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From Here to There: An Occupational Screening Tool for Transitioning Soldiers

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From Here to There: An Occupational Screening Tool for Transitioning Soldiers

by

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A Scholarly Project

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for the degree of

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Approval Page

This Scholarly Project Paper, submitted by Bailey Fruit and Hannah Williams in partial fulfillment of the requirement for the Degree of Master’s of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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Title: From Here to There: An Occupational Screening Tool for Transitioning Soldiers

Department: Occupational Therapy

Degree: Master’s of Occupational Therapy

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We want to thank all the men, women, and their families who are serving/have served our country and grant us the freedoms we desire. It is our hope that this project will provide a way to serve and benefit the veterans and their families when returning home from deployment.

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ABSTRACT

Time has shown that it can be difficult for military personnel to resume their typical life roles within civilian life. The wars in Iraq and Afghanistan were the longest wars in United States history and involved some of the most intense ground engagements since Vietnam (Cogan, 2014). This left many soldiers to deal with the traumatic experiences they went through. This study aimed at developing a screening tool to address the difficulties experienced by veterans during their transition into civilian life.

The researchers began with a thorough review of literature to identify the occupational challenges the project would address. Following completion of the literature review, the researchers identified an occupational therapy model to guide the development of the screening tool and accompanying manual. Once the tool and the manual was created the researchers presented the documents to a local veterans club and finally presented the project at oral comprehensive exams at the university.

The researchers created the Military Community Reintegration Screen (MCRS), which addresses three domains related to the person, occupation, and environment. Each domain is further broken down into subdomains and tasks that are specific to a veteran’s transition to civilian life. The manual addresses how to use and score the screening tool, as well as when to make a referral to occupational therapy services.

This tool has not been clinically tested or used. Further research on the development, usefulness, and effectiveness of the screening tool is still desired by the researchers. Screening tools and assessments are available to military personnel for reintegration into the community; however, they are generally used from research purposes or are not part of the separation requirements, therefore, are not being
completed by the soldiers. There are still individuals who are not receiving the treatment they need and due to the stigma around mental illness, many soldiers who are vulnerable to mental illness are denying their need for mental health treatment.
CHAPTER 1
Introduction

Key Terms/Concepts

Since 2001, 2.4 million military personnel have deployed to Iraq and Afghanistan in efforts related to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) (Cogan, 2014). These two conflicts have involved the most intense ground engagements since the Vietnam War, leading to an increase in the prevalence of mental health diagnoses in veterans based on the inevitable trauma experienced during war. More individuals are experiencing mental health challenges and are unable to cope with the stressors of those symptoms (Cogan, 2014). Research has indicated that veterans who have participated in violence during their deployment appear to have an increase in post-deployment dysfunction and psychological effects compared to those who do not experience violence during their deployment (Frankfurt, Frazier, & Engdahl, 2017). Additionally, the same study showed that there was a relation between killing in combat and the onset of Post-Traumatic Stress Disorder (PTSD) symptoms. Therefore, early intervention and proper treatment is a priority when helping veterans' transition back into civilian life.

According to Seal, Bertenthal, Maguen, Gima, Chu, and Marmar (2008), early intervention, incorporated with evidenced-based mental health treatment, has been shown to minimize or prevent chronic mental illness. With the use of screening tools, there is an increase in the potential for early detection of mental illness symptoms, therefore,
increasing the ability to provide early intervention for veterans and provide assistance with the transition from the military to civilian life. By identifying gaps present in the military separation process and reintegration barriers, the student researchers developed a screening tool that will aid in combatting community reintegration barriers within the military population.

The model used to guide the development of this scholarly project will be the Person-Environment-Occupation (PEO) model. This model encompasses each component that a veteran may face when re-entering into civilian life. The project will also include a literature review that will encompass research regarding military history, screening tools, and gaps with the community reintegration process. Furthermore, there will be a methodology, product/results, and a summary presented. This research has been conducted to address the number of military personnel that struggle with community reintegration, so assistance may be provided to find ways to ease the challenges that may be present with transitioning to civilian life.

Key Terms

- *Active duty*- an individual who is full-time, actively serving in the military, including members of the Reserve on full-time training duty. However, it does not include full-time National Guard duty (Powers, 2019).

- *Activities of daily living (ADL)/Instrumental activities of daily living (IADL)*- occupations that an individual wants to do or needs to do in their everyday life (AOTA, 2014).

- *Battlemind*- a training system supporting soldiers and families across the seven phases of the deployment cycle (Huseman, 2008).
• **Civilian life**- an individual who has returned to the United States, living in the community, and is no longer serving in the armed forces (Sayer et al., 2011).

• **Community reintegration**- individuals transitioning from military duty to civilian. Soldiers are transitioning from a state of not being a functional member of society into a state where individuals control and direct their own life (Your Dictionary, 2019).

• **Deployment/deployed**- the process of moving soldiers or equipment to an area for military action (Dictionary.com, 2019).

• **Military**- multiple branches of the armed forces developed to train individuals to fight in war (Merriam-Webster, 2019).

• **Mental Health**- the field of medicine concerned with the maintenance or achievement of such well-being and adjustment (Dictionary.com, 2019).

• **Military duty**- a branch in the United States military where individuals are responsible for specific missions and jobs to complete (U.S. Department of Defense, 2005).

• **Military personnel**- individuals serving in the military forces (Seal et al., 2008).

• **Occupational Therapy**- a form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life (Dictionary.com, 2019).
• *Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)*- the most recent war engagement of U.S. involvement (Bourn et al., 2016).

• *Posttraumatic stress disorder (PTSD)*- a mental health diagnosis that is triggered by a terrifying event, resulting in nightmares, flashbacks, or reoccurring thoughts regarding the terrifying event (Bourn, Sexton, Raggio, Porter, & Rauch, 2016).

• *Reintegration* - Reintegration into civilian life, refers to the return to participation in life roles in which the veteran was separated from within their normal community living environment (Maiocco & Smith, 2016).

• *Screening tools* - written material, examination, or other such tests that can be completed quickly to determine a disease or defect that is not easily detected. These tests are completed prior to further evaluation or intervention to determine the need for additional professional treatment (Morabia & Zhang, 2004).

• *Separation* - the process of when a soldier is leaving the military (Seal et al., 2008).

• *Soldier* - an individual who is trained for war (Merriam-Webster, 2019).

• *Veterans* - an individual who has served in any branch of the military within a specific timeframe (VA.org, 2019).
CHAPTER II

Literature Review

Introduction

Military personnel in the United States of America sacrifice their lives to serve our country and grant us the freedoms we desire. The trials and tribulations they endure are unfathomable to anyone who has not experienced them firsthand. Time has shown that it can be difficult for military personnel to resume their typical life roles within civilian life (Plach & Sells, 2013). There have been various programs available through the Veteran Affairs (VA) to assist with this transition after deployment, however, challenges have persisted. Although mental health difficulties cannot be prevented when extreme trauma has occurred, there may be a way to minimize the effects when soldiers return home (Plach & Sells, 2013). One of the ways to address this need may include providing a more effective screening process prior to separation from the military. Unfortunately, there is yet to be an effective screening tool available that will address veteran needs for community reintegration such as, identifying individual barriers or concerns to community reintegration and the need for additional services, resources, or training to ease the transition from military duty to civilian life.

Community reintegration is a transition for military personnel and a time when mental health deficits often become apparent. To address this issue, the following literature review will explore the research regarding community reintegration for
veterans, how mental health is related to the problem, and the lingering gaps that may be present. The key themes found in the literature review will address the historical overview of the effects that war has on soldier’s mental health; the screening tools utilized over time; how mental health has been addressed in soldiers throughout the decades; and past challenges with community reintegration. Additionally, the review will cover a present day overview, identifying current issues with veteran community reintegration. This will lead to the need for the project, occupational therapy’s role in this process, and the theoretical framework used to guide the development of this project.

**Historical Overview**

Throughout U.S. history, war has played a significant role in the lives of everyday American citizens. While the impact of war has presented severe implications for many individuals, the soldiers who have been in combat and experienced war-related trauma, have been affected the most. Over the course of U.S. history, the country’s involvement in multiple conflicts and severe combat has resulted in lifelong functional implications for the service members involved. These implications are found in veterans who served in World War I (WWI), World War II (WWII), the Vietnam War, the Korean War, and various other conflicts.

Research analyzing the psychological effects of the WWII experience was quite extensive in the first years after the war (Hunt & Robbins, 2001). Researchers examined the relationship between war zone experiences and lasting psychological effects in soldiers. Throughout this research, it was evident that a distinction needed to be made between soldiers who experience psychological symptoms during battle and those who made it through the battle free of symptoms, only to find that war-related psychological
symptoms arose at some point thereafter. Some fifty years later, further research on the topic of war-related psychological implications has found that many WWII veterans are still experiencing some kind of war-related psychological dysfunction (Hunt & Robbins, 2001). Even after years of typical functioning, these veterans still reported psychological disruptions related to war trauma.

In a study of WWII veterans, Macleod (1994), found that many had experienced a recent reactivation of posttraumatic stress disorder (PTSD). The most important factor predicting reactivation of PTSD, was declining health status. A number of life stages and other factors have been identified as contributing to declining health status; these include, retirement, anniversaries, service reunions, feelings of loneliness, comorbid psychiatric illness, and use of alcohol (Hunt & Robbins, 2001). Macleod (1994) also suggests that problems related to aging and approaching death, incited PTSD symptoms. Studies suggest that age-related changes might exacerbate the problems and reduce the veteran’s ability to cope, as veterans cannot always extinguish their painful memories (Hunt & Robbins, 2001).

WWII is not the only major conflict in which significant psychological implications were identified in soldiers; the Korean and Vietnam Wars had serious impacts on soldiers as well. In a study conducted by Hunt and Robbins (2001) they examined symptomology of psychological effects from past wars and determined that the Vietnam veterans exhibited more mental health related symptoms than veterans from other wars. WWII veterans recalled more incidents about physical injuries and captivity, while the Vietnam veterans recalled brutality, mutilated bodies, the death of children, and
the loss of friends (Hunt & Robbins, 2001). According to Hunt and Robbins (2001) there are a large number of ageing WWII and Korean War veterans who are still experiencing mental health challenges related to their service time.

In the last decade, approximately 2.6 million soldiers have been deployed in support of the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) wars, and almost half of those soldiers have been deployed more than once (Radomski & Brininger, 2014). The wars in Iraq and Afghanistan were the longest wars in U.S. history and involved some of the most intense ground engagements since Vietnam (Cogan, 2014). Advances in warfare and medical treatments in the field, have led to more soldiers surviving high trauma situations (Plach & Sells, 2013) and living to tell about their lived experience of war and the impacts it has had on their lives. It is widely accepted that no one leaves combat without incurring profound physical, psychological, and emotional changes. Many will return home with physical disabilities inflicted during combat, while others will return with less apparent but equally significant emotional and psychological disabilities (Coll, Weiss, & Yarvis, 2011).

Coll et al. (2011) report that 15-30% of all returning veterans would meet the DSM-IV criteria for serious mental health disorders involving PTSD, mood disturbances, anxieties, and comorbid substance abuse. Of the several diagnoses, 13-20% of the OEF/OIF service members may receive PTSD prevalence (Maiocco & Smith, 2016). PTSD is one of the most cited diagnosis in all of the literature prepared for this review. Three key symptoms that must be present for a PTSD diagnosis are re-experiencing trauma, avoidance and numbing, and hypervigilance (Cogan, 2014; Mankowski & Everett, 2016). In addition to PTSD the most common risks these veterans face upon
returning home are substance use disorder, depression, and anxiety (Pease, Billera, & Gerard, 2016). Subsequent symptoms such as hopelessness, anger, and feelings of dependency on others, may also be experienced (Pease et al., 2016). Furthermore, common issues service members may struggle with during this time include difficulty sleeping, headaches, nightmares, anger, and irritability (Cogan, 2014).

**Screening processes.** Over time the United States military has used large quantities of mental health screening tools dating back to WWI. The earliest screenings were used primarily to determine intelligence levels and psychological vulnerability among military recruits. This determined an individual’s ability to be an effective soldier and exclude any person who would have the potential to experience extensive psychological deficits from service (Morabia & Zhang, 2004; Seal et al., 2008). However, these screenings have unsuccessfully addressed ways to identify and reduce the service member’s psychological casualties after they serve (Seal et al., 2008).

