D.H.S.
Pyschiatric Battle Casualties

Further to conversation Brig C.P. Fenwick - Col. E.N. vec. Kostrans, 3 April 44.

1. We are in agreement regarding the following points of policy.

(a) Psychiatric diagnosis must not be permitted to provide an easy and honourable escape for the soldier who has no disability except lack of moral fibre (guts).

(b) The maintenance of morale and prevention of psychiatric battle casualties are essentially the responsibility of the combatant officer and the unit M.O., but the Field neuropsychiatrist will act in an advisory capacity.

(c) The early recognition, initial treatment and triage are the responsibility of the F.E.O.'s and the I.O.'s of Field Ambulances, F.D.3's, C.C.3's and General Hospitals. (Approximately 2% of the routine admissions to General Hospitals in the theatre of war have psychiatric disability).

(d) Definite diagnosis (exhaustion is not a definitive diagnosis), prolonged treatment and recommendation of change of medical category are the responsibility of the neuropsychiatric specialist.

(e) The term "Exhaustion" should be used in forward area until definitive diagnosis can be made by observation by competent medical authority.

(f) Since we have ample evidence that the early adequate treatment of N.P. battle casualties results in the return to duty of at least 50% of patients, whereas there is very little salvage of this type of case in General Hospitals and Base Psychiatric Centres, mild cases and in particular cases of "Exhaustion" must not be evacuated beyond Corps level until it has been proven that routine treatment by rest, sedatives and psychotherapy are ineffective.

(g) Primary triage should be carried out as far forward as possible so that frankly psychotic patients and chronic psychoneurotics do not encumber Divisional or Corps units.

2. The American, British and Canadian Medical Services are agreed that primary triage and the initiation of treatment should take place as early as possible, but there is slight difference of opinion as to where it is practical to first retain psychiatric patients. (See Appendix 'A').

The treatment of psychiatric battle casualties in forward area must depend on the organization of the force and on the tactical situation.

Although in theory the retention of "Exhaustion" cases at unit or Field Ambulance level is ideal, it is pointed out that the current battle fronts in Italy are relatively static and it cannot be assumed that similar conditions will obtain in a new theatre of war, except for short periods. It is my opinion that in present planning, the most forward centre for the retention of psychiatric battle casualties should be in Corps area and that this Exhaustion Centre (Corps Medical Centre, Corps Rest Station or what have you) should be
operated by a Corps Medical Unit with the addition of personnel specially trained in the treatment of mental disease. In continental base area there must be base Psychiatric Centres and/or special psychiatric hospitals for cases requiring long treatment and for the retention of psychotic patients pending evacuation to U.K. As the L. of C. lengthens, it is necessary to fill in the gap between Corps Exhaustion Centre and Base Psychiatric Centre. The R.A.M.C. have done this in Italy by forming advanced psychiatric wings of 100 - 200 beds functioning as expansions of the more forward 600 bed General Hospitals. Lieut. Col. M'Keith advises 200 such beds for every four divisions.

3. In a combined Canadian and British force, it is obvious that our psychiatric organization should follow as closely as is practical that of the British Army. Slight variations are necessary because of the size and composition of the Canadian Force, e.g. a 600 bed base psychiatric hospital is only economical when it serves a force of 300,000 or more.

4. In view of the above considerations, it is recommended that in a Canadian expeditionary force of one Corps or more the following organizations should be set up:-

(a) One Exhaustion Centre per Corps, similar to that of the British Army. The field medical unit most suitable is a Corps Field Dressing Station.

(b) In lieu of the British advanced psychiatric wing, if and when the length of the L. of C. warrants it, it is recommended that in one or more of the appropriately situated General Hospitals, a block of 50 beds be designated for psychiatric patients and that a Neuropsychiatric Specialist be placed in charge of them. It is not recommended that this be an increment, but will be part of the Medical Division of the Hospital. The Specialist will require the assistance of one of the Junior General Duty Officers of the Medical Division.

(c) As an increment to one of the General Hospitals in base area, there should be a Base Psychiatric Centre similar to the one now functioning with 14 C.G.H. This necessitates a special War Establishment of specially qualified officers, N/S's and O/R's.


We are unable to predict the incidence of psychiatric disease during any battle, but we are able to predict that in a campaign of modern warfare, psychiatric battle casualties will form from 10% - 15% of all battle casualties. Psychiatric battle casualties bear no close relationship to total casualties during a campaign, because of the occurrence of epidemics such as malaria, dysentery, epidemic jaundice, etc.

In the Mediterranean theatre of war, the R.A.M.C. consider that 2 psychiatric beds are required for every 1,000 troops. After visiting British Base Psychiatric Hospitals and Centres, it is my opinion that this is inadequate. It is, therefore, suggested that our present planning be based on 2.5 - 3 beds per 1,000 troops. This does not include those in Corps Exhaustion Centres.


Since the above was written, I have talked with
Pte. Senior Psychiatrist British Army, Brigadier Sandford, Director of Psychological Medicine, and Lieut. Col. Pain, Psychiatrist Adviser to 21 Army Group.

(a) We are agreed regarding forward area treatment. The key will be the Exhaustion Centre in Corps areas and the retention of cases in Unit or Divisional areas will only be attempted under exceptional circumstances.

(b) The attachment of psychiatrists to a Corps on the basis of one per Division is much preferable to one per Corps. The only reason that the British have not done this is because of the shortage of specialist Specialists. It is agreed that these should not be divisional troops but should come under the direction of D.D.M.S. Corps.

(c) Lieut. Col. Pain's criticism of the proposed Canadian organization is that psychiatric casualties should be completely separated from the sick and wounded. Therefore there should be an Advance Psychiatric Wing as a separate unit and in practice there should be two lines of evacuation of casualties from forward area to base.

Although the advantages of having a separate advance psychiatric wing are obvious, it is my opinion that these are offset by two factors.

(i) Many of the psychiatric cases who have psychosomatic symptoms require investigation which can only be carried out in a General Hospital, e.g. C.I. Series to rule out peptic ulcer.

(ii) In spite of forward area screening, many psychiatric cases will still be admitted to General Hospitals because their symptoms suggest disease or injury. Therefore, my recommendations set out in para 4 (b) still stand.

(d) Patients who have recovered after treatment at the Corps Exhaustion Centre should be returned to their former units by the shortest possible route. If they are evacuated to a Base Reinforcement Depot even for one day, there will be increased wastage of man power.

(e) The organization for the treatment of neuropsychiatric casualties in the theatre of war should be kept as flexible as possible. We are in a position to do this because in addition to the Neuropsychiatrists attached to Divisions, each General Hospital sent abroad has on the staff of its Medical Division at least one M.O. who has had special training in neuropsychiatry.

7. Field Neuropsychiatrists. Since the work of the Field Neuropsychiatrist is primarily the prevention of psychiatric casualties, it is necessary for him to frequently visit all units in his area and to submit reports on out patients referred to him by Regimental and Field Ambulance F.O.'s. He therefore requires one clerk, a batman driver, a typewriter and a vehicle.

8. Corps "Exhaustion Centre". There has been much discussion regarding the minimum requirements for establishment of a Corps Exhaustion Centre.

(Over)
(a) Major A.F. Doyle, RCMC, C.M., states:

"The following is suggested as the minimum requirements for establishment of Corps Exhaustion Centre:

Personnel:

Psychiatrist - Specialist, RCMC
Assistant Psychiatrist (or Gen. duties M.O.)
Sergeant, M.O., RCMC
Corporal, L.M.O., RCMC
Private, M.O., RCMC
Sergeant Clerk, RCMC
Driver Batman

Lieut. Col. MacKeith, RMC, C.M., recommends a similar establishment with one 30 cwt truck and one jeep. This type of establishment would appear to be ideal. It is mobile, carries its own specially trained personnel and a small amount of technical equipment, can be attached to any unit which admits and treats patients and can function immediately after moving.

(b) A Corps Medical Unit, preferably Corps FDO or part of one, can operate an Exhaustion Centre without any change in War Establishment, but for efficient operation, one L.C. at least one FGO and 4 Ptes. should be trained in the treatment of psychiatric patients.

It is not economical for a unit of this size to operate only an Exhaustion Centre of 50 - 120 beds. If it can be assumed that this Corps FDO will remain in Corps area for the treatment of minor sick and wounded and/or operating V.D. Centre, Corps Rest Station etc., it is recommended that it also operate the Corps Exhaustion Centre. If on the other hand it becomes expedient to send the FDO forward to replace a Divisional FDO, the Corps Exhaustion Centre would be left without sufficient personnel to care for its patients.

5. Base Neuropsychiatric Centre (Theatre of War).

This may be formed by:

(a) Mobilizing special neuropsychiatric hospitals.

(b) Utilizing sections of neuropsychiatric hospitals already mobilized.

(c) Creating increments to 600 or 1200 bed General Hospitals - the increment consisting almost entirely of specially trained medical officers, Nursing Sisters and other ranks.

(d) Setting up Base Neuropsychiatric Centres within the War Establishment of existing 1200 bed General Hospitals by replacing present M.O.'s, W/S's, and other ranks with specially trained personnel.

In the C.A. (O), (a) is impractical because of the size of the force and the fact that it is geographically divided.

(b) is impractical because the Medical Division of 3.1. & P.O. Hospital has only 250 beds and we have already ear-marked additional emergency accommodation in another Canadian Hospital for the retention of psychiatric casualties who do not require further investigation or active treatment.
Either (c) or (d) are practical, but (c) has definite advantages because:

(i) the Base Neuropsychiatric Centre can be detached from the parent hospital in the event of that hospital being required to move away from the port of evacuation.

(ii) the increment can be attached to either a 600 or a 1200 bed hospital, whereas the Base Neuropsychiatric Centre can only be created within the War Establishment of a 1200 bed hospital.

(iii) The Base Neuropsychiatric Centre requires buildings for the retention of its psychotic patients and it is unwise to restrict the siting of a 1200 bed General Hospital because of the requirements of a small part of it.

10. Summary.

(1) Our psychiatric experience in this war has not been materially different from that of the British and American armies.

(2) Prevention of psychiatric battle casualties must be unit responsibility. In this and in the early recognition and treatment, the field Neuropsychiatrist will act in an advisory capacity.

(3) Although treatment will be initiated by the Unit E.C., Corps area is the most forward area in which it is planned to retain psychiatric casualties for treatment. Here cases will be treated for 2 to 7 days. If on admission to the Corps Centre or any time after admission it becomes obvious that they will not be fit for duty within a week, they will be evacuated.

(4) The term "exhaustion" will be used in forward area.

(5) Early and adequate treatment is emphasised.

(6) The advantages and disadvantage of various types of organization have been discussed.

(a) It is recommended that each field Neuropsychiatrist be supplied with a vehicle, a driver-batman, a clerk and a typewriter.

(b) It is my opinion that the formation of a Corps Exhaustion Centre which is parasitic but has its own W.E. of special personnel is preferable to modifying an F.D.S.

(c) In lieu of the British Advanced Psychiatric Wing, it is recommended that Neuropsychiatrists be attached to appropriate 600 bed Canadian General Hospitals.

(d) It is recommended that a Base Neuropsychiatric Centre be made by increment rather than by replacing personnel in a 1200 bed hospital.

(7) It is estimated that 2.5 to 3 neuropsychiatric beds per 1,000 troops will be required. We are unable to predict the incidence of psychiatric battle casualties in any given engagement, but we must expect wide fluctuation in numbers. It is my opinion that the proposed Canadian organization is sufficiently flexible to meet our needs.

F.H. van Nostrand

(F.H. van Nostrand) Colonel, RCMC
Consultant Neuropsychiatrist.

FHvanNYA

/over.
NOTES:

(1) With the recent arrival of two Neuropsychiatrists from Canada we have a sufficient number of experienced specialists for our requirements for 1944.

(2) Although the Junior Psychiatrists requested from N.D.H.Q. last March have not arrived and we cannot expect the first one for another month, we have sufficient Medical Officers of a rank of Captain, and who have been trained at Basingstoke, to meet our requirements for the next three months. Some of these are sufficiently experienced to replace Major Specialists in and/or some of our field Neuropsychiatrists becoming casualties.

(3) One experienced Neuropsychiatrist is attached to each Canadian Division in England. The remaining Specialists earmarked for theatre of war are either employed at Basingstoke N. & P.S. Hospital or as Regional Neuropsychiatrists in C.U.U. area and are available for immediate reposting or attachment.

(4) In order to benefit by the recent experience in Italy, we have requested the return of Major C.E.C. Gould.
### Appendix 'A'.

#### COMPARISON

Psychiatric Treatment - C.M.F. - January 1944.

<table>
<thead>
<tr>
<th></th>
<th>U.S.M.C.</th>
<th>R.A.M.C.</th>
<th>R.C.A.M.C.</th>
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<tbody>
<tr>
<td><strong>Divisional Area</strong></td>
<td>1) At unit level, by Unit M.O. Sedative treatment and retention up to 36 hours.</td>
<td>1) Unit level - treatment by R.M.O. and retention 24 - 36 hours. (No retention at Field Ambulance Level).</td>
<td>Small Advanced Psychiatric Centre. 20 - 40 beds, operated by a Field Ambulance under the direction of a divisional neuropsychiatrist.</td>
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<td></td>
<td>2) At Advanced Collecting Posts. Retention up to 36 hours.</td>
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<td><strong>Corps Area</strong></td>
<td>1) Evacuation Hospital with 20 - 40 beds under Psychiatric Specialist. Triage and treatment with retention up to 5 days. and/or 2) An Advanced Psychiatric Centre operated by a Clearing Platoon of Medical Battalion.</td>
<td>1) Corps Exhaustion Centre - 100 beds, operated by a Company of a Field Ambulance, under the direction of the Corps Psychiatrist. Patients retained 2 - 7 days.</td>
<td>Corps Medical Centre having a psychiatric section comparable to British Corps Exhaustion Centre.</td>
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<td><strong>L. of C.</strong></td>
<td>1) Psychiatric section of Station or General Hospital and/or 2) Special Psychiatric Hospital.</td>
<td>1) Advanced Psychiatric Wing with its own W.E. 100 - 200 beds, attached to a General Hospital. Patients retained up to 3 weeks.</td>
<td>No special unit in this area. Neuropsychiatric casualties admitted to #1 &amp; #5 Cdn.Gen.Hosps were treated by the Medical division with the assistance of one Field Neuropsychiatrist - Major A.E. McKercher.</td>
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<tr>
<td><strong>Advanced General Hospital level</strong></td>
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<td></td>
<td>1) Special Psychiatric Hospitals.</td>
<td>1) Base psychiatric centre with its own W.E. - expansions of 100 - 300 beds attached to General Hosp. 2) Base Psychiatric Hospitals 600 - capable of expansion up to 1000 beds. A 200 bed section of this may be detached and function as a separate unit.</td>
<td>Base Psychiatric Centre with special W.E. operating as an increment to a 1200 bed General Hospital - #14 Cdn.Gen.Hosp.</td>
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<tr>
<td><strong>Base Area</strong></td>
<td>1) Special Psychiatric Hospitals.</td>
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<td></td>
<td>2) Psychiatric sections of Station &amp; General Hospitals.</td>
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<tr>
<td></td>
<td>3) Psychiatrists attached to General Hospitals.</td>
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