and forms part of the 'Battle-mind'. Families should be advised not to be surprised that when people come home, they may still be jumpy for a while, and a bit more aware of everyday risks (such as nearby vehicles or deserted alleyways) for a while.

"Homecoming service personnel may also sometimes feel unneeded…you are likely to have successfully found a way to deal with all the bits and pieces that your loved one used to do…even the boring tasks. Sometimes, it may seem a little crazy to you that your loved ones 'miss' doing these often tedious tasks."

"It takes time to let that control go (we call the is the 'Battlemind') …often anger or irritability are the first emotions that come back….as can be sadness, including grief,…don't be too concerned about your loved ones showing some strong emotions, even shedding a tear or getting upset…these sort of emotions usually work themselves out and settle…if they want to talk about it, and by all means very gently encourage them to do so, that's fine…but sometimes they may just need some time out. Try not to be too concerned at first as long as nothing serious is happening or about to happen."

"Similarly, It can take time to 'unlearn' the skills that keep people safe when they are away. You should try not to be overly concerned about seeing your loved one jump…it may simply be a sign that he or she had properly learnt the necessary skills to have kept them safe when they were in theatre. But slowly allowing the homecoming service person to get back into their usual (positive) ways can help."

"You may also find your own emotions, and those of the rest of your family, being a little more fragile than normal too. Having looked forward to seeing your loved one come home, you may find yourself resenting the stories they tell you about 'how it was out there' or you may simply resent them simply walking back into your life without seeming to realise what you have also been through."

"You might also be fearful about why your loved one appears to be different to they way they were before they went away or perhaps angry at what the Armed Forces have done to him or her."

"Sometimes people have noticed children can be grumpy, stand-offish or just more difficult than you are used to. If you are a parent, you may wish to discuss any childcare issues or events with your returning service person so that they can be aware and adapt to changes. "

10. The key message is to reassure families and loved ones and to expect that whatever 'negative' emotions or behaviours that they or the SP experience at first are likely to settle within a few weeks or so. This may concern many of the audience, however it's very fair to say, many people experience the excitement and joy during the homecoming process with no problems at all.

"The Key is to try to take things easy. At first being home can be a bit of an emotional pendulum for the whole family…all good….all bad…..all good…all bad…slowly the pendulum will settle and most people get back to normal…it just takes a bit of time and patience."

11. **When and Where to Get help - Coping with difficult emotions**. Planning the big events soon after the homecoming period starts is fraught with difficulty for both parties. Encourage SP and their loved ones to arrange these some time (a few days) after the immediate reunion period. It is important to impress on the audience the importance of positive communication. Returning SP often won't discuss some of the more difficult thoughts and feelings and may take a considerable amount of time to do so. It is also normal that they will want to talk to their colleagues. Often active discussion and listening (but not pressing) can help with this. The Army Families Guide to deployment has further detailed advice for the situations below for both Regular and reserve personnel.

Some tips about better ways of coping

"Take it slowly. Don't arrange the holiday, homecoming party and his or her family to arrive at the house on their first day back. Let the family come back together slowly. Don't expect everything to be as it was, or even better, straight away. Be confident that although some things will invariably be different, for most people this will become the norm very quickly and the service persons (and your own) personalities will begin to come through."

"Talk…talk some more and then talk some more. Remember to talk in the same proportion as the proportion of ears to mouths…twice as much listening as talking (which allows for a bit of silence too). Returning service personnel often won't want to tell you everything at once and some of the more difficult stuff may take a considerable amount of time too. It's likely that they will want to talk to their mates who they have been serving with too…try not to be too resentful about them doing so some of the time…remember they have been through a lot…they will open up to you (with gentle encouragement) but it may take time."

"Should your partner tells you something that is quite unpleasant…try your best not to judge them or their colleagues. Simply listening and reassuring them that they did their best (remember one's best in a war zone may be very different to what one's best may be in other situations) and accepting their words can often help."

"Should your partner or relative not be doing well over the week's ahead, try your best to encourage them to talk to anyone they feel they can trust…we will give you some examples of where they might seek help later in this presentation. If they feel more comfortable talking to a mate or a medic or padre …especially at first, try to encourage them to do so."

"You cannot force your loved ones to speak…what you can do though is create an opportunity for them to do so…and not to be too worried if they don't tell you too much about their experiences…especially at first."

" DO….

- ***Try to plan for everyone in the family to get some 1:1 time with the homecoming service person. Don't rush it, but planning opportunity for spending some 'quality time' during the first few weeks is a great idea.***

- ***Try not to force the visits to relatives or friends or to those that involve a great deal of travel and preparation.***

- ***Remember not only will your loved ones have been through a lot out there…it's likely they will be physically as well as mentally tired (even if they wont admit it). And of course being overly tired does not make for the best environments to rekindle relationships. "***

"DO NOT….

- ***If something's not right….it's fine to leave it for a bit…but not for ever. Do try and gently ask what's up or go for a stroll or otherwise create an opportunity for them to open up a little…either to you or to someone else they might talk to. If you are feeling angry or resentful….then speak to someone about it too…try and get another person's point of view…don't just cross your fingers and hope it will all get better. If your loved one is being highly unreasonable…then gently but firmly tell them so.***

- ***If your loved one is not performing very well…in any respect…then try not to put them down…instead try and encourage whatever they are doing that is good rather criticising what's not so good.***

- ***Remember also, that your world now is one of homecoming…you are in a process…sometimes one that goes slower than you would like….but as long as the general direction is right….then remember the pendulum swinging from good to bad…and back…in most cases it will settle into a normal rhythm…whatever that might be for you."***

Annex I to
LFSO 3209
Dated Apr 14

GUIDANCE ON USING JPA FOR THE RECORDING OF POSM ACTIVITY

1. POSM activity is to be captured on the JPA OSM record as soon after the event as possible. The following table illustrates POSM activities that are to be recorded.