Furthermore, evidence indicates that pre-screening for mental health does not predict an individual’s success in military performance. This is due to the screening process having the inability to address important factors such as the type of leadership received, degree of motivation, type of position and unit assigned to them, and the extent to which they would be exposed to external stress (Ritchie & Cardona, 2007).

**Intelligence testing.** During WWI, from 1909 to 1915, 83% of all individuals who applied for military service, were denied. At that time, the age to enlist dropped from 21 years old to 18 years old. The screening criteria at the time addressed pre-requisites to determine if the person was appropriate to serve in the military. This screening was
known as Intelligence Testing. During this screening protocol there were 468 per 1,000 men who were considered “defective”. Of those 468 turned away, six percent were rejected due to “mental health defects” (Ritchie & Cardona, 2007, p. 31).

**Medical survey program.** During the WWII era, the need to quickly test new recruits was in high demand due to the influx of draftees needed following the attack on Pearl Harbor. The screening process spurred various opinions regarding how screenings should be used and implemented to recruit service members. Some believed individuals diagnosed with neuropsychiatric disorders would be unable to handle the pressures of war. However, evidence demonstrates that individuals with previously treated psychological diagnoses were able to adequately adjust to military duty (Ritchie & Cardona, 2007). In response to the findings of this survey, a psychiatric consultant was included in the survey team to assist medical examiners during the drafting process. The medical examiners would complete their initial evaluation and those who passed the examination were then progressed to the final phase where intelligence testing was completed. Additionally, during this time, there was a strong emphasis in obtaining a history of the draftee. This was known as the Medical Survey Program. The individual’s history reviewed legal, medical, educational, and mental health records. However, this system did not work for long due to the limited number of social workers available to review the records, leading to incomplete screening forms that only contained pathological histories (Ritchie & Cardona, 2007). There was also a limited number of psychiatrists available in the military service. This encouraged the government to recruit civilian general practitioners to complete psychiatric exams. The psychiatrists and
practitioners then created their own homemade screenings and tests that addressed past and present psychological symptoms and antisocial behavior (Ritchie & Cardona, 2007).

**Neuropsychiatric screening adjunct.** Also during the WWII era, Dr. John Appel attempted to validate one screening tool to simplify the process. This tool was known as the Neuropsychiatric Screening Adjunct. This tool consisted of a 15-item test that addressed common psychiatric diagnoses with eight questions screening for psychosis and antisocial behavior. If an individual scored low, they were seen for an individualized psychiatric exam (Ritchie & Cardona, 2007). This screen did not replace the original psychiatric interview, but was a tool used to assist with the psychiatric screening process. The screen was found to be useful and identified 80% of psychiatric diagnoses. However, it was not fully implemented due to the recognized need for further standardization, which was not completed (Ritchie & Cardona, 2007).

**Retraining units.** WWII screening standards for mental health criteria was not an adequate representation of predicting the service member’s appropriateness for military duty (Ritchie & Cardona, 2007). Also recognized during this time, was the potential importance and value of training sessions used to help military personnel prepare for the transition to and from active duty. In a study conducted by Ritchie and Cardona (2007), the determinant they found to be effective for predicting suitability of military duty, was to evaluate the individual’s performance within military conditions rather than evaluating them during the admission process. This led to completion of screenings during the induction stage and when the individual was in the military environment. The researchers incorporated standardized mental hygiene and life skills
lectures as a transitions training program for individuals who were entering into the military. Within the training, the researchers developed retraining units where recruited soldiers were placed in a supported environment to assist with their transition into military service. Seventy percent of individuals who participated in the study and completed the supported training program were successful with transitioning into military service (Ritchie & Cardona, 2007). This demonstrates the benefits of incorporating a formal training for recruits to ease the transition process into the military. Therefore, the same idea may be beneficial to assist with the transition from the military to civilian life.

**Satisfaction screening tools.** After the Korean War, there was continuous research being conducted to further develop and improve screening measures. General psychiatric and cognitive screenings had been fully accepted and put into use. However, additional screening efforts focused on measures that addressed personality characteristics that would predict military service satisfaction (Ritchie & Cardona, 2007). The *Fort Ord Inventory* was a screening tool used to determine an individual’s qualities in relation to poor adjustment and their leadership potential. The *Psychological Screening Inventory* was used to address the individual’s potential for military duty, how they would respond to training, behavioral modifications, and group dynamics. The *Assessment of Background and Life Experiences* was a self-report which screened motivational factors and first-term attrition and performance factors (Richie & Cardona, 2007).

The student researchers conducted significant searches and sought guidance from the University of North Dakota librarian to which no studies were available that identified screening tools that were utilized for soldiers during the Vietnam era. However,
there has been research conducted in more recent years (2006-2018) that primarily focuses on Vietnam veterans who are experiencing continued PTSD effects long after they have been separated from military duty. (Bhattarai, Oehlert, & Weber, 2018; Bourn, Sexton, Raggio, Porter, & Rauch, 2016; Maguen et al., 2007; Marshall et al., 2006; McNally, 2007; McNally, 2007).

**Afghan and Iraq post-deployment screen.** In 2004, the U.S. Department of Veteran Affairs implemented a national directive to start the Afghan and Iraq Post-Deployment Screen. This screen was designed as a brief, yet valid screening tool to detect symptoms of PTSD, depression, and high-risk alcohol use in veterans of OEF/OIF that received care at the VA (Seal et al., 2008). Clinicians at the VA are advised to complete this screen in order to determine if the veteran meets criteria for a mental health referral. If the veteran meets criteria, the clinicians are encouraged, but not required, to refer at risk individuals for further mental health assessment and treatment (Seal et al., 2008). The student researchers were able to find the research regarding this screening tool on the VA website, however, it remains unclear whether this tool is utilized at this present time. According to Seal et al. (2008), research shows that VA screens may assist with overcoming the “don’t ask, don’t tell” culture that is representative of the stigma around mental illness. However, the Iraq and Afghan Post-Deployment Screen is not a VA performance measure and other screens and evaluations may be more of a priority depending on the facility and the clinicians.

Military personnel are not aware of the mental health difficulties they may experience when leaving the military and begin to reintegrate into civilian life. In the
study conducted by Seal et al. (2008), 69% of OIF/OEF veterans who completed a post-deployment screen within the VA facility screened positive for PTSD, depression, or high risk alcohol use. Furthermore, a study from a US military post-deployment screening program demonstrated that, of more than 300,000 military personnel, only 15% reported concerns with their mental health (Seal et al., 2008). The research suggests that military personnel are not aware of the mental health difficulties or social/environmental barriers they may experience when leaving the military. Therefore, early identification of personal barriers to community reintegration will assist with identification of mental health symptoms and early intervention.

**Military to civilian questionnaire (M2C-Q).** The M2C-Q is a short, self-report that is used to measure problems related to post-deployment community reintegration among OEF/OIF veterans. The form was created from information gathered through a literature review and items were developed based on, “functioning problems among combat veterans, measures of psychosocial functioning, measures of community integration used for patients with disabilities, descriptions of reintegration problems among combat veterans, and qualitative data from a study examining factors associated with PTSD treatment seeking among veterans” (Sayer et al., 2011, p. 662, 664). The items selected are used to assess hypothesized problem areas for veterans when they transition into the community. These items include, “interpersonal relationships with family, friends, and peers, productivity at work, in school, or at home, community participation; self-care, leisure, and perceived meaning in life” (Sayer et al., 2011, p. 664).
The M2C-Q is rated on a 5-point Likert Scale and the participants are able to identify if an item does not apply to them, such as having a spouse/partner, children, work, or school. The wording was written so it is easily understood by the veteran population. The researchers also incorporated one item that was intended to address the veteran’s perceived overall difficulty with being able to readjust to civilian life over a 30-day time period that was measured on a 5-point Likert Scale. Sayer et al., (2011) conducted a study to determine the reliability and construct validity of scores for the M2C-Q. There was a total sample of 745 OEF/OIF veterans who were selected and participated in the study. Each participant was sent a pre-notification letter that explained what the study was about. Two weeks later each participant was sent a cover letter (re-stating the goal of the study, risks, benefits, and notification that participating is voluntary, verifying their consent to participate if they complete and return the questionnaire), the M2C-Q, and a five dollar incentive. The questionnaire demonstrated high internal consistency and scores provided initial evidence of construct validity. The researchers also did not measure stability over time or sensitivity to change. This is needed to determine the usefulness of the questionnaire for outcomes research. It is also important to note that it is a subjective report. Construct validity within the M2C-Q is weak due to the use of a single item to assess overall community reintegration. Therefore, more research needs to be completed.

The M2C-Q measures are intended to assist researchers in being able to describe the difficulties associated with veteran community reintegration and determine interventions that will assist with the process. Although the aim of the M2C-Q study was
not intended for clinical use, the authors hypothesize that it may be useful in a clinical setting. However, before it is used in a clinical setting, future research should be completed that aims to address the use within the clinical setting. Additionally, further research should be conducted to determine the psychometric properties of the M2C-Q in a variety of different samples, such as veterans who do not use the VA. However, the M2C-Q is providing a way for new measures that will identify personal difficulties that veteran’s experience with reintegrating into the community, relating to interventions, repeated deployment, or life events. Although not suitable for a clinical setting to date, additional research may help clinicians develop a care plan to assist veterans with challenges they may face with reintegration (Sayer et al., 2011).

**Deployment risk and resilience inventory (DRRI).** A current assessment authored by Vogt, Proctor, King, King, and Vasterling (2008), known as the DRRI is a psychometric tool used to assess factors related to deployment and the health and well-being of military veterans. The DRRI assesses two pre-deployment factors (prior stressors and childhood family environment), ten factors during deployment (combat experiences, perceived threat, aftermath of battle, difficult living and working environment, sense of preparedness, nuclear, biological, and chemical exposures, concerns about life and family disruptions, deployment social support, sexual harassment, and general harassment), and two factors related to post-deployment (social supports and stressors). Factors that may contribute to post-deployment stressors include aftermath battle, threats in combat experiences, and environment hazard exposure in war zones. Although the DRRI addresses many useful informative components, further development needs to be completed for validation of the instrument (Vogt et al., 2008). According to
the U.S. Department of Veterans Affairs (2016), this is a useful tool for therapists to use for research purposes and a tool for discussion; it has not been validated as a clinical instrument, therefore, it cannot be used to diagnose.

Mental health concerns continue to be prevalent in veterans and the current military population. As demonstrated above, the history of mental health has historically been a problem for military personnel and continues today. Although the past screenings provide a starting point in what has been useful and tools that require further research, more needs to be done to ensure that history does not continue to repeat itself. In addition to historical trends, being familiar with past and present screening tools that have been utilized will assist health care professionals in identifying key features and determine the effectiveness of various tools. Currently, there is no gold standard in existence to measure or assess reintegration or readiness for reintegration; and the length of successful reintegration is not specified in the literature (Maiocco & Smith, 2016). While there is evidence of a mental health crisis for this population, there is minimal research addressing appropriate screening tools used after an individual is separated from active duty, and many service members are not seeking out appropriate intervention.

Pre- and Post-Deployment Procedures

**Battlemind.** Upon initial entry into any U.S. military entity, there are many trainings in which soldiers are required to complete before they are able to serve deployment terms. According to Coll et al. (2011), the military’s response to promoting the psychosocial well-being of service members is done through a protocol known as Battlemind. There are many components to the protocol, however it mainly focuses on
resiliency skills training throughout the cycles of deployment, including pre- and post-
deployment. The protocol prepares the service member for combat through strengths-
based, team-based, and direct cognitive applications. In addition, this training provides
soldiers with an in-theater debriefing program for soldiers who have experienced
potentially traumatic events. The debriefing is an opportunity for service members to vent
their feelings related to their military experience (Cogan, 2014), however, the stigma
regarding the physical, mental, and emotional strength of a soldier, impacts the number of
soldiers who utilize this method of stress relief. In addition, service members are advised
to seek out additional services if deemed necessary, as this debriefing should not be
considered a counseling or therapy session.

_Proximity, immediacy, expectancy, and simplicity principles (PIES)._ Aside
from the Battlemind debriefing program, there is a military-based approach in place to
treat the psychological effects of war-zone experiences called the PIES; the Proximity,
Immediacy, Expectancy, and Simplicity Principles as cited in Coll et al. (2011). Harrison,
Sharpley, & Greenberg (2008), explained during WWI, a new group of military
psychiatrists shared an interest in the treatment of soldiers with psychological disorder,
thus they developed the PIES. Currently this method is employed by Combat Stress
Control Teams (CSC), to provide front-line behavioral health care for the military. This
is a method which was designed during WWI, as an effort to provide an early
intervention program to normalize the experiences soldiers were having in combat. The
aim of this method was to return soldiers back to the battlefield as quickly as possible.
However, even with such a system in place, soldiers often return to the United States with
serious psychological disorders as a direct result from their war zone experiences (Coll et al., 2011).

**Follow-up care.** Prior to discharge from military duties, all soldiers are required to complete a reintegration program before they return home. There is no specific definition of reintegration and therefore, no specific program is identified. However, the programs generally emphasize finding purpose in life, interpersonal relationships, employment or schooling, and access to benefits, housing, and health care (Sayer et al., 2011). This shows that the military strives to ensure they prepare the soldiers for life as a civilian. In addition, clinicians are encouraged to complete assessments and make appropriate referrals for further assessment if the veteran has a positive screen for mental health concerns, however the veteran must accept the mental health follow-up appointment. The veteran’s decision to follow-up is determined by their interest in seeking further treatment, preferences, and willingness. It has been reported that veterans who received post-deployment screenings were more likely to have them completed at a primary care visit in a VA community clinic rather than a VA medical center or other non-VA settings (Seal et al., 2008). Veterans who were seen at a VA community clinic or primary care facility were more likely to complete a follow-up mental health visit within 90 days of screening than veterans who received care at a VA medical center or an outpatient setting (Seal et al., 2008). This demonstrates the importance of extending the mental health screen follow-up with a primary care provider who may be able to assist the veteran with overcoming their symptoms and accepting mental health treatment.
Community Reintegration

Reintegration into civilian life, refers to the return to participation in life roles in which the veteran was separated from within their normal community living environment (Maiocco & Smith, 2016). This also includes finding a purpose in life, having inter- and intrapersonal relationships, being employed or receiving an education, having access to housing, health care and other benefits, as well as engaging in roles as an independent being (Pease et al., 2016). Community reintegration has been proven to be a challenge for military personnel returning from combat. The most frequent challenges, as identified by Coll et al. (2011), are related to cultural dissonance, mental health problems, or physical disability.

This issue with veteran reintegration is timely due to the high volume of soldiers transitioning home at the conclusion of OEF/OIF (Pease et al., 2016). Nearly 1.5 million service members have left the military within the decade leading up to the conclusion of OIF/OEF in late 2014 and many more would follow in the coming years (Cogan, 2014). In 2016, more than 2.5 million members were projected to be separated from the armed forces, leaving several individuals to reintegrate into civilian life. To further complicate reintegration Kelly, Berkel, and Nilsson (2014), report that many individuals who are National Guard or Army Reserve will not undergo deployment debriefing once they return to the States, nor will they return to a military base. Instead, they will return to communities and families who may be unaware of the realities of deployment and be unprepared to support their loved one during this transition. These soldiers are therefore left unable to create a culture of support and acknowledgement with others who share the same or similar deployment experiences (Kelly et al., 2014).
Research has shown that within the first year of returning from deployment, mental disorders and symptoms arise (Sayer et al., 2010). The first year is often the time when veterans are undertaking many different components of reintegration, such as their social life, place of residence, vocation, environmental stimuli, and other important life roles. However, in the instance that those components do not align, veterans may develop mental health symptoms and occupational challenges after their one-year anniversary has lapsed. Similarly, veterans who have been in the community for longer periods of time may also develop mental health symptoms and occupational challenges not previously present or identified prior to reintegration (Seal et al., 2008). Therefore, understanding the interactions occurring between the person, their environment and valued occupations, is important for both veterans with recent reintegration as well as with veterans who have been a civilian for a longer period of time.

**Challenges with Reintegration**

Studies have shown that the transition to civilian life for OEF/OIF veterans who served in combat can be particularly difficult, with over 50% describing the readjustment to civilian life as a “real struggle,” (Pease et al., 2016, p. 83). According to Pease et al. (2016), there are very few similarities between civilian and military cultures. Thus, soldiers transitioning into the veteran role find it challenging to successfully reintegrate into civilian life. Coll et al. (2011), illustrate the experience of soldiers reintegrating as, “encountering the same type of culture shock that immigrants experience when first arriving to the United States; there is disorientation, change of status, and a search for identity and meaning” (p. 488). The current generation of military personnel returning
from these wars are perhaps even more at risk than prior generations of veterans as they have served substantially longer tours throughout the course of multiple deployments (Coll et al., 2011).

The most researched challenges that soldiers experience include, the soldier’s home life, social supports, and employment status. Once a veteran is home, he or she is impacted by the life roles they must resume and attend to their responsibilities. After the veteran’s experience combat, many feel a disconnect between themselves and family members, feel out of place, and/or afraid that their families no longer understand them (Cogan, 2014; Maiocco & Smith, 2016; Pease et al., 2016). Once a member of a large unit, the soldier had a purpose and a position. Now returning home, the adjustment issues may be present within the context of returning to an individualistic society where the close bonds and collectivist value system experienced in the military, is not present (Pease et al., 2016).

Reintegration challenges may include the following: post-deployment stressors, low and/or lack of social support, depression, PTSD, substance abuse, anxiety, sleep disturbances, intimate partner violence, eating disorders, obesity, or chronic pain (Maiocco & Smith, 2016). Young veterans who are returning from OEF/OIF are at extreme risk for developing psychological disorders affecting their ability to successfully re integrate into their community. Approximately one third of the soldiers coming home from OEF/OIF will struggle with at least one of the listed disorders: PTSD, traumatic brain injury (TBI), or major depression. In addition, findings indicate an increase in alcohol misuse, challenges in relationships, school, physical health, driving, and sleep disturbances (Maiocco & Smith, 2016; Plach & Sells, 2013). These soldiers are also at
risk for experiencing disruptions in their daily occupations; more so than soldiers from past wars.

Due to military enlistment being voluntarily at this present time (Radomski & Brininger, 2014), there are demographic differences from those of previous conflicts (Cogan, 2014). According to the Department of Defense (2010), as cited in Cogan, (2014), statistics show that 38% of active duty service members were married with children and more than five percent were single parents. In addition, 34% of selective reserve members were married with children and nine percent were single parents. Comparatively, in 1968 during the Vietnam War, only 17% of enlisted members were married and fewer than 10% were married with children. The gap in statistics demonstrates the immediate impact of the deployment cycle on the service member but also the extension of impact into family life as well (Cogan, 2014).

Service members may face relationship difficulties with spouses, children, and significant others (Pease et al., 2016), all of whom are affected when a soldier is deployed. Upon reintegration into the home, family member roles have changed and adjustments to those changes are not easily incorporated. According to Pease et al. (2016), veterans suffering from PTSD experience significantly higher rates of marital or familial problems than those without PTSD. Additionally, female veterans are more likely to have negative personal and family reintegration experiences, such as life stressors or lack of social support, which may lead to depression, PTSD, substance abuse, anxiety, sleep disturbances, intimate partner violence, low social support, eating disorders, obesity, and chronic pain (Maiocco & Smith, 2016). Moreover, mental health
issues for female veterans typically do not occur until after separation (Maiocco & Smith, 2016).

Aside from difficulties within the familial context, reintegrating veterans also experience challenges within the scope of employment opportunities. Returning veterans are often in the prime years of employability, therefore, employment is a high priority among this cohort. However, barriers to employment include insufficient education or specialized military training that does not necessarily translate to the civilian world (Pease et al., 2016). Veteran unemployment is also higher than the national average due to disability, limited civilian work experience, and obstacles for veterans making the transition (i.e. complex licensing requirements) (Plumer, 2013). Additionally, the media and news portray veterans as dangerous, which creates a stigma and damages the veteran’s ability to reintegrate into civilian life (Bonnan-White, Yep, & Hetzel-Riggin, 2016).

Further, reintegration struggles are exacerbated due to the social stigmas and fears related to having mental health challenges. Coming back from war is remembering war experiences that never end (Maiocco & Smith, 2016). Wary of attacks in Iraq or Afghanistan, veterans remain hyper vigilant to people, events, and sounds in the environment (Maiocco & Smith, 2016). Unfortunately, veterans with community reintegration difficulties experience many barriers, one of which is seeking medical care. It has been shown that there is a barrier for veterans and returning combat soldiers when seeking mental health treatment due to the stigma around mental illness (Sayer et al., 2010). Regardless of the diagnosis, military personnel would be more receptive to
seeking treatment if it were entitled “community reintegration services” rather than mental health treatment (Sayer et al., 2010, p. 596).

Although progress is being made in the military system related to mental health, there is still evidence to support the need for further investigation into the well-being of the veteran population after reintegration into the civilian community. Concern continues for veterans facing PTSD, other mental health issues, TBI, chronic pain, and opiate addiction (Kilbourne & Atkins, 2015). Another concern regarding veterans and their mental health status is the risk of suicide. Functional implications of these challenges include disrupting function in their home lives, place of work/education, and social lives. More specifically, the most common occupational performance deficit in veterans is seen in driving, productivity, physical health, relationships, and inability to sleep (Kashiwa, Sweetman, & Helgeson, 2017).

If veterans do not have their mental health issues treated, it may lead to negative consequences in their ability to function in the community and socially interact. These issues decrease the individual’s quality of life and thoughts of suicide arise. If a veteran has meaningful relationships, access to mental health treatment, and are provided with coping strategies, it will decrease social isolation and the feeling of not belonging. It has also been shown that coping strategies and group or individual intervention provide the opportunity for social interactions, which in-turn could reduce the potential for mental illness (Kashiwa et al., 2017). However, more research would need to be conducted to create an effective screening process and establish supportive services to assist veterans with reintegration.
Taking Action

While there are many components of a soldier’s life that effect reintegration, there has been research conducted through the Department of Veteran Affairs Rehabilitation Research and Development Services. The research has consisted of progressing the field of outcome measures for rehabilitation-related studies (Resnik et al., 2012). These studies were designed and implemented by the VA in an effort to combat reintegration related stressors such as mental health illness.

A State of the Art (SOTA) conference was created to advance the research behind outcome measures for rehab-related studies. Experts on mental health, spinal cord injury (SCI), TBI, limb loss, vocational reintegration, community reintegration, and alternative research designs for rehab research, were involved. These experts who were invited to participate could be involved in the VA or be outside the VA. The SOTA Working Group on Community Reintegration evaluated community integration outcomes, identified measures that need to be developed, and found where future research needs to focus its attention.

The Community Reintegration for Service members (CRIS), was designed to address services to injured veterans, caregivers, and clinicians. The CRIS uses the International Classification of Functioning Disability and Health (ICF) to measure objective, subjective, positive, and negative components of participation. However, several studies have indicated that satisfaction with activities is inconsistently associated with participation (Resnik et al., 2012). Additionally, measures such as the Community Integration Questionnaire (CIQ) and the Craig Handicap Assessment and Reporting Technique are assessment tools used to address the components of participation.
However, they are objective measurements and do not address the individual components of personal preference, choices, and values related to the satisfaction of participating in certain activities (Resnik et al., 2012).

The Department of Defense has taken measures to support the health of military families, such as screening service members for PTSD as they return home from combat zones and offer special programs to support families throughout deployment. However, their screening process has proved to be insufficient as they do not identify many of the service members who seek mental health intervention during the post-deployment period (Cogan, 2014). Although, there has been resources available to family members of deployed soldiers. The Department of Defense has taken preventative measures in an effort to provide mental health interventions by offering Military OneSource, which is a website that contains information about different aspects of military life and also offers a toll-free number for immediate phone counseling (Cogan, 2014). While the Department of Defense has offered these services to the families and military personnel, it is left in the hands of the individuals to utilize the services. Referring back to the stigma, many members fear it is unlikely that no one would personally seek out resources without a professional referral. Cogan (2014), identified that the military is currently working to change the culture with an anti-stigma campaign. This campaign is designed to encourage service members to seek help while reassuring them that their careers will not be damaged if they do so.

In addition to the above action, there has been an increase in interest to incorporate evidence-based programs and policies that will address the welfare of active
duty service members. These include, stronger evaluation designs, specifically randomized program evaluations, or ones with similar comparison groups. Doing so will determine the effectiveness of the programs and policies, and therefore, highlighting the usefulness of the evaluation designs before being fully implemented (Kilbourne & Atkins, 2015). Psychiatric deficits experienced by service members who return from duty have been identified as a component that needs to be addressed within the evidence-based programs. However, although mental health has been identified, there is less known about the need to address reintegration into civilian life. Additionally, community reintegration for veterans has not been significantly studied for the service members who are not in a rehabilitation setting (Sayer et al., 2011).

**Present Gaps**

Currently, there is not one screening tool found to be comprehensive, nor effective, in measuring the mental health needs of discharging combat soldiers. Additionally, there is a lack of standard procedures declaring which tools are used consistently with all discharging soldiers. Without effective screening tools and a standardized administration procedure, individuals are likely to miss the opportunity to receive appropriate referrals and treatment to assist with the challenges they face during reintegration.

Although there are certain measurement tools used to assist with community reintegration, which are addressed above, each veteran has unique social roles and responsibilities within their community and therefore, these measurements may not address the unique differences each individual veteran experiences in the reintegration process. Depending on the person and their experiences, when they return home, they
may find it easier to connect with other soldiers rather than their family, or they may find
life as a civilian meaningless compared to their life in combat. Rehabilitation experts
shared that community reintegration needs to provide a sense of belonging or acceptance,
connecting with people, and becoming involved in leisure and community activities.
However, these areas of community reintegration are not typically assessed with existing
measurement tools (Sayer, et al., 2011).

Within the current military system, there is a need for a screening tool to be
implemented in all branches of service. The screening tool should address concerns
related to mental health needs of all soldiers when discharging from the service. This
screening tool would provide the appropriate officials with information regarding soldier
readiness to reintegrate into the civilian community as well as the need for further
assistance, in which a referral would be indicated. Occupational therapy is one of the
best professions to help fill the current gap and provide services to veterans needing
further support and training so they may achieve the occupational performance they
desire upon reintegration.

**Role of Occupational Therapy**

Historically, the occupational therapy profession can be traced back 100 years to
its role in caring for and helping veterans after discharge from active duty. During WWI,
occupational therapy reconstruction aids were individuals who took initiative to assist in
the war effort by helping injured soldiers (Christiansen & Haertl, 2014). This group of
women used arts and crafts to occupy the minds of the soldiers while they were
recovering from their injuries. The unique aspect of the crafts that were being created by the soldiers, were items used for everyday appliances.

WWII followed and was catastrophic in many ways, such as destruction of property and mass casualties. As a result, increased funding was directed to research and services for veterans returning from war. One such example of services for veterans was stimulated by the Vocational Rehabilitation Act, which was amended in 1943 and 1954. The intent of the act was to address physical and mental renewal which led to the creation of workshops to assist in remediation and healing for the veterans (Christiansen & Haertl, 2014). Occupational therapy was impactful during this time due to the professional knowledge regarding the importance of “doing” and finding work to occupy the mind of the soldiers. With the onset of mental illness and PTSD, medical providers had to address the psychological effects of war, however, mental illness did not take precedence over the physical injuries (Christiansen & Haertl, 2014).

During the WWII era, there was a demand for most health care professions, including occupational therapy, to treat veterans returning from war. This was a time for change in the occupational therapy profession due to the shift in focus from using arts and crafts to scientific-based rehabilitation techniques. As the number of mental illnesses increased, efforts were being made to address the concerns of individuals and their families. Therefore, there was an emphasis put on assisting veterans with reintegration into the community, thus focusing on activities of daily living, ergonomics, and vocational rehabilitation (Christiansen & Haertl, 2014).

Occupational therapists continue to play an integral role in the rehabilitation of soldiers coming home from war. This unique profession equips therapists with the skills
and knowledge to address both the physical and mental traumas presented by individuals enlisted in the military. This profession uses meaningful occupations to aid the injured through rehabilitation of the mind, body, and spirit. Occupational therapy as a profession is responsible for the use of traditional and novel methods of therapeutic occupation to address occupational dysfunction among service members and veterans (Radomski & Brininger, 2014). The profession is also tasked with rigorously studying the impact of occupation on recovery, resilience, and reintegration (Radomski & Brininger, 2014). Therefore, occupational therapy has an incredibly large role to fulfill with assisting the veteran population in a successful community reintegration.

An occupational therapist has the skills and knowledge to enable each area of occupation (rest/sleep, work, play, leisure, social participation, activities of daily living (ADL), instrumental activities of daily living (IADL), and education) and aid in the reintegration process (AOTA, 2014). An occupational therapist has the education, training, and skills to view the individual as a holistic person, considering the individual mentally, emotionally, cognitively, physically, and spiritually, in order to progress their reintegration as smoothly as possible. Additionally, occupational therapists are unique as they also have the ability to analyze the person’s environment and context as well as the person’s occupations. By analyzing the person, environment, and occupation together, occupational therapy will use that transaction to identify barriers and supports that will influence an individual’s occupational performance.

With this specific population, an occupational therapist may be challenged with diagnoses such as PTSD, suicidal ideation, depression, anxiety, and other diagnoses
impacting an individual’s ability to participate and complete their daily occupations. Defining occupational therapy’s role in suicide prevention requires an understanding of the association between psychiatric disorders and barriers to occupational performance related to suicide risk. Occupational therapy practitioners skillfully evaluate the interactions between a client’s context and environmental factors, which may interfere with occupational engagement and increase suicide risk (Kashiwa et al., 2017).

As health care professionals, occupational therapists are equipped to develop a screening tool that will address the psychosocial needs of military personnel during the significant life transition from activity duty to civilian life. A tool developed from the occupational therapy perspective may address several factors specific to military personnel, such as, components specific to the person, various environmental factors including physical, social, and cultural, and the occupational factors with which the individual engages. Additionally, occupational therapy may assist with addressing an individual’s skills that they have gained through their military experience to apply for a suitable employment opportunity. By developing a screening tool that addresses important factors related to reintegration, it may assist veterans and others to more easily understand the significance of the transition, when and where difficulties are most likely to occur, and where the gaps are in present services.

**Theoretical Framework**

An occupational therapy model was chosen to guide the development of this scholarly project. The Person-Environment-Occupation Model (PEO) was chosen to encompass the “fit” between each domain that will address the trials veterans face with reintegration. The model was originally developed in the 1990’s in response to the
professional shift from using theories developed by other professional disciplines, to models of practice specific to the occupational therapy profession (Law et al., 1996). There are three key components to the PEO model: person, environment, and occupation. Each component addresses specific factors. The person factors include physical, cognitive, sensory, affective, and spiritual. The environment factors include physical, social, cultural, institutional, and virtual. The occupation factors include self-care, productivity, work, leisure, and rest/sleep. The interactions between the person, environment, and occupation influences a veteran’s ability to perform their occupations in their environment as well as indicates the quality in which they are able to perform their occupations.

In this model, the interactions between the domains are referred to as transactions. Each transaction provides an explanation of how the “fit” between each domain is organized. When the “fit” is closely analyzed, specific problem areas surface and potential areas of need may become apparent (Baptiste, 2017). Therefore, when analyzing a veteran’s transition, there may be events that relate to the person and environment, person and occupation, or environment and occupation that may influence the veteran’s occupational performance. The PEO model, when applied to the occupational therapy profession, offers a firm foundation for practitioners to analyze the person holistically. The model also assists in identifying the veteran’s strengths and limitations in relation to the “fit” between each domain. Therefore, this model is appropriate when determining community reintegration barriers for veterans upon separation from the military.
Conclusion

Approximately 2.6 million service members have been deployed to Afghanistan or Iraq war zones (Radomski & Brininger, 2014) and 57% have since been separated from the military, earning the title of veteran (Cogan, 2014). Upon returning home, veterans face several challenges as they reintegrate into civilian life, some of which include social withdrawal, hypervigilance, difficulty managing anger, emotional numbing, and re-experiencing war time traumas. Unfortunately, these reactions and behaviors interfere with a veteran’s ability to participate in valued occupations.

Screening tools and assessments are available to military personnel for reintegration into the community; however, they are generally used for research purposes or are not part of the separation requirements, therefore, are not being completed by the soldiers. There are still individuals who are not receiving the treatment they need and due to the stigma around mental illness, many soldiers who are vulnerable to mental illness are denying their need for mental health treatment. Identifying barriers related to mental health challenges and reintegration is vital when developing a mental health screening program. The various factors related to mental health stigma, inability to geographically attend treatment, barriers with family, work, or school, avoidance, low motivation, and denial, all contribute to challenges faced when assessing and providing services to veterans (Seal et al., 2008). These barriers are all related to the psychological symptoms that veterans face when reintegrating into the community.

In order to identify gaps in services, continued research should address areas of need for veterans and their families, as well as determine the best ways to reach the majority of the veteran population. Providing a routine assessment that relates to
concerns with community reintegration, may assist with identifying a person's risk of struggling with reintegration. Additionally, supportive services, training, and resources will assist in promoting better community reintegration outcomes and optimizing occupational performance (Resnik et al., 2012). Therefore, further efforts should expand reintegration training to more veterans and identify reintegration barriers early to enhance veteran success with community reintegration.
CHAPTER III

Methodology

Introduction

To begin the development of this project the authors started with the University of North Dakota’s School of Medicine and Health Sciences Library, the Harley E. French library. From there the authors narrowed their search by using the PubMed and CINAHL databases. Once in the databases, the authors used any combination of the following search terms, military, community reintegration, mental health, occupational therapy, screening tools, assessments, history of, etc. Utilizing the articles returned from the search the authors compiled a thorough literature review. In the event that the authors were not able to yield the results they were looking for, they consulted the Devon Olson. Devon Olson is the assigned librarian for the occupational therapy department. The authors consulted with Devon twice throughout this project.

The literature review outlines the project in depth to further explain the historical overview of past assessments used in the military; the screening process men and women go through before, during, and after their service time; pre- and post-deployment measures taken to prepare soldiers for duty and discharge; the community reintegration services provided through military entities once soldiers are discharged; the most common challenges associated with community reintegration after discharge; the gaps that are present in the current military system in regards to enabling successful
community reintegration; and the role of occupational therapy with this specific population and the distinct issue of veteran community reintegration.

Once the authors had compiled the literature review, they began forming the screening tool using their findings. In order to do this, the authors utilized the evidence they found in the literature, supplemented by the Occupational Therapy Practice Framework: Domain & Process, 3rd edition (American Occupational Therapy Association, 2014), and the Person-Environment-Occupation Model (PEO), to screen important and relevant areas of concern. The PEO model, created by Law et al. (1996), divides one’s life into three domains; person, environment, and occupation. The authors chose to use this occupational therapy model to guide their project as it clearly outlined key areas related to a veteran which were identified as areas of concern in the research.

Once they have formulated a draft of the screening tool, the authors then formulated an accompanying manual for the screening tool. The authors wanted to provide administrators with directions on how to use and score the tool. The manual quickly became a larger piece of the project than they initially intended. The manual comes complete with sections designed to help individuals administer the tool seamlessly. Each section of the manual was created for the administrators to reference when giving the tool. The authors created each section as they felt the information was pertinent to successful administration of the tool. Once the tool and the manual were developed the authors presented it to Casper College Veterans Club in Casper, Wyoming. The authors of the tool presented the screen at a monthly club meeting and asked the members for honest feedback on the relevance of the specific topics addressed on the tool and overall
usefulness of the tool. Using the feedback from the group, the authors made amendments to the tool for clarity and informative purposes.

**Design**

The design of this project is a screening tool with complementing instructional/informational manual. The screening tool is a self-report 5-point Likert Scale with space for personal information of both the veteran and the administrator, as well as, space for further information obtained through informal interview. The screening tool has sections which question aspects of the person, environment, and occupation, which are further broken down into subdomains. For example, the subdomains of occupation are, Self-care, Productivity/Work, Leisure, and Rest/Sleep. The manual is complete with the following sections: Introduction, Features, Theoretical Basis, Development, Administration, Using the MCRS, Scoring/Interpretation, Referral, Follow-up, Overview Short Form, Occupational Therapy Implications, References, and Appendices A, B, and C.
CHAPTER IV

Product

Introduction

The Military Community Reintegration Screen (MCRS) is an individualized screening tool designed for soldiers’ who are transitioning from military duty to civilian life. The purpose of the tool is to: (1) identify individual barriers and concerns for transitioning solders; (2) address the need for additional services, resources, or training for transitioning solders; and (3) identify the need for a referral to occupational therapy services for soldiers transitioning from military duty to civilian life. This screening is designed to be used with combat veterans during the transition back to civilian life. As such it should be administered as a preface to formal occupational therapy services.

The MCRS was designed to be administered by a range of health care professionals whom interact with military personnel during the separation process. However, the end result of the screen, if services are indicated, is a referral to an occupational therapy professional. This tool was created by occupational therapy students under the advisement of a licensed and certified occupational therapist; in an effort to reduce the number of military personnel who experience challenges with the transition into civilian life and to increase awareness and understanding of the unique value that the occupational therapy profession can contribute to assist our veterans.
Frame of reference

The authors chose an occupational therapy model to guide the development of this screening tool. The authors wanted the screening to view the veteran holistically and through an occupational therapy lens, thus Person-Environment-Occupation (PEO) model (Law, Cooper, Strong, Stewart, Rigby, & Letts, 1996) was chosen. There are four key components to the PEO model: person, environment, and occupation. This screening tool was built by addressing the person, environment, and occupation, which became the three domains of the tool. The tool recognizes that the interactions between the person, environment, and occupation influences a veteran’s ability to perform their occupations as well as the quality in which they are able to perform those occupations. In this model, the interactions between each domain are referred to as transactions. Each transaction provides an explanation of how the fit is organized. The fit explains the interaction between each of the domains. When the fit is closely analyzed, specific problem areas surface and potential areas of need may become apparent (Baptist, 2017). Therefore, when analyzing a veterans’ transition, there may be events that relate to the person and environment, person and occupation, or environment and occupation that may influence the veteran’s occupational performance.

The MCRS is a screening tool that was developed with an accompanying manual to guide the administrator in conducting the screening process. The manual encompasses relevant information needed for increased multidisciplinary understanding of how to administer the screening tool. The manual also includes a short form to allow a concise clear synopsis for the relevance of the screening tool. Additionally, the screening tool itself provides clear instructions for its use. The MCRS is designed in an easy to use
format that is time efficient. The MCRS is located in Appendix A and the MCRS user manual is located in Appendix B.

Ideally, the MCRS would be utilized during the separation process when the veterans participate in the Transition Assistance Program (TAP) class before they leave base. However, further research needs to be employed prior to complete implementation. Therefore, the MCRS will be shared with VA clinics, hospitals, Department of Defense, American Legion, and primary care clinics. Any health care professional will have the opportunity to administer this screening tool to determine the need for additional services and an occupational therapy referral. If an occupational therapy referral is made, the veteran will attend occupational therapy treatment in order to receive community reintegration training. Referrals should be made to a licensed, registered, and practicing occupational therapist. The veteran should clarify where their preferred location for services is, and the individual administering the screen should locate an occupational therapist in the area where the veteran will be returning. Additionally, the administrating professional should inquire about previous occupational therapy experiences the veteran has had. If a referral is made, but the veteran has a relationship with a different therapy clinic, the professional should refer to the clinic which the veteran is most likely to attend. If possible, the referral should be made in a location where the veteran is already attending as to not burden the veteran with more appointments, travel costs, or time off from their typical lives.

The occupational therapist receiving the referral will determine how the veteran scored on their screen. The results will assist the therapist in determining the priorities of
the veteran and identify appropriate steps to begin treatment. After three months have passed from the initial administration of the screen, the veteran will be provided the screen a second time. The therapist will compare the pre-test and post-test to determine if responses have changed and what additional occupational performance challenges the veteran is experiencing. The occupational therapist will address the functional deficits the veteran may be facing during reintegration into the community.
CHAPTER V
Summary

Veterans sacrifice their lives so that our country may be free. This project was designed to assist veterans in “picking up the pieces” of the life they put on hold during deployment. To do this, the authors completed a thorough literature search to identify barriers veterans experience during community reintegration. Based on the barriers identified in the literature, the authors developed a screening tool to facilitate a positive experience with community reintegration. This screen is known as the Military Community Reintegration Screen (MCRS). The MCRS, is a self-report screening tool designed by occupational therapy students for use with the veteran population. This tool is designed to be administered to veterans upon discharging from the service. Ideally this tool would be implemented during the outing process completed by military when soldiers are being discharged. However, the authors understand the feasibility of that and look to local Veteran Affairs offices, family practices, and various other health care agencies which come in contact with veterans near their time of discharge. The tool was created to help identify struggles related to the community reintegration process when soldiers are discharging from the military. The tool takes a veteran through three domains that are further broken down into several subdomains related to the person, the environment, and the occupations in their lives. From there, the administrator scores the assessment which indicates whether the individual may or may not benefit from a referral to occupational therapy services.
Limitations

Though the project will be highly valuable once implemented, there are currently limitations related to the use of the tool. When the authors began seeking out literature and research on this population, they found the military system difficult to navigate. There was not a lot of information easily accessible to the public regarding the terms and conditions of the discharge process. It is still unclear to the authors how this process takes place. The authors were able to speak to veterans who went through the discharge process. They gained more information about the system the military has in place to discharge soldiers, however, much is still unclear about this process. The lack of information on this process is considered a limitation to the project, as the authors have only a small margin where they believe the MCRS could be best implemented. Additionally, the MCRS has not been piloted with the veteran population. The scoring mechanism used within the tool has not yet been validated. Therefore, piloting the tool would be the next step to ensure the effectiveness and accuracy of the tool.

Proposal for Implementation

While it will be extremely difficult implementing this tool within a military entity, we have been advised through the Casper College Veterans Club to present the tool to local Veteran Affairs Offices, Legion Clubs, family clinics, and other healthcare facilities that veterans might be associated with. This would provide more exposure to the tool and information regarding the usability and relativity of the tool with this population.

Recommendations for Future Research

As stated above, the tool will need to be piloted. Once that occurs, future research could include the creation of an assessment tool and intervention handbook for referred
occupational therapists. Once an assessment tool is created, it will need to be proven valid and reliable which will further require research. After presenting this project to the University, the director of the VA research facility in Minneapolis, MN, also an occupational therapist, offered to further investigate the MCRS. The authors will provide her with the tool and allow further research to be implemented on the usefulness and effectiveness of the tool.

**Conclusion**

Through extensive research, community reintegration post-deployment has been identified as a significant barrier to the veteran population. The MCRS is a starting point to overcoming reintegration challenges. Although the screening tool will need improvements to determine its position within this population, it may provide a starting point to further investigate the challenges experienced. The authors are hopeful that the tool will open the conversation, identify individual veteran needs, and identify the need for appropriate referrals with the goal of minimizing barriers and increasing occupational performance and participation during community reintegration.
Appendices
Appendix A

MCRS Screening Tool Form

The Military Community Reintegration Screen (MCRS) is an individualized screening tool designed for use with soldiers’ transitioning from military duty to civilian life. The purpose of the tool is three-fold: (1) identify individual barriers and concerns for transitioning soldiers; and (2) address the need for additional services, resources, or training for transitioning soldiers; and (3) identify the need for referral to occupational therapy services for soldiers transitioning from military duty to civilian life. The MCRS is intended for use as a screening tool. As such it should be administered as a preface to occupational therapy services to establish need for services, projected benefit of services, potential intervention areas, and resource identification related to reintegration. The MCRS is used to:

- Identify mental health challenges related to reintegration
- Identify potential barriers in veteran’s occupational performance
- Provide veterans with resources
- Provide veterans with occupational therapy referral, if applicable
- Provide a basis for possible occupational therapy intervention areas
- Understand client’s perception of his/her ability to re integrate

Military Community Reintegration Screen (MCRS)
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# Military Community Reintegration Screen

**For Administrator Use:**

<table>
<thead>
<tr>
<th>Screening Tool Administrator’s Name &amp; Title:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Location of Administration <em>(VA Medical Center, VA Community Clinic, Primary Care Clinic, etc.):</em></td>
<td></td>
</tr>
<tr>
<td>Facility Name:</td>
<td></td>
</tr>
<tr>
<td>Date of Screen:</td>
<td>Planned Date of 3 Month Follow-Up:</td>
</tr>
<tr>
<td>Date 3 Month Follow-Up Occurred:</td>
<td></td>
</tr>
<tr>
<td>Date 6 Month Follow-Up Occurred:</td>
<td></td>
</tr>
</tbody>
</table>
For Veterans Use:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Military Branch, Rank, &amp; Duty:</td>
<td>Number of Years in the Military:</td>
</tr>
<tr>
<td>Military Occupational Specialty (MOS):</td>
<td></td>
</tr>
<tr>
<td>Number of Deployment(s):</td>
<td>Sites Deployed To:</td>
</tr>
<tr>
<td>Dates of Deployment(s):</td>
<td></td>
</tr>
<tr>
<td>Where will you be living upon discharge:</td>
<td></td>
</tr>
<tr>
<td>What are you most concerned for after separation from the military and becoming a civilian?</td>
<td></td>
</tr>
<tr>
<td>What have you been doing since returning from deployment? (i.e. did you go home, are you still on base, do you have a job within a military entity, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

What is your overall stress level currently?

No Stress | Stress Level |
--- | --- |
0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Crippling Stress
**Person:**

A person is a unique being who can take on many roles and who can participate in activities that are needed or desired within a given environment. The person consists of physical, cognitive, sensory, affective (mood & emotions), and spiritual aspects (Baptiste, 2017).

Considering your upcoming transition to civilian life, rate your level of concern with the following tasks. Scoring: 1 – not concerned, 2 – somewhat concerned, 3 – concerned, 4 – very concerned, 5 – extremely concerned, N/A – does not apply to me

### Physical

<table>
<thead>
<tr>
<th>Task</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically completing daily tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing pain limiting daily life tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrating physical strength to complete daily life tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrating physical energy to complete daily life tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Cognitive

<table>
<thead>
<tr>
<th>Task</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making decisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Following directions (i.e. assembling a dresser)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asking for help</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using good judgment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrating logical and coherent thought</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Demonstrating intact memory (i.e. take medication on schedule)</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

**Sensory**

<table>
<thead>
<tr>
<th>Experience various sounds</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Experience various lights</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Experience various smells</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Experience various visual stimuli</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Experience various touches</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Affective**

<table>
<thead>
<tr>
<th>Identify emotions and mood</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Monitor emotions and mood</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Experience joy and happiness</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Manage stressors</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Control anger and other difficult emotions</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Feel and display confidence</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>
## Spiritual

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating in religious practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying personal values and beliefs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finding meaning/purpose/belonging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecting to something greater than self</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Raw Person Total:**

|                                               |   |   |   |   |   |     |

**Final Score:**

Identify the tasks rated at 3 and above.

|                                               |   |   |   |   |   |     |

Explain your reasoning for rating the tasks at that level.

|                                               |   |   |   |   |   |     |
Environment:

Environment is everything that surrounds a person including living things, built structures, and natural surroundings. Environmental aspects include physical, social, cultural, institutional, and virtual (Baptiste, 2017).

Considering your upcoming transition to civilian life, rate your level of concern with the following tasks. Scoring: 1 – not concerned, 2 – somewhat concerned, 3 – concerned, 4 – very concerned, 5 – extremely concerned. N/A – does not apply to me

### Physical

<table>
<thead>
<tr>
<th>Experience</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiencing change in housing/living structure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing change in environmental climate</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being in your physical workspace environment</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Being in a park</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Being in/around water (ponds, lakes, pools, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing change in physical built environments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(stores, offices, businesses, streets, sidewalks, etc.)</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Social

<table>
<thead>
<tr>
<th>Connection</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecting with family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecting with previous friends/peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecting with co-workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecting with significant others</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
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<tr>
<td>----------------------------------------------</td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>-----</td>
</tr>
<tr>
<td>Connecting with children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interacting with people in your community</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>(people in a grocery store, shopping mall, gas station, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making new friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Being in a large crowd</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Isolating self or being isolated</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Cultural</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing variation in food type</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Adapting to expectations on U.S. soil</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Experiencing changes in clothing/uniform</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Participating in rituals/ceremonies</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Experiencing behavioral expectations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Institutional</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abiding by laws/policies</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Accessing institutional systems (finances, education, and justice)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Task</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
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<td>---</td>
<td>---</td>
<td>---</td>
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</tr>
<tr>
<td>Understanding of the institutional systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Navigating the institutional systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Accessing and understanding your benefits and rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>N/A</td>
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</tbody>
</table>

**Virtual**

<table>
<thead>
<tr>
<th>Task</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessing and using technology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Accessing and using social media</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Accessing and using the internet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Raw Environment Total:**

**Final Score:**

**Identify the tasks rated at 3 and above.**

**Explain your reasoning for rating the tasks at that level.**
### Occupation:

Everything we do is considered an occupation. Occupation looks different for everyone: there is a human need for occupation that relates to health and well-being and how occupation organizes time and structures life. Occupation includes self-care, productivity/work, leisure, and rest/sleep (Baptiste, 2017; Townsend & Polatajko, 2007).

Considering your upcoming transition to civilian life, rate your level of concern with the following tasks. Scoring: 1 – not concerned, 2 – somewhat concerned, 3 – concerned, 4 – very concerned, 5 – extremely concerned, N/A – does not apply to me

#### Self-Care

<table>
<thead>
<tr>
<th>Task</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completing dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Completing bathing/showering</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Completing toileting and toilet hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Completing personal hygiene and grooming</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Managing and maintain your health (medication management, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Completing meal preparation and clean-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Productivity/Work

<table>
<thead>
<tr>
<th>Task</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing your finances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Participating in driving and community mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Taking care of others and pets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Establishing and managing your home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>---</td>
<td>-----</td>
</tr>
<tr>
<td>Completing your shopping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Participating in educational experiences</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Demonstrating adequate job performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Identifying employment interests and pursuits</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Seeking and acquiring employment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Preparing and adjusting to retirement</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Exploring and participating in volunteerism</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Communicating with co-workers, teachers, bosses, etc.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Leisure**

<table>
<thead>
<tr>
<th>Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuming hobbies</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Finding meaningful activities to engage in</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Exploring and participating in leisure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Socializing in community</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Socializing with family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Socializing with peers/friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Rest/Sleep

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falling and staying asleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing nightmares/flashbacks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishing a healthy sleep routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxing and resting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Raw Occupation Total:**

**Final Score:**

Identify the tasks rated at 3 and above.

---

---

---

**Explain your reasoning for rating the tasks at that level.**

---

---

---

**What resources or supports do you know of or plan to utilize when leaving the military?**

---

---

---
Clinical Reasoning/ Observations

**Subjective** *(observed mood, behavior, attention):*

**Objective** *(check all completed):*
- [ ] Completed screening tool
- [ ] Discussed and identified access to resources
- [ ] Discussed and identified access to supports
- [ ] Provided additional resources
- [ ] Other (please describe):

**Assessment** *(clinician’s assessment; barriers to transition; readiness for transition):*

**Plan** *(recommendations, next follow up):*
Scoring & Interpretation

Refer to manual for complete scoring instructions. If the scores are higher than the recommended referral score, the administrator is encouraged to use their professional judgment and observation skills to determine if the veteran would benefit from a referral. If the administrator identifies more than five barriers in the veteran’s life during their observation, the administrator is encouraged to make a referral to occupational therapy.

**Person:** If the final score is **20 or greater**, this indicates the need for a referral.

**OR**

**Environment:** If the final score is **23 or greater**, this indicates the need for a referral.

**OR**

**Occupation:** If the final score is **23 or greater**, this indicates the need for a referral.

<table>
<thead>
<tr>
<th>Raw Task Totals</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person: 25 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment: 28 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation: 28 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reference


## Referral Form

(Send a copy of the screening, scores, and scoring/interpretation page to referred practitioner)

**Veteran Name:**

**DOB:**

<table>
<thead>
<tr>
<th>Raw Task Totals</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person: 25 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment: 28 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation: 28 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason for Referral:**

**Does the veteran have access to technology?**  YES  NO

**Would he/she be interested in receiving services via Telehealth?**  YES  NO

If NO, what barriers are identified?

**Please add together the scores from each transaction and place scores here:**
- Person & Environment:
- Environment & Occupation:
- Occupation & Person:

**Additional Comments:**

________________________

________________________

________________________

Print Name

________________________   _______________________
Signature                          Date

15
Military Community Reintegration Screen (MCRS)

First Edition

Bailey Fruit // Hannah Williams // Cherie Graves
MCRS

Military Community Reintegration Screen

Bailey B. Fruit, MOTS
Hannah N. Williams, MOTS
Cherie A. Graves, MOT, OTR/L

First Edition
Preface

We are pleased and proud to offer the first edition of the Military Community Reintegration Screen (MCRS). This screening tool was created in acknowledgement of combat veterans returning home from involvement in war-related conflict. With the conclusion of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), the United States is experiencing the largest group of veterans returning home from war in over two decades (Plach & Sells, 2013). The large influx of discharging soldiers has highlighted the need for further investment in veteran’s wellbeing. Based on the barriers experienced during this transition period, the researchers have identified the most common barriers that many veterans will experience. The authors felt compelled to create a screen which would assist in identifying possible barriers impacting the transition process from combat soldier to veteran and would indicate when referral for further services would be necessary.

Each author has indirectly experienced the challenges that result from difficult reintegration experiences. Whether this was a first-hand experience or looking from the outside in, the authors are aware of the many challenges in the reintegration process. The authors are passionate about the occupational therapy profession and see the benefit of broadening the established relationship between occupational therapy and the military, in an effort to ease the transition process and lessen the number of individuals who struggle with the reintegration process. Occupational therapy can play an integral role in this major life event for these individuals and their loved ones.

This screening tool addresses 3 domains; person, environment, and occupation. Within the 3 domains are 14 subdomains and 81 tasks related to reintegration into the civilian world that have been found to be problematic for combat veterans. The Military Community Reintegration Screen (MCRS) is an individualized screening tool designed for use with soldiers’ transitioning from military duty to civilian life. The purpose of the tool is three-fold: (1) identify individual barriers and concerns for transitioning soldiers; and (2) address the need for additional services, resources, or training for transitioning soldiers; and (3) identify the need for referral to occupational therapy services for soldiers transitioning from military duty to civilian life.

The development of the screening tool was guided by an occupational therapy model of practice; Person-Environment-Occupation Model (PEO). The authors used this model to identify what specific domains to address and to further guide which subdomains and tasks to include.

The research team is eager to continue exploring possible solutions for the reintegration challenges as well as learning about the usefulness and practical implications resulting from the addition of this tool.

-The MCRS Authors
**Author Affiliations**

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**Cherie A. Graves, MOT, OTR/L** is an instructor and Associate Academic Fieldwork Coordinator for the University of North Dakota’s Department of Occupational Therapy, Grand Forks, North Dakota.
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Introduction

The Military Community Reintegration Screen (MCRS) is an individualized screening tool designed for use with soldiers’ transitioning from military duty to civilian life. The purpose of the tool is three-fold: (1) identify individual barriers and concerns for transitioning soldiers; (2) address the need for additional services, resources, or training for transitioning soldiers; and (3) identify the need for referral to occupational therapy services for soldiers transitioning from military duty to civilian life. This screening is designed to be used with combat veterans during the transition back to civilian life. The MCRS was designed to be administered by a range of health care professionals whom interact with military personnel who will be reintegrating back into their community. However, the end result of the screen, if services are indicated, is a referral to an occupational therapy professional. This tool was created by occupational therapy students under the advisement of a licensed and certified occupational therapist, in an effort to reduce the number of military personnel who experience challenges with the transition into civilian and to increase awareness and understanding of the unique value that the occupational therapy profession can contribute to assist our Veterans.

The MCRS is intended for use as a screening tool to identify a need for services, projected benefit of services, potential intervention areas, and resource identification related to reintegration. As such it should be administered as a preface to formal occupational therapy services.

The MCRS is used to:

- Identify mental health challenges related to reintegration
- Identify potential barriers in veteran’s occupational performance
- Provide veterans with resources
- Provide veterans with occupational therapy referral, if applicable
- Provide a basis for possible occupational therapy intervention areas
- Understand client’s perception of his/her ability to reintegrate

The authors of the MCRS have completed extensive research in the area of reintegration and have found the expressed domains to be highly prioritized by veterans. Additionally, further research will need to be done to test the validity of the screening tool.
Features of the MCRS

The MCRS:

- Is based on an occupational therapy theoretical model
- Recognizes the interaction amongst the person, environment, and occupation
- Person domain includes subdomains of: physical, cognitive, sensory, affective, and spiritual aspects of the Veteran
- Environment domain includes subdomains of: physical, social, cultural, institutional, and virtual environments in relation to the Veteran
- Occupation domain includes subdomains of: self-care, productivity/work, leisure, and rest/sleep in relation to the Veteran
- Subdomains consider social participation, including familial and friend, and personal and professional relationships
- Subdomains consider educational tasks and ability to participate in education
- Identify specific tasks related to the above domains and subdomains
- Recognizes the individuality of each Veteran
- Identifies military specifications for each Veteran

The MCRS addresses several areas of concern for veterans making the transition, which were identified by the authors through an extensive review of the literature. The screen is highly personalized as it addresses areas of possible concern which often go undetected by other tools.
Theoretical Basis of the MCRS

The authors chose an occupational therapy model to guide the development of this screening tool. The authors wanted the screening to view the veteran holistically and through an occupational therapy lens, thus Person-Environment-Occupation Model (PEO) (Law, Cooper, Strong, Stewart, Rigby, & Letts, 1996) was chosen. The model was originally developed in the 1990’s in response to the professional shift from using theories from other professional disciplines to models of practice specific to the occupational therapy profession.

There are four key components to the PEO model: person, environment, occupation, and occupational performance. This screening tool was built by addressing the person, environment, and occupation, which became the three domains in the tool. The tool recognizes that the interactions between the person, environment, and occupation influence a veteran’s ability to perform their occupations as well as the quality in which they are able to perform their occupations. In this model, the interactions between domains are referred to as transactions. Each transaction provides an explanation of how the fit is organized. The fit explains the mesh between each of the domains. When the fit is closely analyzed, specific problem areas surface and potential areas of need may become apparent (Baptist, 2017). Therefore, when analyzing a veterans’ transition, there may be events that relate to the person and environment, person and occupation, or environment and occupation that may influence the veteran’s occupational performance. To demonstrate the concepts of the model the following situation will be used.

John is a veteran who has a goal of returning to a regular exercise routine (occupation). He recognizes that he is somewhat sensitive to extra noise and a lot of visual stimulation (person). He also knows that he doesn’t particularly do well when he is in a crowd of people (environment). Using the model would help to identify the fit between the person, environment, and occupation domains. Because of John’s sensory sensitivities related to sound and visual stimulation (person) and his dislike of being in a crowd (environment), it would be clear that John’s occupational performance of participating in a regular exercise routine at a populated fitness center at peak time of day, would not be the best fit for him. The fit between the two domains of person and environment would not be compatible, thus influencing John’s ability to perform his occupation of returning to a regular exercise routine. A better alternative would be to identify fitness centers that would be less populated and consider the time of day where fewer people would be present. Another alternative would be to create an exercise routine in his home where he would be less impacted by sensory sensitivities and a crowded environment.

The first major domain is person. The person domain addresses the individual as a unique being. One which assumes multiple roles at one time and who can address many occupations which are both needed and desired. The person holds the power of choice when tasked with several demands. The person is made up of physical self (the body), cognitive and affective self (the mind), and spiritual self (Baptist, 2017). Each person presents unique and particular personal attributes and life experiences which are specific to the individual.
The second major domain is the environment. The environment is a total sum of what surrounds a person. Through the PEO lens, the environment is a very broad and inclusive perspective (Baptist, 2017). The model views the environment as the direct environment an individual is in and then expands it to the home, neighborhood, communities, and even further yet. Each component of the environment is essential to understand as every aspect impacts an individual client and his/her family. Since the initial development of this model, there has been additions to the environment domain. The environmental domains now consist of physical, social, cultural, institutional, and virtual. A key feature of this model is the inclusion of the cultural environment. The original authors of the PEO model, identified the inherent difference from person to person and from country to country. They were aware that not all people concerned themselves with the same food, clothing, tasks, etc. and therefore created a component of the model which would further individualize the model.

The third domain is the occupation. The model identifies that the absolute nature being, doing, and belonging never changes. Additionally, occupation is central to the occupational therapy profession. The main areas of occupation discussed in this model are self-care, productivity/work, leisure, and rest/sleep. The main areas of occupation were derived from the notion that occupation can mean different things to different people. Occupation could be providing fulfillment and social connection, bringing joy and satisfaction, being purposeful, giving meaning, and enabling self-expression (Baptist, 2017).

<table>
<thead>
<tr>
<th>Person</th>
<th>Physical, Cognitive, Sensory, Affective, Spiritual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Physical, Social, Cultural, Institutional, Virtual</td>
</tr>
<tr>
<td>Occupation</td>
<td>Self-Care, Productivity/Work, Leisure, Rest/Sleep</td>
</tr>
</tbody>
</table>

The PEO Model, when applied to the occupational therapy profession, offers a firm foundation for practitioners to build off of. Since the model’s conceptualization, the model has provided a clear and understandable foundation for users starting to delve into the complex profession of occupational therapy. Using this framework provides scaffolding for approaching critical thinking experiences as they relate to each case. The model also clearly identify the fit between the domains. Thus, mapping out the need for and areas of intervention which should be addressed during treatment. The three components of this model address all areas of a person and allow the clinician to better understand a client on a unique platform. The domains establish a relationship with one another to better portray how damage in one area can upset the entire balance between person, environment, and occupation.
In summary, this model was chosen to guide this screening tool as it is easy to understand, integral to the therapeutic rapport building process, and universally understood. The fit between the three domains offers a chance to determine the absence or existence of appropriate performance levels, in turn pinpointing future areas of concern to be addressed by the occupational therapist. Occupational performance is easily identified as the sum of all the any and all interactions between the three major domains. To identify occupational performance, there must be a well-coordinated assessment of the key domains and the transactions between the domains.

The MCRS is grounded in the PEO model and encompasses the major domains in an effort to give the administrator a holistic guide to the individual. The veteran population is a dynamic and complex group of individuals and therefore, deserve a screen which will address their individuality. The PEO model provided the authors of the MCRS with a clear guide to addressing the unique needs of this population.
Development of the MCRS

The authors of this tool set out to create a screen to be used with combat veterans which would identify the barriers to community reintegration. Initially, the authors were interested in narrowing the gap in which veterans with mental health challenges often found themselves falling in. The authors were passionate about veteran’s mental health needs, as this population sacrifices themselves for the freedoms of all civilians. An extensive literature review found the following information, and thus, this screening tool was created.

Studies have shown that the transition to civilian life for OEF/OIF veterans who served in combat can be particularly difficult, with over 50% describing the re-adjustment to civilian life as a “real struggle,” (Pease, Billera, & Gerard, 2016). The current generation of military personnel returning from these wars are perhaps even more at risk than prior generations of veterans. They have served substantially longer tours throughout the course of multiple deployments (Coll, Weiss, & Yaris, 2011). This issue with veteran reintegration is timely due to the high volume of soldiers transitioning home at the conclusion of OEF/OIF (Pease, Billera, & Gerard, 2016). Nearly 1.5 million service members have left the military within the decade leading up to the conclusion of OIF and OEF in late 2014 and many more would follow in the coming years. In 2016, more than 2.5 million members were projected to be separated from the armed forces, leaving several individuals to reintegrate into civilian life. According to Pease, Billera, and Gerard (2016), there are very few similarities between the civilian and military cultures. Thus, soldiers transitioning into the veteran role find it challenging to successfully reintegrate into civilian life. Coll, Weiss, and Yaris (2011) illustrate the experience of soldiers reintegrating as, “encountering the same type of culture shock that immigrants experience when first arriving to the United States; there is disorientation, change of status, and a search for identity and meaning” (p. 488).

Among the most researched challenges are the soldier’s home life, social supports, and employment status. Once a veteran is home, he or she is impacted by the life roles they must resume and responsibilities they must tend to. After combat experience many veterans feel a disconnect between themselves and family members, feel out of place, and/or afraid that their families no longer understand them (Cogan, 2014; Pease, Billera, & Gerard, 2016; Maiocco & Smith, 2016). Once a member of a larger unit, the soldier had a purpose and a position. Now returning home, the adjustment issues may also be viewed within the context of returning back to the individualistic society, and lacking the close bonds and collectivist value system experienced in the military (Pease, Billera, & Gerard, 2016).

Reintegration challenges may include the following: post-deployment stressors, low and/or lack of social support, depression, post-traumatic stress disorder (PTSD), substance abuse, anxiety, sleep disturbances, intimate partner violence, eating disorders, obesity, or chronic pain (Maiocco & Smith, 2016). Young veterans who are returning from the OIF and OEF, are at extreme risk for developing psychological disorders affecting their ability to successfully reintegrate into their community. These soldiers also are at risk for experiencing disruptions in engagement in
occupations of daily living: more so than soldiers from past wars. Approximately one third of the soldiers coming home from OIF and OEF will struggle with at least one of the listed disorders: PTSD, traumatic brain injury (TBI), or major depression. In addition, findings indicate an increase in alcohol misuse, challenges in their relationships, school, physical health, driving, and disturbances during sleep (Maiocco & Smith, 2016; Plach & Sells, 2013).

As the military forces today are served voluntarily (Radomski & Brininger, 2014), there are also demographic differences from those of previous wars (Cogan, 2014). According to the Department of Defense (2010), statistics show that 38 percent of active-duty service members were married with children and more than five percent were single parents. In addition, 34 percent of selective reserve members were married with children and nine percent were single parents. Comparatively, in 1968 during the Vietnam War, only 17 percent of enlisted members were married and fewer than 10 percent were married with children. The gap in statistics demonstrates the immediate impact of the deployment cycle on the service member but also the extension of impact into the family life as well (Cogan, 2014).

Service members may face relationship difficulties with spouses, children, and significant others (Pease, Billera, & Gerard, 2016), all of whom are affected when a soldier is deployed. Upon reintegration into the home, family member roles have changed and adjustments to those changes are not easily incorporated. According to Pease, Billera, and Gerard (2016), veterans suffering from PTSD experience significantly higher rates of marital or familial problems than those without PTSD. Additionally, women veterans are more likely to have negative personal and family reintegration experiences, such as life stressors or lack of social support, which may lead to depression, PTSD, substance abuse, anxiety, sleep disturbances, intimate partner violence, low social support, eating disorders, obesity, and chronic pain (Maiocco & Smith, 2016). Moreover, mental health issues for women veterans typically do not occur until after discharge (Maiocco & Smith, 2016).

With the above information known, there is still a lack of comprehensive screening tools used with this population. Due to this, challenges and barriers to reintegration have persisted. Although there are certain measurement tools used to assist with community reintegration, each veteran has unique social roles and responsibilities within their community and therefore, the aforementioned measurements may not address the unique differences in the reintegration process. Depending on the person and their experiences, when they return home, they may find it easier to connect with other soldiers rather than their family or they may find life as a civilian meaningless compared to their life in combat. Rehabilitation experts shared that community reintegration needs to provide a sense of belonging or acceptance, connecting with people, and becoming involved in leisure and community activities. However, these areas of community reintegration are not typically assessed with existing measurement tools (Sayer, et al., 2011).

The authors have created this screening to be utilized when the veteran is nearing discharge from the military or directly thereafter. This tool should be administered by either military personnel before discharge or by a healthcare professional providing follow-up care with the veteran. Ideally, this tool would be implemented by a case manager, social worker, occupational therapist, or a nurse. However, no specific healthcare profession should be responsible for the
administration of the tool, rather a collective effort of the healthcare industry to ensure the well-being of each veteran.
The Military Community Reintegration Screen (MCRS) is an individualized screening tool designed for use with soldiers transitioning from military duty to civilian life. The purpose of the tool is three-fold: (1) identify individual barriers and concerns for transitioning soldiers; and (2) address the need for additional services, resources, or training for transitioning soldiers; and (3) identify the need for referred to occupational therapy services for soldiers transitioning from military duty to civilian life. The MCRS is intended for use as a screening tool. As such it should be administered as a preface to occupational therapy services to establish need for services, projected benefit of services, potential intervention areas, and resource identification related to reintegration.

The MCRS is used to:
- Identify mental health challenges related to reintegration
- Identify potential barriers as veterans' occupational performance
- Provide veterans with resources
- Provide veterans with occupational therapy referrals, if applicable
- Provide a basis for possible occupational therapy intervention areas
- Understand client's perception of his/her ability to reintegrate

The cover page reminds the user of the purpose of the MCRS and what the MCRS can be used for.
Page 2

### Military Community Reintegration Screen

For Administrator Use:

<table>
<thead>
<tr>
<th>Screening Tool Administrator’s Name &amp; Title:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location of Administration (ED Medical Center, VA Community Clinic, Primary Care Clinic, etc.):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Screen:</th>
<th>Planned Date of 3 Month Follow-Up</th>
<th>Planned Date of 6 Month Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date 3 Month Follow-Up Occurred:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date 6 Month Follow-Up Occurred:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Page 2 should be filled out by the professional who is administering the screen. This page should be filled out to keep record of the administrator who implemented the screen. There is a space on this page to plan two follow up appointments. The proposed date of each follow-up should be documented in the space provided. The administrator should then document the date of the actual follow-up appointments once they occur.
Page 3 is to be filled out by the veteran. This should be used to get an understanding of the veteran’s time in the service. The administrator should encourage the veteran to provide as much information about their time in the service here. The more information provided the better the administrator can understand the situation and individualize the experience. This section allows the veteran to further explain their position in the military in order to individualize the screening process. The Likert Scale at the bottom should be used for the veteran to rank their overall stress.
This could be stress related to any component of reintegration. Rather than breaking down the type of stress, this should be used to determine the veteran's stress at the time of administration.

**Screening Tool**

<table>
<thead>
<tr>
<th><strong>Person:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A person is a unique being who can take on many roles and who can participate in activities that are needed or desired within a given environment. The person consists of physical, cognitive, sensory, affective (mood &amp; emotions), and spiritual aspects (Baptiste, 2017).</td>
<td></td>
</tr>
</tbody>
</table>

Considering your upcoming transition to civilian life, rate your level of concern with the following tasks. Scoring: 1 = not concerned, 2 = somewhat concerned, 3 = concerned, 4 = very concerned, 5 = extremely concerned, N/A = does not apply to me

**Physical**

<table>
<thead>
<tr>
<th>Task</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically completing daily tasks</td>
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<tr>
<td>Experiencing pain limiting daily life tasks</td>
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</tr>
<tr>
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<tr>
<td>Demonstrating physical energy to complete daily life tasks</td>
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</tr>
</tbody>
</table>

**Cognitive**

<table>
<thead>
<tr>
<th>Task</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making decisions</td>
<td></td>
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<tr>
<td>Following directions (i.e. assembling a dresser)</td>
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<tr>
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<tr>
<td>Using good judgment</td>
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<tr>
<td>Demonstrating logical and coherent thought</td>
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</tbody>
</table>
The body of the screening tool should be filled out by the veteran as well. These blocks are divided into three main domains and are further separated into subdomains and relevant tasks. The veterans should score each item according to the Likert scale as explained at the top of each domain section. Additionally, when the veteran has completed each domain, the administrator should find the raw scores of the 3, 4, and 5 ratings. The raw score will be used to calculate the final scores. See Appendix A for complete screening tool form.

Identify the tasks rated at 3 and above.

________________________________________________________________________

________________________________________________________________________

Explain your reasoning for rating the tasks at that level.

________________________________________________________________________

________________________________________________________________________

Once the veteran has completed the Likert sections of a domain, they should continue on to the written portion of the screen. After each domain is scored, the veteran should elaborate on their reasoning for the chosen scores. The first written section allows the veteran to write out each task that was rated as a 3 or above. The second section allows the veteran to explain why they are 3-concerned, 4- very concerned, or 5- extremely concerned with doing the task specified. This will give the administrator further information about the client and provide the administrator with grounds for conversation.
Using the MCRS: A Case Example

Reggie

Reggie is a 35-year-old male who has served in the Army for eight years. Within the Army, Reggie served four tours overseas to Afghanistan. His rank within the military was intelligence, where he would navigate the buildings while on the ground to locate the enemy or locate dangerous areas; therefore, he was in active combat. This year he decided he did not want to re-enlist so he could return to his wife and three kids in Missouri. The third child is six months old and Reggie has not had the opportunity to see his son in person. During the week of his discharge process, Reggie completed his physical, DD-214 form, and completed his Transitional Assistance Program (TAP) class. During the TAP class, a nurse administered the Military Community Reintegration Screen (MCRS) to Reggie and learned what his concerns were for returning to civilian life and returning to his family. Reggie scored a 14 in person, 20 in environment, and a 35 in occupation. Through the screen, the psychologist was able to learn that Reggie was nervous to meet his new son and about fitting into his family’s routine. He wondered if he would be able to discipline his six and nine-year-old, or would they be mad at him for being gone so much. Additionally, he is nervous about finding employment to help with the family’s bills. As he thought about it further, he is nervous about connecting with his friends and figuring out where he belongs again. He wants to be able to drive, but it has been a while and he does not know how it will go.

