Chapter 22

US ARMY OCCUPATIONAL THERAPY: PROMOTING OPTIMAL PERFORMANCE

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INTRODUCTION

Occupational therapy (OT) utilizes engagement in meaningful occupation (purposeful everyday tasks and activities that "occupy" one's time) to facilitate function and achieve a healthy and balanced lifestyle.[1,2] Early history records the use of activity, music, and games to assist with the recovery of mental health. In 172 CE, Galan wrote: "Employment is nature's best physician and is essential to human happiness."[3] The profession grew out of the moral treatment movement of the early 19th century, with a focus on compassion and occupation using manual labor such as agriculture, sewing, and tailoring to treat the insane.[4] The founders of OT in the United States came from a variety of backgrounds including psychiatry, social work, and architecture. Adolf Meyer, a psychiatrist, observed human behavior and habit in relation to the environment, writing

> the whole of human organization has its shape in a kind of rhythm…work and play and rest and sleep, which our organism must be able to balance even under difficulty. The only way to attain actual balance in all of this is actual doing, actual practice, a program of wholesome living as the basis of wholesome feeling and thinking and fancy of interests.[5]

During the 20th century, OT became closely aligned with treating wounded soldiers and sailors in response to the two world wars.[6(p158),7] Then, as now, the profession's foundation is the belief that occupation, or purposeful activity, is vital to regaining or maintaining the health of the entire person. This purposeful activity is graded according to the individual's ability. Furthermore, the philosophies of OT and treating service members with combat or operational stress reactions go hand-in-hand.[6]

The use of OT in the US military dates to World War I, when the US Civil Service Commission (precursor to the Office of Personnel Management) called for individuals trained in OT and other professions such as teachers and artists to serve as reconstruction aides in military hospitals. Early in 1918, the Surgeon General's Office began recruiting reconstruction aides to work with and treat service members who were wounded or suffered from battle neurosis to return to the battlefield. In February of that year, the Army's first trial of OT, occurring at Walter Reed Hospital, demonstrated its value in treating both the mind and the body of the wounded service member using occupation in the form of treatment: physically, to improve upper extremity function; and psychologically, to help prevent depression, control attention, and calm the wounded.[3(pp159–160)] By June 1918 the first OTs arrived at Base Hospital 117 in France, serving as civilians in the American Expeditionary Forces.[3]

During World War I, OT was established in Army hospitals for the reconditioning of convalescent soldiers by the Division of Physical Reconstruction within the Office of The Surgeon General, established in January 1918. Its intent was "through the use of mental and manual work, to restore to complete or maximum possible function, any military person disabled in line of duty."[7(p70)] The overall goal of the reconditioning program was to return soldiers to military duty in the highest state of physical and mental fitness in the shortest possible time. If disqualified for further military service, the aim of reconditioning was to return the soldier to civilian life in the best possible physical condition, "well oriented in the responsibilities of citizenship and prepared to adjust successfully to social and vocational pursuits."[8(p329)] The mission was accomplished by a coordinated program of educational reconditioning, physical reconditioning, and occupational therapy.

OCCUPATIONAL THERAPY IN WORLD WAR II

During World War II, OT grew in breadth and scope of practice in both physical medicine and neuropsychiatry. Programs developed to treat the physical and psychological injuries incorporated educational reconditioning, activity-based workshops, industrial therapy, and recreational therapy. OT carried out within physical medicine addressed "the restoration of physical function to impaired joints and muscles…seeking (1) improvement of the general physical condition, (2) the development of work tolerance through graded activity, and (3) stimulation of mental acuity through interesting occupation."[8(p344)] Occupational therapists' observations of behavior, attitude, and reactions of patients were extremely valuable to the medical team and were reported during interdisciplinary staff conferences. These regularly scheduled meetings helped staff to plan and adjust the overall treatment program as needed.

OT in the neuropsychiatric section was placed under the immediate direction of the psychiatrist. The goals of OT within neuropsychiatry were "(1) to guide mental attitudes into healthy channels, (2) to promote a desire to get well, (3) to restore self-confidence and a sense of security, (4) to substitute encouragement

for discouragement, (5) to establish and maintain good work habits and (6) to afford opportunity for socialization."[8(p348)] General treatment principles used with neuropsychiatric patients included (*a*) quiet, soothing work to help calm patients; (*b*) noisy, active work to discharge tension; (*c*) responsible work to promote self-confidence; (*d*) simple, easily completed tasks for encouragement; (*e*) interesting, colorful work for stimulation; (*f*) absorbing, detailed tasks for improving concentration; and (*g*) group work for socialization.

OT's role in educational reconditioning included identifying the service members' goals and interests and providing valuable information for the establishment of individualized treatment programs. Essential components of the educational reconditioning program included OT laboratory shops that provided practical experience for patients following the completion of academic courses sponsored by the educational reconditioning program in fields such as photography, radio, electricity, and motor mechanics. The "noisy" shop was used for patients who needed to discharge tensions through work. Activities in the noisy shop included carpentry, metalworking, work with plastics, and printing. The "quiet" shop was used for patients who were easily distracted or disturbed by noise and included activities such as weaving, leatherworking, ceramics, and art. Patients confined to the ward participated in OT through the use of small handicrafts carried out under close supervision.

An industrial therapy program also emerged during World War II, in which occupational therapists organized therapeutic "industrial" assignments involving hospital maintenance. The program included identifying available job assignments by gathering information on each job title, duties required, physical and mental requirements, and work standards. The program successfully provided participants a balanced work program, helped maintenance personnel complete daily tasks, and provided therapeutic activity for a large number of patients while requiring few trained supervisors. It was designed as a transitional program to meet the work requirements of patients who had progressed beyond the need for specific therapy but could not yet return to full duty. The work activities improved

> general physical ability including muscle tone, strength, and joint motion, to combat the effects of prolonged hospitalization, to increase work tolerance, to re-establish work habits counteracting the effect of periods of mental and physical idleness and to stimulate mental alertness.[8(p352)]

Job task analysis was an essential component in the World War II reconditioning program. Occupational therapists analyzed jobs from both a physical and a psychological perspective, and subsequently identified a variety of job opportunities. Work areas utilized for reconditioning included the utility shop, motor pool, warehouse, post office, laundry, mess hall, supply department, administrative office, medical laboratory, photographic laboratory, orthopaedic shop, messenger service, drafting, landscaping, and gardening. The patients' clinical appointments and medical consultations took precedence over industrial work assignments, and high standards were maintained: work projects were not allowed to deteriorate into a source of "cheap labor," and the therapists ensured that the job task was appropriate for the soldiers' physical and mental capabilities.