2. The right of the table shows existing OSM headings on JPA which POSM activity is to be recorded against and where responsibility lies.

POSM	JPA – Operational Stress Management (OSM)	Responsibility for Input			
		Regular	Regular Reserve	Reserve	IA (OCE)
Open Record		Unit	Host Unit	Unit/Host Unit	Host Unit
Stage 0 – Pre-Deployment Briefing during OPTAG*	Stage 1 – Pre-Deployment – Briefing	Unit	Host Unit	Unit/Host Unit	Host Unit
	Stage 1 – Pre – Deployment RAF Interview				
	Stage 2 – Deployment – Coming Home Brief				
Stage 1 - Decompression	Stage 2 – Deployment – Decompression	Unit	Host Unit	Host Unit	Host Unit
Stage 2 – Normalisation – 2-5 days in barracks	Stage 3 – Post Deployment – Dismounting Course	Unit	RTMC/ Host Unit	RTMC/ Host Unit	Host Unit
	Stage 3 – Post Deployment – Interview				
	Stage 3 – Post Deployment – RAF station Recall				
Stage 3 – In Service Support – 6-12 week brief	Stage 3 – Post Deployment – Subsequent Interview	Unit	MS Reserves	Reserve Unit	New Unit
Close Record		Unit	MS Reserves	Reserve Unit	New Unit

*** Units/RTMC will undoubtedly give their own brief. The OPTAG brief will ensure that all individuals have been briefed on the POSM process.**

3. A guide to inputting data onto the OSM record is at: http://www.ipublish.dii.r.mil.uk/nlapps/data/folders/JPA_Docs/IN908007.htm
Handy tips on how to raise the OSM report are at:
http://defenceintranet.diiweb.r.mil.uk/DefenceIntranet/Library/Army/BrowseDocumentCategories/InformationPolicyAndServices/InformationManagement/InformationManagementPolicyAndGuidance/SmicHandyTips.htm

Annex J to
LFSO 3209
Dated Apr 14

RECORD OF OPERATIONAL STRESS MANAGEMENT (OSM) SUPPORT RECEIVED

Personal Details			
Name:	Rank:	Service Number:	
Details of Operation			
Name of Op:	Start/Arrival Date:	Completion/Departure Date:	
Unit:	Donor Unit:	Receiving Unit	
Duties Held:	Details of In-Theatre Activity:		
Confirmation Signature: Name: Rank: Appointment: Date:			
Stage 0 – Pre-Deployment			
Briefing Undertaken: Yes ☐ No ☐	Location Where Conducted:	Dates (From/To):	
Confirmation Signature: Name: Rank: Appointment: Date:			
Stage 1 – Decompression			
Coming Home Brief Undertaken: Yes ☐ No ☐	Location Where Conducted:	Dates (From/To):	
Confirmation Signature: Name: Rank: Appointment: Date:			
Decompression Undertaken: Yes ☐ No ☐	Location Where Conducted:	Dates (From/To):	
Confirmation Signature: Name: Rank: Appointment: Date:			
Stage 2 – Normalisation			
In Receipt of FMED 1019 and 1020: Yes ☐ No ☐	Location Where Conducted:	Dates (From/To):	
Confirmation Signature: Name: Rank: Appointment: Date:			
Stage 3 - In-Service Support			
Post-deployment briefing (6 - 12 weeks after deployment).	Date Conducted:	Unit:	
Confirmation Signature: Name: Rank: Appointment: Date:			
Stage 4 – Aftercare			
Notes to be recorded on reverse.			
Stage 5 – JPA Entries Input			
JPA OSM Event Finalised on Date:			

This record is to be raised locally by the unit and retained in the Service Persons' AF B9999.

Annex K to
LFSO 3209
Dated Apr 14

DCMH AGREED POSM EXEMPTION FORM

Mental Health Liaison Team (RCDM) Inpatient Summary:

SURNAME:	**FORENAME(S):**
SEX: MALE FEMALE	DATE OF BIRTH:

DATE OF ARRIVAL:	**DATE OF DISCHARGE:**

RATE / RANK:	**SERVICE:**	REGULAR / RESERVIST / OTHER*
LENGTH OF SERVICE:	**OPERATIONAL TOURS:**	
LENGTH INTO TOUR AT P.O.I:		

SERVICE NUMBER:	**UNIT:**
UNIT ADDRESS:	**TRADE:**
HOME ADDRESS:	
CONTACT NUMBERS:	**CONTACT REMARKS:**

OP AREA:	NOT DEPLOYED	
COMBAT INJURY? YES	NO	OTHER ……..

RCDM MENTAL HEALTH TEAM INPUT.

POSM DELIVERED YES NO IF NOT, REASON WHY……

The Unit are directed to complete the POSM record on RTU: YES / NO
The POSM record has been closed and completed on JPA: YES / NO

LITERATURE PROVIDED TYPE: NO. OF CONTACTS:

DISTRIBUTION: SMO DMRC MHT DCMH…… RAO

COMPLETED BY: DESIGNATION:

SIGNATURE: DATE: