

CHAPTER 8

COMBAT STRESS CONTROL RESTORATION

8-1. Restoration of Battle Fatigue Casualties

a. Restoration. Restoration is the 1-to 3-day treatment of BF casualties at medical units which are as close to the BF casualties' units as their condition and the tactical situation allow. Restoration can be divided into first line (the furthest forward, with few staff, under very limiting and fluctuating conditions), second line (still limited, but with more expert staff and more predictability) and third line (performed at Echelon III or Echelon IV hospital).

b. Screening and Treatment. Adequate medical screening and treatment must be done in the supported units by organic medical platoons or by the supporting medical companies. The BF casualties who enter restoration should be only those HOLD and REFER cases who require continuous medical and/or mental health evaluation and observation for 24 hours or more. Although still on their unit roll, they are not available to that unit for even limited duty and are, therefore, true casualties. DUTY (mild) cases will have been returned to their small units and REST (moderate) cases sent to rest in their units' CSS elements.

c. Restoration Priority. Restoration usually has the fifth priority following consultation, reconstitution support, combat NP triage, and minimal essential stabilization. However, when true BF casualties are numerous, or when the tactical situation makes it difficult for forward units to manage DUTY and REST BF cases, the influx of BF cases may force restoration to take a temporarily higher priority.

(1) To the maximum extent possible, restoration should be increased. This means a lower priority for reconditioning and stabilization being restricted to the minimum

requirements for cases and unit safety while awaiting (and during) evacuation.

(2) To the greatest extent possible, preventive consultation, operational planning and RTD-related coordination must continue or the influx will worsen!

(3) Combat stress control personnel should be freed up for reconstitution support missions even if that means evacuating some BF casualties who appear likely to require disproportionate effort for restoration. Otherwise, more BF soldiers who could have recovered and returned to duty in their units will just add to the already great work load for restoration.

d. Categories of Restoration. Restoration can be categorized as first line, second line, or third line, depending on where it is provided. The three categories may also differ in duration of restoration which they usually provide. This is dependent on the level of specialized skill, experience, and knowledge of the providers.

8-2. Generic Tactics, Techniques, and Procedures of Restoration

a. Reprieve from Extreme Stress. Initial restoration begins at the most forward echelon where the label "REFER BF" can be changed to "HOLD." Normally, restoration facilities are part of (or collocate with) the clearing station of the supporting medical company.

(1) Criteria for when to hold cases for restoration were discussed under combat NP triage in Chapter 6.

(2) Restoration is not feasible at locations which are consistently under artillery.

air, or direct-fire attack, unless they are exceedingly well fortified and resistant to damage. However, safety on the modern deep battlefield is never complete; relative security is sufficient to provide restoration. If there is potential for attack, there should be reasonable cover and defensive position to provide a sense of relative safety to a jumpy combat soldier. A good work detail for recovering BF casualties is the digging, building, and camouflaging of these positions.

(3) Ideally, the location is still “within sound of the artillery,” that is, within the sounds of the distant booms or rumble that remind the soldier that comrades are still in battle. Other relatively distant noises, such as helicopters, aircraft taking off, or road traffic, are also acceptable provided they are not so noisy as to disrupt sleep.

(4) In addition, the location should not be one from which a move is likely within 24 (or 48) hours. If there is a significant possibility of a move, only those cases who can participate actively in the move with minimal supervision should be held for treatment at this location. Any time the unit is given a warning order to standby to displace, the CSC staff may have to conduct a quick sorting of the cases on hand. The staff uses more stringent combat NP triage criteria and sends to the next-line restoration facility all those who are not readily transportable with the team.

(5) The specific site of the restoration facility should be out of immediate (close) sight of the triage area. Battle fatigue casualties should not be able to see severely wounded soldiers come into the MTF. The expectant area or temporary morgue areas, when mass casualty situations occur, should also not be seen from the restoration facility. It may be close to, but ideally slightly separate from, the treatment area for RTD wounded and DNBI cases. However, these can merge if provision is made to stabilize overly dramatic cases elsewhere. Ideally, the restoration

area is close to the host unit’s field kitchen and other support facilities.

(6) Restoration facilities collocated with medical units in the BSAs and DSAs will often be restricted by the local commander from displaying the red cross on the grounds that it reveals the entire unit’s location. This is consistent with the principle of treating BF cases as “soldiers, not patients.” In the corps area, there is a greater chance that the medical unit will be allowed to display the red cross. The restoration (and/or reconditioning) facility leader will need guidance on whether to display the red cross or not. If the red cross is displayed, there is greater assurance of protection under the Geneva Conventions. For discussion of the issue of Geneva Conventions status and its limitations on CSC activities, see Appendix D.

b. Reassurance. Restoration begins after the initial combat NP triage evaluation described in Chapter 6. Immediate reassurance is given to BF soldiers,

(1) Tell them that they are temporarily joining the unit, not as patients, but as soldiers who need a couple days to recover from BF. Emphasize that BF is a normal response to extremely abnormal conditions and that rapid recovery is also normal.

(2) Orient the BF casualty to the program. Tell them that they will get plenty of food and beverages, good sleep, a chance to clean up, and light duties for 1 or 2 days (or at most, 3 days). By that time, they will have regained strength and confidence and will return to their unit.

(3) Reassure them (as much as you honestly can) about safety and what to do in the event of an attack or march order.

(4) Personal possessions are not taken away. These personal items remind the

soldiers of their normal lives and are a comfort in time of stress. The soldiers are expected to take care of their personal items. This applies even to knives or other weapons (with the exception of firearms), unless there is significant reason for concern that this soldier might harm himself or others. Soldiers for whom there is such concerns need stabilization and should be segregated, at least temporarily, from the restoration program.

(5) If the soldier arrives with a firearm, the weapon is secured by the medical company supply element. Ammunition, grenades, mines, or other explosives must also be collected and turned-in. The soldier should be told that this is the TSOP for all medical units. Tell the BF soldier that his weapon will be returned to him if he is assigned guard duty or if the medical unit is under the threat of an attack.

c. *Structured Military Environment.* Maintain a structured military chain of command. When the BF soldier is processed into the restoration program, he is received as a soldier performing temporary duty and not as a patient.

(1) Assign the BF casualty to a “squad” under supervision of a specific squad leader. At larger facilities, several squads may be organized into a platoon, under a platoon leader. In an extremely large restoration center, several platoons could be organized into a company. The squad leader may be a CSC unit or mental health section officer, NCO, or section member, or a member of the host medical unit’s patient-holding squad. In a pinch, a carefully selected line NCO with a minor wound or injury that temporarily prevents his RTD may be detailed as a squad leader. Ideally, each squad leader should not have more than 6 to 8 BF casualties to supervise. For brief peak periods, the squad leader may be assigned 10 to 12 BF casualties to manage.

(2) The soldier’s FMC (filled out during combat NP triage) is not kept attached to

the soldiers, but is kept at a central place until the soldier is ready to RTD or be evacuated.

(3) The initial interview and activities depend upon the symptoms of the BF casualty and the degree of physical/psychologic stress in relation to the cognitive/emotional stress. The attitude of the interviewer should be that of a good, caring leader. As a leader, he is getting to know the recent experience, background, and skills of a new soldier just assigned to his unit as a combat transfer, not as a therapist doing an intake interview.

- A BF casualty who is in good physiologic shape, but who clearly has much to talk about, should be encouraged to talk immediately.

- More often tending to and restoring physiologic status comes first. The order of priority varies with the nature of the deprivation.

(4) The newly arrived soldier is not assigned to a ward tent as a patient but rather to the squad’s quarters tent. In many situations, it will be appropriate and necessary for the squad leader(s) to sleep in the same tent with the team members. Ponchos or blankets can be hung to screen off areas where true patients are resting and to provide privacy.

d. *Replenishment of Physiologic Status.*

(1) Restore temperature regulation. Get the soldier under shelter and cool down if overheated, warm up if cold, dry off if wet.

(2) Replenish hydration with palatable beverages (cool if hot, warm or hot if cold).

- Soups are ideal as they are also foods.

- Milk, soft drinks, Kool-Aid, and fruit juices are good.

- Minimize caffeine-type stimulants in coffee, tea, or beverages, unless increased wakefulness is desired.

- Intravenous fluids may be used in exceptional cases when speed of dehydration is important. Effort is then required to reinforce the fact that the soldier is not a patient and that this is just routine.

(3) Replenish nutrition. Offer the best possible filling meal, preferably high in carbohydrates with some protein.

(a) A-rations from the host unit's field kitchen are best. Hot tray-packs (especially the noodles and potatoes tray) and even hot MREs are acceptable. If the latter are used, try to have some special seasonings or garnishes to increase variety and palatability. Break up and stir most tray-pack selections to normalize their texture and appearance, rather than serving them as a solid rectangular "brick."

(b) Since BF casualties may arrive at any time, day or night, a restoration facility must have means to quickly heat food. The minimum standard is a large pot of water ready to boil at all times. If the supporting field kitchen cannot provide this, CSC personnel should coordinate for other arrangements.

(c) If a BF casualty is too tired, anxious, or depressed to eat at first, provide an assigned area for sleeping. "Three hots and a cot" are essential throughout the period of restoration.

(4) Restore hygiene. Unless the soldier is totally exhausted and already falling asleep, institute some personal hygiene.

(a) Wash face and hands with wash cloth, warm/hot water and soap. The men shave with hot water, soap or lather, and sharp safety razors. This may extend to a partial or full sponge bath, if feasible. The restoration facility needs a supply of sundry packs plus a basin.

(b) Hot showers, if available. A quartermaster shower/bath unit may be present in a corps base defense cluster DSA or BSA. The shower point may be some walking or riding distance away, and scheduled hours of operations should be considered.

(c) In hot or temperate weather, CSC personnel (and/or the host medical unit) should set up a field shower.

- This could be an Australian shower bucket, a collapsing canvas bucket with nozzle. A shower could be improvised by perforating other large buckets or 55-gallon drums (see FM 21-10).

- The shower can be screened with poncho liners for privacy and given a wooden pallet "floor" above the water run-off. In cold weather, a tent with a heater would need to be dedicated to the shower.

- Hot water from the field kitchen or an alternate source is blended with cool water to give a suitable shower temperature. Dry, clean towels are also necessary, since most of the BF casualties will not bring their own.

- The hot shower is an excellent way for new arrivals to relax and unwind before sleep, if they are not already too exhausted, or if harsh weather does not make it too difficult. Otherwise, it can be an "event" or "duty activity" for subsequent restoration days.

(d) The importance of clean clothes (if available) depends on the condition of

(how wet, sweaty, filthy, bloody, or torn) the BF casualties' own battle-dress uniforms.

- In principle, BF casualties should remain in combat uniform which includes helmet and protective mask. Reasonably complete load bearing equipment (LBE) and clean uniforms are desirable. However, BF casualties do not need to be in uniform while sleeping, provided adequate sleeping gear (bedding) is available.

- A problem may arise because medical treatment companies, unlike hospitals, do not stock either patient pajamas (which BF casualties should not be given on principle), spare uniforms, or a large supply of sleeping bags. Nor do they have an organic laundry.

- Those personnel who are supervising BF casualties must work with the medical company's supply element to priority requisition necessary clothing, bedding, and equipment items through the supporting logistic element (the FSB, MSB, or area support battalion's S4). It may be necessary to improvise until required items are available. In the corps, the AG replacement company will issue RTD soldiers new clothing, as required,

- A field-improvised laundry (hot water pots and soap) plus patching and sewing repairs may also be a useful "work project" for the recovering BF casualty.

(5) Restorative sleep should be as normal as possible. Most BF casualties will fall asleep quickly with only strong positive reassurance that they will be safe, provided they have relative comfort compared to what they have been used to. It is important to minimize interruptions to sleep. As much as possible, ensure relative quietness (facilitated by dispo-

able earplugs) and darkness (perhaps facilitated by a cravat blindfold).

(a) Bedding may be on a cot, a ground pad, an air mattress, or field expedient hay, pine needles, or leaves. The quality of sleep is important, especially for the first night or two, so the shelter should be as comfortable as is practical and neither too cold nor too hot.

(b) The soldier should be told bad dreams will probably occur soon after he falls asleep and be reassured that they are normal and that he should go back to sleep if awakened.

(c) Muscle stretching routines, massage, and other simple relaxation techniques may help the tense or anxious soldier get to sleep. If available, audiotapes of relaxing background sounds can be played.

(d) Medication for sleep should not be used if food, a hot shower, or relaxation will do. However, BF casualties who are too tense, depressed, or frightened to sleep can be given just enough sleep medication to help them doze off. Possible sleep aids are—

- Diphenhydramine, a sedative antihistamine in most medication sets).

- Low-dose diazepam. A dosage of 2.5 or 5 mg may be administered. The trouble with diazepam is that it and its active metabolites are slowly cleared from the body. Their continued presence in the body and brain may interfere with motor coordination and task performance the next day. The persistence of some pharmacologic antianxiety effect may seem like an advantage, but it actually interferes with the treatment, which is based on helping the soldier master his own anxiety himself.

- Temazepam, if available. This has a biological half-life under 8

hours and should have no residual sedation, antianxiety, or motor skill deficit the next day.

- Triazolam (Halcion).

This sleep aid is even more rapidly cleared but has been reported to produce some memory problems, especially if sleep is interrupted. The person may appear to be normal, but does not remember his experiences later. Some people have difficulty in learning new information the following day.

(e) Antianxiety drugs should not be given routinely during restoration. In most cases, soldiers should not be medicated even with their anxiety. Unmedicated soldiers will be better able to participate actively in their own recovery and perform with appropriate capability if the facility comes under attack or must move.

(f) The duration of sleep should be sufficient to make substantial progress in repaying the sleep debt. It should also begin the process of restoring a reasonable sleep/wake cycle. The start time and wake-up time should be flexible but tend towards sleeping most of the night and being awake all day (or split shift, with sleep in the graveyard shift plus an afternoon nap). Initial sleep should be 8 to 12 plus hours.

e. *Support the Soldier's Military Identity.* Sustain the soldier's identity as a soldier.

(1) Maintain appropriate rank distinctions, titles, and military courtesies from the outset.

(2) Expect the soldier to maintain military bearing, personal appearance, uniform (to include LBE [with canteen, rolled poncho, and first-aid dressing pack as a minimum]), protective mask, and helmet when outdoors unless under special circumstances.

(3) Conduct basic soldiering skills. See FM 8-10 and Appendix D for the limitation of the Geneva Sick and Wounded Convention regarding who may teach what to whom.

f. *Structure Activities During Unit Formations.* Provide structure to the day's activities through regular group formations.

(1) Regularly scheduled formations provide occasions to announce the day's schedule of activities, assign tasks/details to each squad leader, introduce new members, and allow participation by BF casualties in planning how to carry out the assigned activities.

(2) The leaders keep everyone informed by briefings on the "big picture" and tactical situation, with special attention to the activities of the BF casualties' units of origin. Obtain and circulate command information fact sheets and newspapers. Radio and/or television may be available in the theater which are good sources for information.

g. *Assign Duties and Work Details.*

(1) Assign militarily relevant work details at the MTF, preferably to pairs or groups which include BF casualties and non-BF casualties. Examples include—

- Digging foxholes and slit trenches.
- Filling sandbags.
- Erecting and garnishing camouflage when permitted.
- Providing perimeter guard or air watch.
- Performing vehicle preventive maintenance or repair.

- Cleaning equipment.

Work activities must be coordinated with appropriate commanders and subordinates well in advance of casualty flow.

(2) Other obviously relevant and necessary work details include assisting with food preparation and food service at the supporting field kitchen. Battle-fatigue casualties may be used for loading, unloading, and moving supplies. Repairing clothing and equipment, operating the field expedient shower, and improving or making a new latrine are additional appropriate work details. Assisting with the care and movement of other minor wounded and ill may be done and is especially indicated for BF medical personnel. However, these and other duties must not expose the BF soldiers to the critically injured or those awaiting treatment (except for those medics who are in the final stage of recovery just before RTD).

(3) Tasks and work details are assigned according to the status and needs of each case.

(a) Some BF casualties need heavy physical activity to work off energy and complete the unfinished stress-release process. They should be given tools which make this satisfying. Give them shovels and picks that can really move dirt and show accomplishment in minutes, not little entrenching tools that just scratch away at the surface.

NOTE

Soldiers who may be violent or unstable should not be given tools which could be used to harm themselves or others.

(b) Other BF casualties who are already physically drained need light duties

that keep them moving and flexible while they recover strength.

(c) Tasks should be chosen to exercise relevant manual and cognitive skills and to ensure a successful and satisfying performance.

(d) Utilize soldiers' skills to teach each other.

h. Schedule Relaxing Activities. Provide enjoyable, relaxing activity.

(1) Provide physical training and ensure all are involved in an exercise program.

(2) Organize cooperative/competitive physical team games (involving BF casualties and non-BF casualties). Examples include relay or cross-country races; tug-of-war; touch football, volleyball, or soccer (using a real or improvised ball); softball; or stick ball. These games should be short, vigorous, and balanced with rest and replenishment, as well as the work details.

(3) Organize cooperative/competitive mental games for teams or pairs of soldiers. These include card games or board games like chess and checkers.

(4) Equipment for the physical and mental games can be brought from home upon deployment. Equipment may be mailed by friends and family on request. The equipment may be obtained from the morale/welfare/recreation set or purchased from host nation retailers. Some of the equipment for games may be constructed out of otherwise worthless trash as an individual or team project.

(5) Teach relaxation techniques in group relaxation sessions in which the mental health/CSC person talks everyone through the technique.

i. Debriefing, Ventilation, and Counseling. Mental health/CSC personnel (or medics trained by mental health/CSC personnel) provide individual or small group discussion and counseling.

(1) Formal critical event debriefing or ventilation is not usually done in large formations or group activities during brief restoration. The turnover is too rapid to form highly supportive relationships and a clear therapeutic mind-set. Instead, the tendency is for the high percentage of new BF casualties (all of whom have had different bad experiences and who are strangers to the group and to each other) to amplify rather than resolve the distress. When the group begins to move in this direction, the leader reassures the distressed soldiers that he will talk with them later and redirects the group's attention to the next scheduled activity.

(2) After each new arrival has settled in, he is interviewed in detail by the assigned squad leader and/or by the mental health/CSC supervisor or consultant. This interview reviews exactly what happened to bring the soldier here. The focus is on recent events in the soldier's unit or back home rather than on the remote past.

(3) The process is similar to after-action or critical event debriefings. As the details are described, the feelings naturally come out or, at least, show enough signs that they can be reflected and validated as honest and normal. The counselor works patiently to get all the facts and feelings out, then subtly helps to put them into a perspective that reinforces their normality in the combat context. The counselor leads the soldier to seeing how to handle the same or other crisis should a similar situation recur.

(4) The counselor may bring one, two, or more other recovering BF casualties together to talk with the new arrival. This is

based on the counselor's understanding of the soldiers' common experiences and the way they are coping with them. These small, focused groups can often confirm the message of normal, shared experiences better than the counselor can by himself.

(5) As BF casualties recover, the counseling process shifts towards how recovering BF casualties can return to their small units and be accepted there. The counselor must work with the CSC coordinator or other resources (such as the unit chaplains) who can assist this reintegration. Ways to coordinate and facilitate RTD were discussed in Chapter 4.

8-3. First-Line Restoration

a. First-Line Restoration in the Division. In the division, first-line restoration is usually provided at the FSMC. It is provided by personnel organic to the FSMC, usually assisted and supervised by mental health officers and NCOs from the division mental health section. The combat stress preventive teams from corps-level CSC units may also assist and supervise restoration at the FSMC (See Chapters 2 and 3).

(1) The FSMC is usually located in the BSA which is 25 to 30 kilometers behind the forward line of own troops (FLOT) so that it is just beyond the range of the enemy's main artillery support, however, not beyond range of longer-range tube and rocket artillery, air attack, or forces for special operations.

(2) Depending on the tactical situation, the BSA may have to displace forward or rearward as part of the scheme of maneuver, or have to displace very hastily to escape persistent bombardment or an enemy probe or breakthrough.

(3) For these reasons, restoration in the BSA will often be limited to 2 days or even

1 day, or may have to be temporarily suspended. At other times, when the brigade is being held in reserve, 3 days may be feasible.

(4) In OOTW (conflict), the FSMC may be located at a relatively large and secure fire base or base cluster. Since each scenario is situationally dependent, the command surgeon will establish holding times for first-line restoration.

b. Separate Brigades or Armored Cavalry Regiments. In separate brigades or ACR, first-line restoration should usually be provided at the medical company, separate brigade or at the medical troop, ACR. It is provided by personnel organic to the FSMC, perhaps assisted and supervised by a combat stress preventive team from a corps-level CSC unit.

(1) In many scenarios, the separate brigade (or regiment) may be in action similar to that of divisional brigades. Its medical company in the BSA would share the same types of difficulties as the division's FSMCs.

(2) In other scenarios, the brigade/regiment may be in division or corps reserve. It may also be engaged in rear battle against forces which lack the long-range artillery capability of the enemy's main force, but may be more likely to infiltrate and harass. The squadrons of an ACR may also be highly dispersed far from the regimental medical troop. They may be supported by the organic medical platoon. This squadron may depend on corps ASMCs for its Echelon II medical care, including CSC.

c. Corps and Communications Zone First-Line Restoration. For CS and CSS units in the corps or COMMZ, first-line restoration should be provided by ASMCs with responsibility for their AO. It is provided by personnel organic to the ASMC, assisted and supervised by NCOs and

perhaps a mental health officer from the ASMB mental health section (see Section II of Chapter 3). If there are large numbers of BF casualties, the ASMCs could also be reinforced by a team from a corps CSC unit.

(1) The ASMC has a holding capacity of 40 cots.

(2) The corps area is likely to be free from artillery attack, except for large, long-range rockets or the smaller rockets or mortars of infiltrating unconventional forces. Air attack is still possible.

(3) Corps ASMCs will be relatively unlikely to have to move on short notice except potentially in rear battle situations. Restoration up to 3 days (and even to 4 days) should usually be feasible.

(4) Those ASMCs in the COMMZ should be even safer and more stable than those in the corps, except in the theater NBC environment. However, they are also vulnerable to rear battle situations.

d. Medical Company Restoration Support. Support provided for restoration is a responsibility of the supporting medical companies.

NOTE

Combat stress control teams bring specialized skills and perhaps some supplies to help with their critical RTD mission, but do not relieve the local medical commanders of their ultimate responsibility.

(1) When total casualties are light, patient-holding squad elements in division- and

corps-level medical companies provide resources where BF casualties can be rested, fed, and restored. The patient-holding squad personnel (two 91Cs and two 91Bs) serve as treaters. Ideally, the treatment will be under the technical supervision of the mental health section or CSC team personnel.

(2) The holding squad will have two GP medium or large tents with up to 40 cots. When there are few patients, the second tent can be the "rest tent" for HOLD BF casualties and other minor DNBI. The first tent remains ready to receive new arrivals, some of whom may be seriously injured. At some times, of course, the company commander may decide to keep one tent packed on the truck, ready to "jump" if a move is ordered.

(3) Those BF casualties whose symptoms are not dramatic (primarily those showing extreme fatigue, other normal/common "psychosomatic" symptoms, and simple memory loss which could also be due to concussion and therefore require a period of medical observation) can be mixed in with the minimally wounded and minor DNBI cases. Recovering BF casualties whose more dramatic symptoms have improved can also be billeted with true "patients" as long as their imminent RTD is emphasized. Selectivity may be required to ensure they do not "catch" the symptoms of the disease patients, either through true infection or unconscious imitation.

(4) Those cases who are showing more dramatic symptoms of anxiety, depression, physical disability, memory loss, or gross disorganization can be quartered temporarily in a separate tent or expedient shelter. These patients are under the observation of trained medical or CSC personnel. If sufficient shelter is not available for these BF casualties, evacuation to a second-line restoration facility is required. If transported by nonmedical vehicle, an attendant must accompany these BF casualties.

(5) The medical unit's holding resources are available only when WIA and DNBI rates are low. Battle-fatigue rates rise in direct proportion to the intensity of combat (as reflected in the WIA rate). It will be at times of such heavy fighting, when the holding assets are preempted for emergency medical and minor surgical care, that it is most important to restore BF casualties close to their units. At other times, mini-epidemics of gastrointestinal, upper respiratory, or other infectious diseases may fill the holding cots to the exclusion of BF casualties. That BF casualties are moved out into "expedient shelters" to make way for true patients is, of course, consistent with the message of treatment that they themselves are "not sick." However, if weather is inclement and no "expedient shelter" is available, these soldiers are evacuated to a second-line restoration center unless assets are hastily sent forward and set up for them.

(6) Obviously the medical company's patient-holding resources cannot be relied upon for consistent first- or second-line CSC support at times of mass casualties. The organic mental health sections in the divisions or in the ASMB in the corps are without BF casualty-holding capability of their own. If restoration is still to continue to return the BF casualties to duty quickly, reinforcing CSC teams must bring sufficient assets. This includes lightweight/low-cube tentage, working tools, and means to heat water to be able to provide the very basic shelter, food, and hygiene which are the minimum essentials for treatment.

8-4. Second-Line Restoration (Fatigue Center)

a . Location of Second-Line Restoration. Each of the forward locations listed above should be backed up by a second-line restoration capability at a location which is relatively less likely

to have to move on short notice. It should have sufficient NP/mental health staff expertise to manage the more problematic cases. These may include clinical psychology, psychiatric nursing, and OT, in addition to social work and psychiatry. The facility should be able to hold these cases for 3 days and conduct a stable, well-organized "fatigue center." Fatigue centers may be located at the MSMC in the division or at the HSC of an ASMB (in the corps or COMMZ).

b. Fatigue Center. The name "fatigue center" is suggested for this facility for two reasons. First, it is a central place where fatigued soldiers are sent to rest and recover their strength. Second, it does not sound too attractive—not as attractive and desirable as a rest center. While there, the soldier will be assigned to work details which can be tiring and not especially fun.

c. Cases Received at the Fatigue Center. The fatigue center receives all REFER BF cases who must be evacuated from the first-line medical companies. Many of these cases may be sent back for purely tactical reasons, but others are evacuated because their symptoms are too dramatic or unstable to manage so close to the battle. Other soldiers requiring restoration may come from nearby units in rear battle.

NOTE

Transportation of BF casualties from BSA to DSA or from ASMC to the ASMB's HSC will be an exception to the usual flow of WIA from the site of initial stabilization directly to hospitals in the corps. For this reason, transportation of BF casualties requires special attention and should be in nonambulance vehicles, if possible.

d. Restoration Techniques. The techniques of restoration at the fatigue center are essentially the same as at the more forward locations. The number of cases at any one time is likely to be larger since they may be coming from several forward MTFs and staying longer (up to 3 days). Dealing with the more symptomatic soldiers will also require more interview and treatment skills.

e. Neuropsychiatric Disorders. Some of the soldiers sent back from the first-line medical companies will prove to have true NP disorders which require further evacuation to a corps hospital. The second-line fatigue center, therefore, needs to have a neuropsychiatrically trained physician or psychiatric clinical nurse specialist to provide stabilization capability.

f. Reinforcement by Combat Stress Control Teams. Combat stress control teams which reinforce to setup a "fatigue center" should bring sufficient tents and equipment to provide formal "holding" for 20 to 40 BF casualties. This can then provide basic shelter" for up to twice that number in the event of a mass casualty situation.

8-5. Third-Line Restoration

a. Operating a Fatigue Center at an Echelon III or Echelon IV Hospital. In some scenarios, units with soldiers in need of restoration may be significantly closer to a CSH in the corps and a FH or a GH in the COMMZ than to any of the ASMB's medical companies. In such cases, the principles of immediacy and proximity justify conducting a restoration program (fatigue center) at the hospital.

(1) Staffing would be as an additional duty to the NP ward, the consultation service, and the MCWs. These personnel could

be reinforced by teams from the medical company, CSC.

(2) If a task-organized CSC element from the corps medical company, CSC collocated with the CSH (usually to staff a reconditioning program as described in Chapter 9), it could also provide restoration.

b. Considerations for Restoration at a Hospital.

(1) The threat to a CSH is similar as to the ASMB. The CSH can move only after much preparation with external assistance.

(2) Restoration at a CSH must be kept clearly separate from the NP ward and ideally from the MCW. It should also be separate from any reconditioning (14 day) program.

8-6. Return to Duty or Further Referral of Restoration Cases

Battle-fatigue symptoms do not necessarily improve completely while the prospect of combat continues. The positive expectancy is for RTD of the soldier with sufficient confidence that he can do his job. It does not require that the soldier feels happy, sad, or frighten about his situation. The soldier's condition may continue as post-traumatic stress symptoms, if not necessarily as PTSDs. The symptoms/disorders may occur after the war is over and the soldier has returned home. Most BF casualties in restoration are ready to RTD when they have regained sufficient confidence in themselves and their symptoms have returned to the range of the "normal/common signs." These normal/common signs are outlined in Graphic Training Aid (GTA) 21-3-4. Every reasonable effort should be made to send these soldiers back to their original unit.

a. Recovered Soldiers in the Brigade Support Area. Recovered cases from units that

are present in the same BSA are returned directly to their units. For example, a soldier from an infantry company can return through his infantry headquarters and headquarters company, whose field trains are part of the BSA. The medical company patient administration specialist notifies the unit (or equivalent) to send someone to get the soldier.

(1) Consultation by the CSC team with leaders of the BF casualty's parent unit facilitates the recovered soldier's acceptance and transportation back to his unit. Some special cases may require reassignment to another unit which is coordinated through the recovered soldier's battalion S1.

(2) This soldier has been kept on the rolls by his unit during the 1 to 3 days duration of treatment. The summary of treatment for medical statistical purposes is captured by carding for record only, utilizing the FMC. Care provided to this soldier will be considered outpatient treatment and any documentation will be done on the FMC. A copy of the FMC is sent back to the major MEDCOM in the TO upon release of the soldier.

b. Recovered Soldiers in the Division Rear. Recovered BF soldiers who have completed restoration treatment in the DSA are returned to duty by contacting the division personnel replacement company. If the soldier's unit is in the DSA, his unit is called. Coordination for return of the soldier to his original unit or for reassignment to a new unit is accomplished through the G1 section. Direct consultation with the forward area unit receiving the recovered BF soldier is coordinated with the forward deployed CSC personnel supporting the unit's AO.

c. Recovered Soldiers in the Corps. Return to duty of recovered BF soldiers in the corps depends on where they received their treatment. If an ASMC provided the treatment,

then the ASMC calls the soldier's unit to provide transportation. If the recovered soldier was evacuated to the HSC of the ASMB for restoration, his RTD must be coordinated. The RTD of these soldiers may be complicated because there may not be a routine means of transporting personnel between the remote base defense clusters. Either the soldier's unit must come the distance to collect him or other transportation must be coordinated. Alternatively, he may be returned to his unit by way of the personnel replacement company. Maintaining accountability for such cases is crucial—otherwise, they get lost in the medical evacuation or transportation system and no one knows where they are.

d. Completing the Recovery. Some cases in restoration do not improve sufficiently in 3 days to be ready to return to their units and full duty. The cases which are making progress may need additional time to complete the recovery. Some may need only another 1 to 3 days, which need not be spent under full-time medical or mental health/CSC care. Soldiers who require only 1 to 3 days of additional rest for full recovery may be placed in their units' CSS trains as REST BF cases. The CSS trains in the BSA, at a DISCOM unit in the DSA, or in a corps support

command unit in the corps could be used. This must be coordinated with the soldier's unit prior to his disposition.

e. Referral to Reconditioning. Those who need further mental health/CSC professional treatment are temporarily reclassified as having "REFER" BF and are sent to the supporting reconditioning program, if one is available. This movement should not be called an evacuation. It should be done without much fanfare (so as not to attract the attention of newly arrived BF casualties). The preferred method of sending the REFER BF casualty is by ground, not air, and in a GP vehicle, not an ambulance. If ambulances must be used, these REFER BF casualties should go as ambulatory (not litter) cases.

f. Referral to Hospital. A few cases may be identified by the division or other psychiatrists as having an NP disorder which requires evacuation to a hospital. These may go by ground (or air) ambulance as litter patients.

g. Referral for Administrative Actions. A few cases may be identified as malingerers who do not respond to counseling and refuse to RTD. They are turned over to their parent unit for administrative disposition.