Another OT effort was a recreational (or "diversional") program used "to divert the patient's mind from thinking of himself constantly, to provide for the constructive use of leisure time, to furnish opportunity for self-expression, to stimulate interests and sustain morale, to conserve initiative and maintain good work habits, to promote socialization by group activities and to improve general physical fitness by stimulating the appetite and the circulation."[8(pp353–354)] The Arts and Skills Corps, composed of craftspeople recruited and organized by the Red Cross; the "Gray Ladies," a group of volunteers assigned to hospital OT departments; and Women's Army Corps assistants expanded the reach of OT to include minor crafts such as model making, art, wood and soap carving, plastics, leatherwork, ceramics, fly-tying, and weaving. Shop programs included photography, radio and electrical work, motor mechanics, and the use of power equipment.[8(p355)] In 1947, the Army established the Women's Medical Specialist Corps under Public Law 36, 80th Congress, giving OTs a permanent military status. In 1955 the name was changed to the Army Medical Specialists Corps under Public Law 294, 84th Congress, reflecting the inclusion of men in the corps.[7(pp5,402)] Current Army OT policies and practices are built on the foundations established in World War II.

ARMY OCCUPATIONAL THERAPY IN THE 21ST CENTURY

Serving throughout the world in times of war and peace, Army occupational therapists (OTs, military occupational specialty [MOS] 65A) and military occupational therapy assistants (OTAs, MOS 68WN3)

currently number over 200 in strength. The mission of OT in today's Army is to promote soldier readiness, healthy living, and optimal performance among all Department of Defense (DoD) beneficiaries using OT principles and practices (Exhibit 22-1). Army OTs incorporate best clinical practices and strive to deliver them in a timely and cost-efficient manner.[9]

Today, Army OT practitioners function as human performance experts whose innovative programs and services help to optimize soldier performance and readiness in both field and garrison settings. OTs treat a wide range of conditions with many soldiers impacted by both physical and psychological injuries. In addition to the behavioral health role of OT in combat and operational stress control (COSC) efforts, OTs provide neuromusculoskeletal evaluation and rehabilitation with an emphasis on the upper extremity; inpatient and outpatient rehabilitation, including specialty areas such as cognitive rehabilitation, community reintegration, driving rehabilitation, and burn care; neurology and orthopaedics; ergonomics, including the development of strategies to prevent injuries and decrease human and economic costs of injuries in the DoD; peak performance training; use of assistive

EXHIBIT 22-1

US ARMY OCCUPATIONAL THERAPY SCOPE OF PRACTICE

The unique role of occupational therapy (OT) emphasizes the enhancing of each individual's performance in his or her various life roles (ie, soldier, worker, parent, student, and retiree). Occupational therapy's services are designed to respond to soldier, patient, family, and military organizational needs and expectations. Army OT helps prevent dysfunction, promotes and develops healthy lifestyles, and facilitates adaptation and recovery. Army OT helps the wounded, injured, or ill adapt daily occupations and routines in the areas of self-care, home management, community participation, education, work, and/or leisure activities. New Army OT initiatives include standardization of a military-specific Functional Capacity Evaluation, driving rehabilitation including the use of driving simulation, animal-assisted therapy, warrior goal-setting training, and use of a toolkit to evaluate and treat concussion/mild traumatic brain injury.

Occupational therapy's scope in the provision of services encompasses the following:

- **Military readiness.** All services provided to the soldier population target optimized effective performance, prevention, and expeditious return to duty following medical or psychological conditions.
- **Priority of care** is directed to the soldier to assist in maintaining his or her highest level of performance and ensure fitness to fight.
- **Prevention and wellness**. Includes screening and health promotion interventions to maintain and promote effective performance of soldiers and Department of Defense beneficiaries.
- **Combat stress prevention and intervention** in the combat environment and in stability and support operations.
- **Unit consultation** to promote psychosocial well-being, including ergonomic evaluation, training, and worksite analysis; identification of and ergonomic intervention for conditions where the etiology is physical or stress-related.
- **Support of humanitarian missions** in the primary care role for upper extremity neuromuscular screening or stress prevention and intervention.
- **Direct patient care** may include but is not limited to basic and advanced self-care (activities of daily living) evaluation and training. Training emphasizes regaining and sustaining functional performance while developing and improving diverse, complex skills including problem-solving and decision-making capabilities.
- **Psychosocial treatment** with emphasis on functional performance in various life roles through insight development, skill acquisition, education, and treatment programs.
- **Work reintegration,** including ergonomic analysis, fit-for-duty programs, and injury prevention and training that keep workers on the job, reduce costs, and improve productivity. Programs that promote work behaviors for improved physical and psychological performance include stress, coping, and life skills education programs.
- **Evaluation and treatment of upper extremity conditions**, including upper extremity neuromusculoskeletal evaluations in support of the orthopaedic physician.
- **Orthotic (splint) fabrication**. Adaptive technology evaluation and recommendations for, or fabrication of, equipment.
- **Developmental pediatric evaluation and treatment** (at specified treatment facilities).

technology; and work reintegration programs within warrior transition units (WTUs). Recognizing the psychological as well as functional value of early return to wearing the uniform following injury, OTs helped develop the Army's Wounded Warrior Clothing Support Program in 2008, which authorizes the wear of uniforms with adaptations/modifications prescribed by OTs or other rehabilitation specialists. Additionally, Army OTs serve in dedicated research positions as well as academic appointments.

Emerging OT practice areas include pilot programs in brigade combat teams to treat individuals with traumatic brain injury, animal-assisted therapy and animal-assisted activities in COSC units, and service-dog training programs. Creative partnerships with 501(c)(3) (nonprofit) organizations have produced successful service-dog training programs. For instance, initial service-dog training may be conducted within a civilian prison with specialized service-dog skills training conducted as part of a WTU work therapy program to prepare future service dogs to meet the unique needs of wounded soldiers. OTs are involved in a growing use of therapeutic riding programs as well. An integrated process team consisting of OTs, veterinarians, and behavioral health specialists is addressing principles and standards, and updating policies related to the human-animal bond.

Army Occupational Therapy Credentials and Training

Army OT practitioners, who serve in command and executive positions throughout the Army Medical Department, must be versatile, competent leaders to successfully operate and manage clinic operations in both deployed and garrison environments. Army OTs are credentialed healthcare providers and, as commissioned officers, they require National Board for Certification in Occupational Therapy (NBCOT) registration and a current, active, valid, and unrestricted OT license from a US state or jurisdiction. Currently, OT recruits entering the Army with a master's degree in OT will be able to earn a doctorate of science in occupational therapy (DSCOT). The DSCOT program and the enlisted 68WN3 OTA program are taught at the Army Medical Department Center and School at Fort Sam Houston in San Antonio, Texas. As of 2010, Army OTAs are required to obtain NBCOT national certification and state licensure. Civilian OTs working within a military setting must be registered by NBCOT and licensed according to the regulatory requirements of the state in which they are practicing.[9] Civilian OTAs are required to take the NBCOT examination and be credentialed as a certified occupational therapy assistant (COTA) with licensure according to the regulatory requirements of the state in which they are practicing.

Role of Occupational Therapy Assistants

OTAs are specialists who bring the perspective of the enlisted soldier to the therapeutic process by assisting the supervising OT in evaluating a service member's occupational performance; conducting initial occupational performance history interviews and mental status evaluations; using observation to gather data as part of task-performance skill assessments; and implementing OT interventions under the supervision of a credentialed OT. OTAs coordinate, set up, and oversee work hardening sites; lead OT groups; and monitor, facilitate, and supervise therapeutic activities. The OTA supervises combat and operational stress reaction casualties, provides status updates for these casualties, and conducts classes on selected stress-related topics. OTAs assist in all COSC functional areas including unit needs assessments and traumatic event management in the deployed environment.

Overview of Occupational Therapy Services in Combat and Operational Stress Control

The role of the OT practitioner in Army COSC is to evaluate occupational performance and implement interventions to enhance that performance.[6] OT's unique core skills are aimed at keeping soldiers able to perform their mission and include

- analysis of jobs and job tasks for underlying requisites (required subtasks, performance standards, equipment used, the social and physical work environment, occupational hazards);
- assessment of occupational performance (functional abilities) relating to specific tasks and jobs;
- configuration of a therapeutic, structured environment in which skills can be developed;
- analysis, selection, and application of occupations (activities) as therapeutic media; and
- the ability to match the individual to tasks he or she can successfully perform.[2(p22),6,7]

Army OTs evaluate soldier performance across the spectrum of occupational areas including activities of daily living, work, education, leisure, and social participation. The OT, or a COSC team member under the guidance of the OT, selects therapeutic occupations (purposeful activities) based on the soldier's current functional ability that support maintaining the sol-

dier's military identity, enhances the soldier's sense of competence, and restores confidence. OTs perform task analysis and functional assessments, structure a therapeutic environment, provide occupation-based treatment, and match soldiers' abilities to the tasks or jobs they can perform. OTs also identify and evaluate mental and physical stressors, stress reactions, and cognitive function. They subsequently develop a treatment plan, which often includes teaching prevention, adaptive coping, and psychosocial skills. Additionally, they utilize therapeutic media and therapeutic use of self within individual and group settings to enhance environmental adaptation and maximize treatment.[10(pp3–8)] Army OTs integrate their diverse training in upper extremity orthopaedics, rehabilitation, ergonomics, and COSC techniques to identify areas of need for both individual soldiers and organizational units. Functional assessments include analysis of skills required by the soldier's MOS, identification of tasks the soldier can perform, and synthesis of therapeutic occupations. Interventions such as "work hardening for Warriors" involve occupation-based treatment that matches the soldier's functional ability with therapeutic occupations that he or she can perform.

OT groups engage in work activities, cognitive and sensorimotor activities, activities that parallel task-performance skills, cooperative activities, expressive arts, and exercise. Psychoeducational training may include selected common and collective soldier tasks or life skills such as stress management, relaxation skills, sleep hygiene, anger management, communication skills, problem solving, assertiveness training, and time management. Therapeutic activities of daily living may include personal hygiene and uniform maintenance; work/productive activities may include military-relevant tasks such as vehicle or site maintenance; and social and leisure activities may include cooperative or competitive sports, games, ceremonies, or celebrations. Therapeutic occupations are graded to offer challenges that are "just right" for each individual, leading to successful performance that instills competence and confidence. The soldier then gradually improves his or her functional capacity and ability to return to duty.[10(pp10–12)]

OT personnel also provide services as members of fitness teams and preventive teams in the delivery of behavioral health services in a deployed setting. The OT's role in a preventive team is the same as the other team members: providing outreach services through establishing rapport with supported units and leaders, assessing unit needs, and making regular contacts with supported units. An OT approaches these tasks from a unique perspective of assessing and addressing functional performance. The OT evaluates a soldier's current level of functional performance in a deployed environment. OTs also assess how psychological and cognitive function impacts task performance. They draw from a battery of standardized assessments that can help identify the presence of a combat and operational stress reaction, behavioral health problem, or traumatic brain injury. Collaborating with the rest of the team, the OT assimilates this information in determining the appropriate interventions, referrals, or other necessary action. For example, the OT may find that the best intervention is to restructure the soldier's job or environment to ensure successful completion of a task. Interventions often involve educating both the soldiers and their leaders.

Observation is one of the tools the OT uses to assess function. Observation can be especially valuable while conducting outreach visits. While performing "walk-abouts" within the area of operation, OTs work alongside soldiers and use their expertise to help them retain the functional ability to perform their mission. By working alongside soldiers, OTs can observe how each soldier is functioning and assess the mental or physical demands required to complete a particular job. Using this knowledge, the OT can begin to identify potential problems in task performance and intervene before problems escalate. For example, during Operation Iraqi Freedom (OIF) I (2003), an OT on the preventive team helped prepare and serve a meal in a mobile kitchen trailer. The OT talked casually with soldiers preparing the meal, getting a better idea of how they were dealing with the stress of operations. Additional stressors quickly presented themselves: working in a hot, crowded kitchen and dealing with large numbers of flies. Even the manner in which the food on the serving line was placed created physical stress. The OT provided suggestions for a more efficient and safer order of food trays, and adjusted the height of a work surface for one of the soldiers so she could more easily reach it. An added bonus was getting a glimpse into the basic cognitive function and general mood of hundreds of soldiers as they filed past the serving line.

The OT's observation skills are helpful when performing a unit needs assessment through evaluating the occupational performance needs of individuals in the unit. OTs identify component factors that are essential to successful performance. They may also assess the behavioral health training needs of soldiers, leaders, the unit ministry team, and other medical personnel within the unit. This may lead to additional interventions to enhance occupational performance and the development of plans to meet the future COSC needs of soldiers and units based on prevention and

early intervention.

To enhance the provision of COSC services, Army OT practitioners utilize their background and training in upper extremity orthopaedics, rehabilitation, and ergonomics in both garrison and theater. Since the early 1980s, OTs have proposed and participated in programs designed to promote the soldier's job performance in garrison.[6(p56)] Occupational therapists have been included in missions to Bosnia-Herzegovina, Peru, and Russia, to name a few. The global war on terror continues to provide opportunities for OTs to utilize their unique skills to promote the health and welfare of service members. OTs have deployed to Afghanistan and Guantanamo Bay in support of Operation Enduring Freedom. In the Iraq and Afghanistan theaters of operations, they offer OT services to US and Coalition military members, national security forces and civilians, and the detainee population. OT practitioners within WTUs help meet the needs of injured, ill, and wounded soldiers through a focus on life skills training and work reintegration. OT personnel were also involved in the development of regional Army Reserve COSC programs on the home front.

AN INTEGRATED ARMY RESERVE REGIONAL COMBAT AND OPERATIONAL STRESS CONTROL PROGRAM

Identifying the need for home-front support as large numbers of Army Reserve soldiers began to deploy in 2003, the commanding general from the 88th Regional Readiness Command (RRC) initiated a COSC program for Army Reserve soldiers and their families within a six-state region in the upper Midwest (Minnesota, Wisconsin, Ohio, Michigan, Indiana, and Illinois). Two COSC officers from the 785th Medical Company (Combat Stress Control) were mobilized (an OT and a social work officer) to initiate a deployment cycle support program. From the inception of the program, the team used an interdisciplinary psychoeducational approach to help build resiliency and coping skills in soldiers and their families (Figure 22-1; Table 22-1). When available, Reserve component behavioral health specialists within the region augmented the team to provide local support. In 2005, a psychiatric nurse was mobilized to enhance the capabilities of the 88th RRC COSC team.

The COSC team established a strong working relationship with the other RRC elements that had direct roles in preparing and supporting deploying soldiers and their families. Program staff brought together representatives from family readiness groups; the chaplain's, public affairs, and casualty affairs offices; and the RRC leadership to establish an integrated approach to meet the comprehensive needs of soldiers and families. A multilevel needs assessment was conducted to identify capabilities, needs, and resources for soldiers, leaders, and families throughout the region. The implementation of an integrated operational stress management program was seen as an essential element in producing secure and resilient soldiers with families prepared to withstand the rigors of military separation, combat operations, and the more routine stressors common to the military lifestyle. The COSC team explained to unit leaders that its mission is to keep their soldiers with them, doing their jobs through programs designed to promote resiliency in the workplace, the family, and the community.

Through a series of meetings and site visits a plan of operation emerged. The plan included the provision of information to leaders, soldiers, and family members as well as other regional military and civilian organizations. The team's goal was rapid response: to provide soldiers and their families with educational, spiritual, and psychological resources to strengthen the basic bonds essential to high morale and good order. The expected outcomes included mission-capable soldiers and self-reliant families who were stress resilient, confident, secure, supported, and healthy (physically,

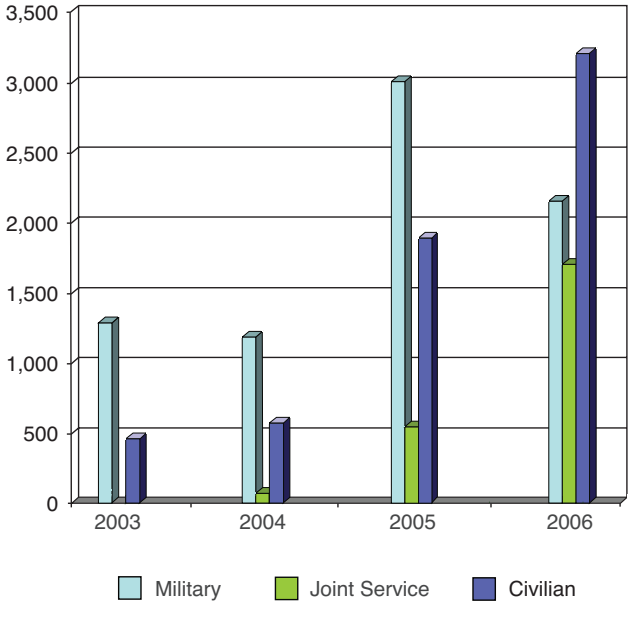

Figure 22-1. 88th Regional Readiness Command educational stress briefings, numbers of participants, 2003–2007.

TABLE 22-1

88TH REGIONAL READINESS COMMAND COMBAT AND OPERATIONAL STRESS CONTROL PROGRAM: ACTIVITY SUMMARY, APRIL 2003–DECEMBER 2006

COSC Briefings*		Individual Counseling	
Mobilization (soldiers/families)	13,398	Soldier/family and stress/PTSD issues	2,363
Midcycle (families)	4,826	Bereavement support (ie, funeral, follow-up, etc)	496
Homecoming (families/friends)	13,839	Well-being (acupuncture and therapeutic massage)	1,901
Reconstitution support (first postdeployment drill)	8,541	PREP couples' support†	934
SRP training	28,247	Marriage/relationship‡	228
Educational stress briefings			
Community groups	6,045		
Military groups	7,548		
Other military (NG, Navy, etc)	2,258		

*Number of participants
†Marriage retreat. No program participation in 2006
‡Single soldier retreat
COSC: combat and operational stress control
NG: National Guard
PREP: Prevention and Relationship Enhancement Program
PTSD: posttraumatic stress disorder
SRP: Soldier Readiness Program

emotionally, psychologically, and spiritually). Soldiers departing for extended missions would have confidence that their families were prepared and supported, and would be more likely to resist the debilitating effects of long-term operational stress. Families who knew their soldiers had a solid base of preparation and training would feel more secure sending them out to serve and would be more likely to support a soldier's decision to make the Army a career. Outcome measures were based on assessments of physical, social, and environmental factors with direct and indirect feedback from soldiers, family members, and leaders. Metrics included the number of training sessions conducted, attendees at each, individual consultations and follow-up referrals, and requests for further information and training sessions, as well as feedback on the effectiveness of the educational material including handouts, presentations, and resources provided.

Training (including informational briefings), command consultation and support, and referral were core features of the program. Crisis intervention, sexual assault prevention and advocacy programs, suicide prevention training and briefings, and grief-counseling support were also incorporated. Family stress support services included community outreach programs and collaborative programs with other branches of the military. For instance, Army Reserve family readiness groups (FRGs) "adopted" family members of service members from other components of the military who were living within their local area.

Training for leaders and soldiers included prevention, identification, and management of combat and high-intensity training stressors and battle-fatigue–related injuries (Exhibit 22-2). The training covered stress reduction techniques, predeployment "hardening," anger management, suicide prevention, sexual assault prevention training, first responder (unit level) training in combat stress control, and buddy aid. The team provided briefings for soldiers and family members, addressing predeployment stressors and coping techniques, midcycle issues related to rest and recuperation visits by soldiers halfway through their deployment, redeployment (reunification) stressors and coping techniques, and reconstitution issues including reestablishing family roles and relationships, anger management, operational stress reactions, traumatic brain injury, and posttraumatic stress disorder. Family stress support services included direct and indirect (consultation support) services to help families develop stress coping skills, address couple dynamics, deal with children's issues, and prepare for reunification. The team worked closely with FRGs following the loss or severe injury of unit members. Linking FRGs with Reserve combat stress control assets and other military, veteran, and community-based resources was a significant part of the COSC team's role.

A well-being program was established at the RRC Headquarters to provide a variety of self-care services teaching leaders, soldiers, and contract personnel ways to build personal coping skills and resiliency. Inte-

EXHIBIT 22-2

88TH REGIONAL READINESS COMMAND COMBAT AND OPERATIONAL STRESS CONTROL TEAM FIRST RESPONDER TRAINING

1. **MISSION**. The Combat Operational Stress Control Team (COSC) of the 88th Regional Readiness Command Surgeon's office will conduct **Operational Stress Control First Responder Training** for Command-designated representatives from subordinate units in support of Department of Defense Directive 6490.5 (Combat Stress Control [CSC] Programs) JP-1-02, Force Protection.

2. **EXECUTION**.

   a. **Intent**: Prepare Soldiers/leaders within the USAR in basic principles of Combat Operational Stress Control to enhance force protection and improve Soldier readiness in support of Contingency Operations. Embedding Soldiers and FRG representatives knowledgeable in COSC into each unit will enhance early recognition, intervention/referral with stress issues that often result in problems that may affect unit efficiency and degrade the quality of life of soldiers and their families. It is assumed that this trained group of first responders will maintain contact with a COSC team and their commands on a regular and as-needed basis.

   b. **Concept of Training**. Conduct 2½-day course with training consisting of Power Point slide presentations, video, handouts and role-playing to familiarize non-medical Soldiers with concepts of operational stress and battle fatigue. A team consisting of operational stress control personnel and chaplains will conduct the training. Both a pre- and a post-test will be administered in order to evaluate the effectiveness of the training. (Training Annex W)

3. **CONCEPT OF OPERATIONS**. To train the participants in the following topics.

   a. Basic combat operational stress principles

   b. Emotional cycles of deployment

   c. Identifying and responding to individuals with suicidal and homicidal behaviors

   d. Recognizing and responding to:

      - aggression
      - domestic violence
      - depression
      - posttraumatic stress disorder
      - combat stress reactions and battle fatigue
      - methods of deescalating potentially dangerous situations
      - sexual assault prevention and identifying sexual harassment

   e. Available military, VA, civilian and other resources—how to access and use them

COSC: combat and operational stress control
USAR: US Army Reserves
VA: Department of Veterans Affairs
Data source: 88th Regional Readiness Command Headquarters, Surgeon's Office, Fort Snelling, Minnesota.

grative healthcare providers from the civilian sector volunteered their services to provide a variety of self-care techniques including seated chair massage, acupuncture, guided imagery, healing touch, reflexology, Reiki, aroma therapy, and relaxation skills training. Information on a variety of stress management topics was provided in the form of brochures, handouts, computer disks, and posters. Topics included but were not limited to information on stress and anger management, sleep hygiene, communication skills, parenting, transitioning, suicide prevention, brain injury, and posttraumatic stress, with resources from Military OneSource, the Brain Injury Association, Veterans Affairs (VA), chaplains, and the Public Health Command (Provisional), formerly the US Army's Center for Health Promotion and Preventive Medicine. Personnel who participated in the program reported decreased pain and stress levels and increased awareness of stress management techniques.

The 88th RRC sustained the highest number of Army Reserve soldiers killed in action during the early part of the war. The COSC team worked closely

with chaplains, public affairs staff, and casualty affairs personnel to establish strong support networks for grieving families, units, and communities. The team addressed the topic of grief and loss at the leadership, FRG, and soldier level. Frequently accompanying the chaplain, public affairs office, and the funeral honors team, the COSC officer provided support to the family, unit leadership, and other unit members and their families, as well as the honors team. In specific instances, COSC team members met with FRGs to provide bereavement support and education on ways to deal with loss. For instance, while five sisters anxiously awaited the beginning of their brother's memorial service, the OT taught them some simple relaxation skills for self-calming. The family reported later how much those simple techniques helped them get through that difficult time. During a funeral, one of the honors team members was having a hard time standing still for his 20-minute rotation. A few minutes spent helping him refocus and practice some simple breathing techniques allowed him to successfully manage the task. In another case, the COSC team provided bereavement support for family members during an FRG meeting following the battlefield death of one of the soldiers. They discussed factors involved in grief and loss including the associated fear of having a loved one still in harm's way, taught self-care techniques for adults and children, and explained how to locate resources for additional support. Following the educational part of the meeting, families shared a potluck meal, local massage therapists provided "pro bono" seated chair massage, and families participated in structured leisure activities while socially engaging with one another within a safe environment. The COSC team provided one-on-one consultation support during this time. Throughout the remainder of the unit's deployment the team provided periodic support to the FRG.

Located in a predominately civilian region, outreach to civilian organizations within the 88th RRC was vital to help the community understand the unique and changing culture of the citizen soldier (the next-door neighbor, coworker, or church member serving as a Reservist). A concerted effort was launched in partnership with the National Guard, VA, and veterans' service organizations to address the reintegration of soldiers into the workplace and community following their return home. Briefings were prepared to meet the individual needs of employers, community groups, and faith-based groups. For instance, OT staff developed briefing material to alert leaders, units, and care providers about the impact of traumatic brain injury, combat stress reactions, and posttraumatic stress disorder.

Community outreach presentations on a regional, state, and national level also provided training and workshops for civilian healthcare workers. Law enforcement training was provided through interagency partnerships. State-based postdeployment healthcare collaborations were supported by the COSC teams in Wisconsin, Ohio (Ohio Cares), and Minnesota (postdeployment collaboration with the VA, DoD, and community health professionals). The team provided training for both Minnesota and North Dakota county veterans' service officers, helping the officers to understand the changing culture and needs of redeployed soldiers and refer them to the appropriate level of services.

College and university presentations focused on the needs of returning combat veterans in the classroom, the needs of families and friends of a combat veterans, and resources available to returning veterans. The state of Minnesota allocated funds for the state college and university consortium to establish campus-based veterans' transition centers. Veterans were encouraged to utilize the services of these centers to identify "battle buddies" as they returned to college living and to focus on formation of attitudes and behaviors to promote success in their college experience. A county library donated thousands of books for deploying troops at Soldier Readiness Processing centers as well as their families to provide constructive diversion from deployment cycle stress. Exhibit 22-3 describes the types of soldier and family briefings provided throughout the deployment cycle.

OCCUPATIONAL THERAPY IN SUPPORT OF OPERATION IRAQI FREEDOM DETAINEE HEALTHCARE

US Army combat support hospitals are responsible for providing quality healthcare with dignity and respect to Iraqi civilians as well as detained insurgents. Individuals with acute injuries can be admitted day and night in an intensive combat environment. Patients on detained status are required to live in the theater internment facility while they receive medical treatment. A dynamic and multifaceted rehabilitation program is necessary not only for the improvement of patients' performance in all areas of occupation, but also to enhance their functional outcomes. The goal is for the patient to achieve a functional level sufficient for discharge in a facility with a rapid turnover rate.

Patients admitted to a combat support hospital have often sustained polytrauma, which can include

EXHIBIT 22-3

88TH REGIONAL READINESS COMMAND COMBAT AND OPERATIONAL STRESS CONTROL TEAM DEPLOYMENT CYCLE SUPPORT BRIEFINGS

Deployment cycle support briefings are the single most important mechanism for establishing rapport with soldiers and family members. Through these briefings, soldiers and family members learn about the effects of chronic stress on the body and on performance. A significant element in all the presentations is improving communication skills: a factual presentation of the negative results of poor communication is given, followed by suggestions for developing positive communication skills. Effects of the deployment cycle on children and significant others are also presented.

Soldier readiness processing briefings consist of 30-minute slide presentation that alerts soldiers to the need to prepare themselves and their families for deployment. Briefings discuss preparation in terms of Preventative Maintenance Checks and Services (PMCS; a routine personal self-care program to maintain mission capability) and stress the need to start working on communication skills and problems before the soldier is mobilized.

Premobilization briefings consist of a 45-minute slide presentation describing the ramp-up to deployment and the effect this process has on soldiers, their spouses and significant others, and the children. Handouts are used to reinforce the briefings.

Mid-cycle briefings are presented to members of a family readiness group. The loosely structured briefings are used to answer questions and allay fears that have become burdens to family members and children, and may include one-on-one talks with individuals with specific questions. Most of the issues revolve around communication. Handouts are used to reinforce the briefings.

Demobilization briefings are ideally presented to family members and interested others 2 to 4 weeks before the soldiers return home; however, they are usually presented the same day the soldiers return. The slide presentations used at homecoming try to cover a range of issues from readjustment of roles to intimacy issues. Handouts are used to reinforce the material.

Reconstitution briefings are directed sessions of teaching followed by small group and one-on-one discussions on issues that have come up since the soldiers' return. Issues include operational stress reactions, posttraumatic stress reactions, and marital and parenting problems. A slide presentation can be used to present issues, but often this briefing takes the form of a more relaxed and unstructured conversation. Handouts are used to reinforce the material.

Data source: 88th Regional Readiness Command Headquarters, Surgeon's Office, Fort Snelling, Minnesota.

many orthopaedic or neurological deficits. OT staff members critically observe and analyze patients to determine a baseline performance for motor, cognitive, and communication skills. OTs and OTAs then work with patients to reconcile the changes to their bodies by empowering them to establish new habits, routines, and roles to maximize performance during daily activities. The model of human occupation frame of reference provides theoretical guidance to OT staff working with detainees, aimed at enabling inpatients to make order out of the disorder that they are experiencing.[11] Active involvement in improving health and learned wellness are two key constructs of the model that are directly applied to detainee healthcare. Detainees may not readily expect to take an active approach in their own recovery process; therefore, adding a patient education piece to other aspects of healthcare service delivery is an important aspect of recovery. Patients must cope with the transition from the status of "detained patient" to an ordinary "detainee" upon discharge. Detainees are expected to perform the activities of daily living requirements independently in the internment facility.

Cultural differences bring particular challenges to detainee care. Many detained patients do not speak English, necessitating interpreters. In addition, gender roles within the Muslim culture are significantly different than Americans are accustomed to; for example, the expectation of taking direction from primarily female nurses can pose difficulty for male patients raised in a male-dominated society. If a detainee is having difficulty complying with medical instructions from staff, the OT may become involved. The therapist would work with the detainee to facilitate understanding of the benefits of inpatient care using the *listen, learn, and comply* approach: the OT explains

that it is the patient's responsibility to listen to directives put forth by the staff to maximize the benefit of multidisciplinary healthcare. For patients to take responsibility for the personal management of their own health, patient education about the injury or illness is imperative. Patient compliance is necessary because the staff must meet the needs of the other patients in a timely manner.

PEAK PERFORMANCE TRAINING IN OCCUPATIONAL THERAPY

The concept of peak performance, developed originally at the US Military Academy's Center for Enhanced Performance and currently used by Army OTs, is derived from "mental toughness training to develop the Army pentathlete."[12] It is based on the principle that Army leaders must be self-aware, mentally agile, and adaptive. Peak performance has been described as "sports psychology taken to the battlefield" in that the core components rely on human performance and behavior, but the thought–performance interaction is essential in successfully completing warrior tasks. A mental imagery research study found that mental imagery (imagining squeezing an immobilized hand without performing any movement) might be of benefit in preventing strength loss during immobilization.[13] OTs have successfully utilized peak performance training with Operation Iraqi Freedom / Enduring Freedom patients, specifically in combat stress casualties or those diagnosed with posttraumatic stress disorder. Peak performance techniques decrease recovery time and prepare individuals for success both physically and mentally in returning to their respective areas of expertise. The OT uses peak performance concepts to help maximize soldiers' physical, mental, and emotional performance during periods of temporary or permanent life changes following illness or injury. Through their knowledge of human factors, occupational performance, and occupational adaptation, OTs help soldiers build their performance capabilities in overcoming physical, cognitive, and emotional challenges posed by illness or injury.

The five core foundations of peak performance are (1) a cognitive foundation, (2) attention control, (3) goal setting, (4) stress and energy management, and (5) visualization and imagery. Improving skills related to each of the five components ultimately leads to optimizing mental agility and performance. An example of an effective therapeutic intervention derived from peak performance training is the use of guided imagery and relaxation. Guided imagery involves using a series of thoughts or suggestions to direct a person's mental focus toward a more relaxed state. Nightingale[14] suggested various ways that imagery could be used for counseling, such as motivation by imagining a positive future, insight through exploration of possibilities, and problem solving. In warrior training and rehabilitation programs, OT services are conducted by an OT and an OTA. The OTA conducts the group program and implements orthopaedic treatments, while the OT completes individual evaluations and treatment sessions.

Peak performance training has been implemented in the form of group intervention, 1 hour per week for 6 weeks. The OT staff facilitates a group addressing the following six topics: (1) goal setting, (2) stress and energy management, (3) visualization and imagery, (4) confidence, (5) attention control, and (6) anger management. To foster esprit de corps, the soldiers in the program develop a unit creed while participating. Group interventions focus on enhancing the thought–performance interaction to maximize performance outcomes. For example, one group might focus on recognizing physiological changes such as skin temperature, heart rate, and muscle tension while experiencing both physical and mental stressors to allow participants to experience physical manifestations of stress. Participants would then implement steps to enhance performance in this stressful environment. Both negative and positive self-fulfilling prophecies can ultimately affect performance on any given event, not only during the training but also in many settings throughout soldiers' lives. These core areas are essential to enhancing soldier performance and can ultimately be applied to either battlefield or garrison environments.

Individual peak performance training augments group topics to develop the skills necessary for successful performance. Soldiers can choose goal setting and / or stress management for their care plan. During goal setting, the soldier develops personal goals ranging from graduating from the Warrior Training and Rehabilitation Program (WTRP) to military retirement. In the goal-setting session, soldiers identify the reasons for participating in any given event, what they want to accomplish, and most importantly, how they will achieve their goals. The end result is energy, persistence, and a prime selection of strategies for achieving each person's goals.[12] Ultimately a personalized "goal sheet" is developed and kept with participants at all times. The stress management option involves the use of Freeze Framer, a computerized biofeedback program, or a relaxation plan. Individual peak performance intervention can either be self-referred or command-referred if the soldier is not adapting well to WTRP.

The stress and energy management model in peak performance is based on a concept called "grip and gravity,"[12] based on identifying things individuals cannot control (gravity), and redirecting focus to things individuals have the ability to control (grip). In a setting where many injured soldiers feel out of control, future plans, current situations, attitudes, and perceptions will always be within their "grip" forces. Once the soldier has grasped the concept of taking control over his or her own life, biofeedback and relaxation techniques can be introduced into the treatment plan.

Biofeedback tools are used to teach soldiers how to recognize physiological changes (such as heart rate and breathing patterns) that occur with stress and make the necessary changes to reduce the magnitude of the stress response. By using biofeedback instruments, the soldier gains increased awareness and sensitivity to internal stress responses. The ultimate goal of this treatment is for the soldiers to recognize internal cues of stress without the aid of the instrument, and implement the steps to regain control. This reemphasizes the thought–performance interaction concept discussed during the group intervention. Equipment required for this program includes a computerized biofeedback instrument for treatment sessions and a relaxation chamber, which allows for optimal relaxation positioning and control of environmental stimuli during the intervention. The biofeedback equipment has been shown to improve overall physical speed and accuracy, enhance problem-focused coping skills, sustain concentration, and manage stress and anger.[12]

Using the peak performance model and its inherent mental agility intervention can improve soldiers' satisfaction with themselves, their careers, and their families. With dedicated work and intervention, it can facilitate patients' return to the unit without removal from theater or return to garrison duty. When utilized in the garrison setting, peak performance training at WTRP enabled soldiers' return to duty earlier when compared to programs that do not incorporate peak performance concepts. Soldiers also reported increased satisfaction in their own outcomes as well as a decrease in negative thoughts. Overall, the peak performance program integrates psychological, cognitive, and physiological concepts to enhance performance and promote positive attitudes among soldiers both in theater and in garrison.

Case Study 22-1: SGT JS, an infantryman, was initially seen by OT for an upper extremity injury following his return from Operation Iraqi Freedom. The therapist noticed that JS was having difficulty dealing with issues related to his deployment, specifically with anger and depression. He was referred to a community mental health social worker and a posttraumatic stress disorder group, which met once a week for 6 weeks. He decided immediately that his goal was to work on anger management, specifically when it came to his relationship with his wife. In a group-learning environment, he acquired many of the skills of the peak performance model, including energy management and goal setting. SGT JS also attended OT for one-on-one intervention for 8 weeks, incorporating a biofeedback heart rate program, guided imagery, and progressive muscle relaxation to gain control and composure when dealing with stressful situations. SGT JS reported an increase in confidence, increased satisfaction with his marriage since his return, and an overall increase in well being after attending the group and one-on-one sessions.

OCCUPATIONAL THERAPY IN THE WARRIOR TRANSITION UNIT

Since World War I, OT's philosophy of matching interventions to the soldier's ability has been an integral part of the effort to help those wounded in combat return to work. It was thought that wounded soldiers should be "restored to trades appropriate to their abilities, interest, and background."[3(p152)] Contributions did not end with direct care. Early OTs were also instrumental in setting national policy, contributing to the passage of the Soldiers Rehabilitation Act in June 1918.[3(p158)] Similar involvement continues today, with OT personnel instrumental in the formation of the Army's Proponency Office for Rehabilitation and Reintegration in May 2007, the development of the Comprehensive Transition Plan, and the development of the role of OT within WTUs.

The goal of a WTU is to promote soldiers' abilities to return to the force or transition to a productive civilian life. OT helps individuals regain, develop, or master everyday skills to live independent, productive, and satisfying lives.[15] Within the WTU, OT's primary role is to address life-skills needs and coordinate work reintegration, thus assisting soldiers to return to productive living. Work includes activities needed for engaging in paid employment or volunteer activities.[16(p341)] Occupation refers to the everyday activities of life that are named, organized, and given value and meaning by individuals and a culture. "Occupation is everything people do to occupy themselves including looking after themselves, enjoying life and contributing to the social and economic fabric of their communities."[17(p34)] Work reintegration is defined as a program that provides a structured environment with participation in vocationally related activities. The participant must

be medically stable and have a goal of competitive employment.[18]

The Comprehensive Transition Plan

The desired outcome is for each participant to be a successful soldier or successful veteran, physically and mentally strengthened, vocationally enabled, with a life-care plan established, able to maintain relationships, and proud of his or her military service.[19] Each soldier's comprehensive transition plan is an individualized, multiphased process with overlapping boundaries. The reception phase is generally 1 week in duration. Upon arrival at the WTU, soldiers are greeted with a unit welcome and orientation that delineates the expectation that they will actively participate in their own healing process. They are educated on the overall mission statement that will be inculcated into their daily life within the WTU:

> I am a warrior in transition. My job is to heal as I transition back to duty or continue serving the nation as a veteran in my community. This is not a status, but a mission. I will succeed in this mission because I AM A WARRIOR AND I AM ARMY STRONG.

The soldier is issued a "Warrior Toolkit" that includes the soldier mission statement, orientation materials, and life-skills material designed to encourage self-empowerment in the healing process.

Next comes the assessment and goal-setting phase, which generally lasts a month. During this initial period, soldiers undergo assessments for behavioral health risk; pain, sleep, and safety (including cognitive awareness, mobility, vision, and hearing tests); and requirements for housing assistance, medical supplies, family needs, and nutrition management. The staff members also appraise the soldier's level of function, vocational goals, skills, abilities, health maintenance and lifestyle, and the initiation/sustainment of rehabilitation. At the same time, the soldier's goal-setting phase begins with a focus on the development of positive life skills and habits. The soldier works with the nurse case manager, primary care manager (a physician or physician's assistant), squad leader, OT personnel, social work, and unit ministry teams to develop goals for improvement in body, mind, and spirit. OTs have a leadership role in warrior goal-setting training. Functional independence and mobility goals are established, including accessing transportation resources. Vocational, educational, social, leisure, and recreation goals are also established during this phase. Intrapersonal goals are identified to enhance self-esteem, responsibility to self, interpersonal relationships, and community responsibility.

Next, during the active rehabilitation phase, the soldier works toward attaining specific goals. This phase is divided into four tiers based on the soldier's abilities, and a training calendar is established to help reset the soldier. Tier assignment levels include tier A (medical recovery/rest) for soldiers who are placed on quarters. Soldiers in tier A are generally unable to participate in any physical, mental, relationship, or spiritual strengthening programs. Tier B (basic reset) consists of soldiers who spend their training day in rehabilitation basics. These soldiers are actively engaged in medical appointments; group or individual therapy to improve strength, range of motion, or endurance; programs and classes in nutrition or weight management; classes in life skills; or classes and workshops on relationships. Tier B includes programs that every warrior in transition needs to build basic skills and strengths as well as individualized programs to address unique circumstances.

Tier C (advanced reset) follows completion of the basic skills program. These soldiers spend part of their duty day in vocational or educational activities, but still require significant time for activities specifically designed to rehabilitate their body, mind, and spirit. Tier C generally involves interventions targeted at addressing a specific goal. Tier D (life reset) is focused on vocational, educational, family, and community pursuits. Soldiers in this tier must have completed tier B basics. They spend the majority of their duty day in vocational or educational activities, but still require ongoing medical treatment or rehabilitation. Throughout the active rehabilitation phase, a mandatory review of progress and reassessment occurs on a regular basis, with the soldier actively participating in multidisciplinary team meetings coordinated by the nurse case manager.

The final transition preparation phase, which may last up to 90 days, occurs once each individual's disposition decision has been made. During this phase, the soldier undergoes final preparation for the expected disposition. Details regarding return to home, family, and community living as well as ongoing vocational or educational pursuits after they leave the WTU are addressed and coordinated to assure a smooth transition.

Work Reintegration Programs

The objectives of a work reintegration program involve returning the soldier to the role of worker either in a military or civilian capacity. This is done through promoting, improving, conserving, and restoring the

skills, abilities, and aptitudes of soldiers through both vocational and avocational reintegration services. A soldier-centered work reintegration program pursues these goals for the soldier in transition. The program focuses on the behavioral, psychosocial, vocational, avocational, and educational needs of the soldier using techniques to facilitate independence and empowerment. The work reintegration program involves collaboration with military and civilian communities to set up safe work sites that promote quality work performance and enhance the quality of the service member's everyday life. The soldier actively participates in the work reintegration program, developing an understanding of how the services provided can positively impact his or her ability to function in a work environment.

The program also incorporates collaboration with appropriate professionals and community members to minimize impairment, maximize independent function, and enhance the quality of life of the service member in transition. Through the use of performance indicators, the work reintegration program measures the effectiveness of services provided along the continuum of care. OTs assist service members to develop and attain realistic short-term and long-term goals that reflect their interests in vocational and avocational pursuits. Service members benefit from this program by increasing the likelihood of attaining their personal goals, while the community benefits by reacquiring responsible and competent workers.

Occupational Therapy's Focus in Work Reintegration

The director of the work reintegration program is a registered and licensed OT who is qualified in both OT and work reintegration. Certified OTAs provide support in areas including screening, programming, life skills training, work-site development and coordination, and networking with internal and external resources to assure a well-balanced program aimed at returning soldiers to productive living. OT personnel work closely with other WTU staff to develop and implement the work reintegration program, which the OT is then responsible for overseeing. OTs are located in proximity to the WTU to facilitate communication with the cadre and increase interactions with participants. The OT and COTAs should be allocated appropriate space to develop and conduct a successful work reintegration program. Responsibilities of the OT assigned to the WTU include but are not limited to:

- working closely with OTs at the medical treatment facility to ensure continuity of care;
- developing and implementing standard operating procedures that support the overall goals and objectives of the work reintegration program;
- assessing limitations that prevent or delay return to work and providing recommendations for modifications and equipment needs;
- working closely with case mangers in coordinating vocational training, job skills training, and work placement;
- conducting visits to work sites to ensure job appropriateness and verifying that the participant is performing the agreed-upon job tasks;
- developing collaborations within the community to determine resources and to prevent duplication of services;
- working closely with other WTU staff to ensure continuity of care and accountability;
- establishing specific quantifiable standards to measure the work reintegration program success; and
- supervising the COTA personnel assigned to the WTU.

All soldiers assigned to the WTU undergo a comprehensive evaluation by the OT to determine eligibility and placement in the work reintegration program. Tools used by the OT may include a vocational interest survey, vocational aptitude assessment, career assessment tests, life skills assessments, cognitive skills assessments, occupational performance assessments, functional capacity evaluations, a driving evaluation in a simulator, and an evaluation of firearm performance in a simulator. All soldiers in transition also should be evaluated by the OT within 1 to 2 weeks of in-processing to determine if they are eligible to participate in the work reintegration program. Soldiers eligible for the program will be assigned a meaningful job within the limits of their physical profile and commensurate with their grade. Work internships are being developed in collaboration with the VA and 501(c)(3) (nonprofit) organizations to provide work experiences in areas of potential career fields. Each work reintegration program should maintain a file on each work site including a job description with work hours, dress code (if civilian), point of contact, memorandum of agreement, and the physical, cognitive, and psychosocial requirements of the job.

OTs collaborate with unit training personnel to help develop a structured daily schedule for each participant consisting of life skills development, work preparation, education, training, and structured duty

assignments to prepare soldiers for return to functional living. Activities are matched to the individual's needs and abilities and may include (*a*) stress management, (*b*) anger management, (*c*) assertiveness/communication skills training, (*d*) functional activities, (*e*) soldier basic skill training, (*f*) MOS training, (*g*) problem-solving and goal-setting skills training, (*h*) financial management skills training, (*i*) time management skills training, and *(j*) work readiness skills—work habits, values, interests, skills, and vocational exploration.

The supervisor at each work reintegration site provides weekly progress reports to the OT. In addition, the OT conducts at least bimonthly follow-ups to reassess each participant for continuance of the current work placement. The OT also decides what type of follow-up is needed when participants leave the unit. By the day of discharge/transition, written recommendations are given to providers in the continuum of care and other stakeholders as appropriate. Depending on the needs of the soldier, the written recommendations address:

- medical issues relevant to job placement;
- functional issues relevant to job performance;
- psychological issues relevant to job placement;
- significant abilities, relevant aptitude scores;
- areas for growth;
- identification of additional training if needed; and
- available community integration services, including local, regional, provincial, or national consumer organizations.

The work reintegration program includes a data collection system for performance indicators—collected initially and reevaluated over time—to measure the effectiveness of services provided across the continuum, including the number of WTU soldiers who were discharged from the military, who returned to duty, who received a permanent job placement, and who enrolled in school. Program staff also record satisfaction of the job site from the participant and family members.

OCCUPATIONAL THERAPY ON THE HOME FRONT

The emotional cycle of deployment affects not only soldiers, but also their families, employers, coworkers, schools, and the surrounding community.[20] The role of OT on the home front involves building skills to withstand the stress of deployment separation as well as focusing on habit training to assist soldiers and their families in the reintegration process. Incorporating rituals and traditions that can carry over throughout the deployment may provide a sense of consistency and order during a chaotic time. A psychoeducational approach using a resiliency model to enhance life skills in predeploying soldiers and their families may act as a protective measure in preparing them to overcome the hardships of deployment separation.

Returning combat troops and their families frequently report increased levels of anxiety and risk-taking behaviors when the soldier resumes driving at home.[21] This may be due to the retention of automatic combat driving behaviors that were overlearned to help the soldier survive in a hostile environment. Although appropriate on the battlefield, automatic combat driving behaviors do not mesh well with local traffic laws at home. OT personnel assess the physical, cognitive, and behavioral components of driving to help soldiers safely perform this daily living skill. Awareness training and specific interventions are useful in managing maladaptive postcombat driving behaviors. Using a consultative approach, occupational therapists collaborated with Military OneSource to develop a handout for service members and their families, providing awareness of and tips for managing postcombat driving behaviors. An article published in a national newsletter for traffic court judges also helped to increase the judges' awareness of these issues when returning soldiers have pending legal action in the traffic court system.[21,22]

A collaborative relationship between an academic institution and an Army OT resulted in the development of postdeployment driving reintegration tools. Research conducted by OT faculty and students at the University of Minnesota described postcombat soldier driving responses and identified specific interventions that effectively enhance driving safety. In consultation with the Proponency Office for Rehabilitation and Reintegration, the student/faculty team incorporated survey results, focus groups, and one-to-one interviews to develop informational brochures for soldiers and family members. The brochures address postcombat driving on the American road and include suggestions to help returning soldiers drive safely at home. In addition, the OT academic researcher developed clinician training for OTs working in military settings to help standardize the use of driving simulation.

SUMMARY

Army OTs are human performance experts and dedicated leaders whose innovative programs and services help optimize soldier performance and readiness in theater and garrison. Providing a functional approach to healing through doing, OTs match the individual's interests, skills, and abilities with activities that have meaning and purpose, along with a "just right" challenge. A focus on occupational performance helps to restore soldier confidence and competence. Life skills components of OT promote functional independence, which enhances future quality of life and productivity. Participation in work and productive activities promotes a sense of mastery, a positive self-identity, and a responsibility to take control over one's future. Bridging the gap between medical care and military performance training, OTs help unit leaders retain their soldiers through assessing physical, social, and environmental factors and recommending interventions to enhance unit climate and living conditions.

The practice of OT has been essential in the rehabilitation of military personnel since World War I. OTs use a variety of strategies to enhance occupational performance, a key factor in retention of the soldier who has sustained a physical or psychological injury. They also assess the soldier's performance and help the service member gain the skills and resilience to remain functional whether returning to the battlefield or transitioning to the civilian community. OTs provide a vital link to practical living and a more satisfactory life through occupational engagement and enhancement of physical, psychological, cognitive, and social aspects of performance.

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