During the session, the nurse was able to observe Reggie’s agitation, worry, nerves, and adequate attention. Additionally, the nurse objectively completed the screening tool, discussed and identified access to resources, discussed and identified access to supports, and provided additional resources. The nurse made an assessment that Reggie lives in a rural location in Missouri with no VA clinic close by, therefore he would need to commute, identifying a barrier to transition. Furthermore, the nurse made an assessment that Reggie had minimal denial for needing transitional assistance. The nurse and Reggie collaborated to identify his parents, two brothers, wife, and two friends as a support system. Additionally, they located the VA in his area in Missouri, a local counseling center, and a primary care facility 45 miles away that he could utilize if he felt the need. The psychologist also provided a referral to occupational therapy within his area to receive transitional services as his scores indicated a need for additional evaluation. A follow-up appointment with the psychologist will be completed within 90 days to determine Reggie’s progress.
Scoring and Interpretation

To score the screen, the administrator should tally up the total number of times the veteran circled each number on the Likert Scales for each domain. Starting with the Person domain, the administrator should review the physical, cognitive, sensory, affective, and spiritual subdomains. If any of the tasks have the 1 circled it should be counted and the total number of 1’s should be filled it on the Raw Person Total space, below the last subdomain. The same process should be used for each number on the Likert Scale for the remainder of the domain. The same process should be used to find the raw score of the 2, 3, 4, and 5 options on the scale. Once each number on the Likert Scale has been tallied to represent the Raw Person Total, the administrator should add together the raw scores for 3, 4, and 5 to get a Final Score.

This process should be used to determine the raw and final scores for each domain, subdomain, and task represented on the screen.

If the scores are higher than the recommended referral score, the administrator is encouraged to use their professional judgment and observation skills to determine if the veteran would benefit from a referral. If the administrator identifies more than five barriers in the veteran’s life during their observation, the administrator is encouraged to make a referral to occupational therapy. See Appendix B for complete screening form.

For example:

Below is the Productivity/Work subdomain of Occupation. The score for this subdomain is at the bottom in the Raw Occupation Total section.

<table>
<thead>
<tr>
<th>Productivity/Work</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing your finances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating in driving and community mobility</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Taking care of others and pets</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Establishing and managing your home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Completing your shopping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Activity</td>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating in educational experiences</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrating adequate job performance</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying employment interests and pursuits</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeking and acquiring employment</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparing and adjusting to retirement</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploring and participating in volunteerism</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicating with co-workers, teachers, bosses, etc.</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Raw Occupation Total:**

|   | 3 | 3 | 2 | 3 | 1 | 0 |

**Final Score:** 6

To determine if a referral is needed, add together the raw scores for 3, 4, and 5. (In this example, this is only one subdomain and therefore will not yield appropriate results.) For the purpose of this example, the final score would be 6.
Referral

A referral should be made based on the score’s received on the screening. If a veteran receives one of the following scores, a referral should be made.

- If the Final Score is 20 or greater under the Person domain, the administrator should write a referral.
  OR
- If the Final Score is 23 or greater under the Environment domain, the administrator should write a referral.
  OR
- If the Final Score is 23 or greater under the Occupation domain, the administrator should write a referral.

If the veteran receives only one of the above scores, a referral should be made. The individual does not need to have scored higher than the designated number in all three domains to get a referral. A high score in only one domain is reason enough for a referral.

After the initial referral has been made, the veteran will attend occupational therapy treatment in order to receive community transitional training. Referral should be made to a licensed, registered, and practicing occupational therapist. The veteran should clarify where their preferred location for services is, and the providing professional should locate an occupational therapist in the area. Additionally, the administrating professional should inquire about previous occupational therapy experiences from the veteran. If a referral is made, but the veteran has a relationship with a different therapy clinic, the professional should refer to the clinic which the veteran is most likely to attend. If possible, the referral should be made to a location that the veteran is already attending as to not burden the veteran with more appointments, travel costs, or time off from their typical lives.

When using the referral page, the administrator should also calculate the transaction scores. These scores are found by adding together each of the domain final scores together. The administrator will find the sum of the person and occupation domains; occupation and environment domains; and the environment and the person domains. This will allow the occupational therapist a representation of problematic transactions related to the PEO theoretical model. See Appendix C for complete referral form.

For example:

For the purpose of this example, the final score of the person domain will be 14. The final score of the environment domain will be 23. The final score of the occupation domain will be 21.

Please add together the scores from each transaction and place scores here:
Person & Environment: 14+23= 37
Environment & Occupation: 21+23= 44
Occupation & Person: 14+21= 35
Follow-Up Care

Upon completion of the initial screen, the administrator and the veteran will identify a suitable date that is 90 days post-screening, to complete a follow-up screening appointment. This appointment may occur either in person or via telehealth. A follow-up appointment will be scheduled for each veteran who undergoes the screening process. The administrator who completed the initial screen will also complete the 90-day follow-up appointment. After the 90 days have elapsed, the veteran will return to the administrator to discuss progress and other concerns related to reintegration.

If a referral to occupational therapy was made, the occupational therapist treating the veteran should send a progress report with the individual for the administrator to review. The occupational therapist treating should identify the need for further transitional training. This will determine if the veteran will need to continue seeking occupational therapy services or if discharge processing should occur.

During the initial screening, referral rates may be low as the veterans will be employing a futuristic review of themselves during the administration. The perceived notion that veterans will be predicting their performance as a civilian prior to entering into the community may skew screening scores. Therefore, without having experienced reintegration yet, the soldier may believe that he/she will not experience challenges. In response to said assumptions, follow-up appointments will be vital to ensure the veterans are adjusting adequately. Once an individual experiences the civilian culture for 90 days, he/she will have a better understanding of their personal transition struggles. Providing follow up will grant the veteran the opportunity to address their concerns more thoroughly since having the chance to capitalize on their civilian experience. Moreover, they will be able to receive services and training through referral based on the barriers truly present during their civilian transition. Once the individual has had some time to understand the civilian experience, he/she can appropriately address each of the presented tasks on the screening tool.
MCRS Overview Short Form

Military Community Reintegration Screen (MCRS), 1st Edition
(2018)

Authors: Bailey Fruit, MOTS, Hannah Williams, MOTS; Cherie Graves, MOT, OTR/L

Format: Self-report with opportunity for discussion

Purpose: The Military Community Reintegration Screen (MCRS) is an individualized screening tool designed for use with soldiers’ transitioning from military duty to civilian life. The purpose of the tool is three-fold: (1) identify individual barriers and concerns for transitioning soldiers; and (2) address the need for additional services, resources, or training for transitioning soldiers; and (3) identify the need for referral to occupational therapy services for soldiers transitioning from military duty to civilian life.

Population: Combat veterans preparing to transition into the community

Time Required: Administration time is typically 15-30 minutes.

Setting or Position: Not prescribed. (Could be in a Veteran Affairs clinic, primary care clinic, on a military base, etc.)

Materials or Tools: Overview & instructions, screening form, and referral form

Description: Based on the PEO model in occupational therapy, this self-report rating scale is divided into three domains; Person, Environment, and Occupation. Veteran uses a 5-point Likert Scale to score themselves on tasks in each domain. The veteran then must explain what aspects of their personal life specifically reflect their concerns identified with the Likert Scale. Then the clinician and the veteran must identify available occupational therapy resources in the area where the veteran will be living.

Interpretation/Scoring: Ratings during initial screening are examined by the administrator administering the screen. The clinician will analyze the concerns of the veteran by using professional judgment and by scoring the Likert Scale to determine if occupational therapy services are needed.

Reliability: Not yet identified.

Validity: Not yet identified.

Source

MCRS Authors
Occupational Therapy Implications

Historically, the occupational therapy profession can be traced back 100 years to its role in caring for and helping veterans after discharge from active duty. During World War I, occupational therapy reconstruction aids were individuals who took initiative to assist in the war effort by helping injured soldiers (Christiansen & Haertl, 2014). This group of women used arts and crafts to occupy the minds of the soldiers while they were recovering from their injuries. The unique aspect of the crafts the soldiers were completing was the fact that the items were used for everyday appliances.

Occupational therapists continue to play an integral role in the rehabilitation of soldiers coming home from war. This unique profession equips therapists with the skills and knowledge to address both the physical and mental traumas presented by individuals who enlisted in the military. This profession uses meaningful occupations to aid the injured through rehabilitation of the mind, body, and spirit. Occupational therapy as a profession is responsible for the use of traditional and novel methods of therapeutic occupation to address occupational dysfunction among service members and veterans (Radomski & Brininger, 2014). The profession is also tasked with rigorously studying the impact of occupation on recovery, resilience, and reintegration (Radomski & Brininger, 2014). Therefore, occupational therapy has an incredibly large role in assisting the veteran population with successful community reintegration.

An occupational therapist has the education and expertise to enable each component of occupation (rest/sleep, work, play, leisure, activities of daily living (ADL), instrumental activities of daily living (IADL), and education) and aid in the reintegration process. An occupational therapy professional views the individual as a holistic person; considering the individual mentally, emotionally, cognitively, physically, and spiritually, in order to progress their reintegration as smoothly as possible. Additionally, occupational therapists are unique as they also have the ability to analyze the person’s environment and context as well as the person’s occupations. By analyzing the person, environment, and occupation together, occupational therapy will use that transaction to identify barriers and supports that will determine occupational performance.

As health care professionals, occupational therapists are equipped with the skills and knowledge to develop a screening tool that will address the psychosocial needs of the active duty military personnel during the significant life transition from activity duty to civilian life. A tool developed from the occupational therapy perspective may address several factors such as, personal factors, occupational performance, and environmental factors that are specific to an individual’s military experiences. Additionally, occupational therapy may assist with addressing skills an individual has gained through their military experience. They can translate those skills into possible work positions and help the veteran apply for suitable employment opportunities. By using this screening tool that addresses important factors related to reintegration, it may assist veterans and others to more easily understand the significance of the transition, when and where difficulties are most likely to occur, and where the gaps are in present services.
This screening tool should be utilized on or near the military discharge date to ensure effective screening results. The screen should be used to identify potential need for occupational therapy services.


The Military Community Reintegration Screen (MCRS) is an individualized screening tool designed for use with soldiers’ transitioning from military duty to civilian life. The purpose of the tool is three-fold: (1) identify individual barriers and concerns for transitioning soldiers; and (2) address the need for additional services, resources, or training for transitioning soldiers; and (3) identify the need for referral to occupational therapy services for soldiers transitioning from military duty to civilian life. The MCRS is intended for use as a screening tool. As such it should be administered as a preface to occupational therapy services to establish need for services, projected benefit of services, potential intervention areas, and resource identification related to reintegration.

The MCRS is used to:

- Identify mental health challenges related to reintegration
- Identify potential barriers in veteran’s occupational performance
- Provide veterans with resources
- Provide veterans with occupational therapy referral, if applicable
- Provide a basis for possible occupational therapy intervention areas
- Understand client’s perception of his/her ability to reintegegrate
# Military Community Reintegration Screen

**For Administrator Use:**

<table>
<thead>
<tr>
<th>Screening Tool Administrator’s Name &amp; Title:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Location of Administration (VA Medical Center, VA Community Clinic, Primary Care Clinic, etc.):**

<table>
<thead>
<tr>
<th>Facility Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Screen:</th>
<th>Planned Date of 3 Month Follow-Up:</th>
<th>Planned Date of 6 Month Follow-Up:</th>
</tr>
</thead>
</table>

**Date 3 Month Follow-Up Occurred:**

<table>
<thead>
<tr>
<th>Date 6 Month Follow-Up Occurred:</th>
</tr>
</thead>
</table>

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2

97
For Veterans Use:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Military Branch, Rank, &amp; Duty:</th>
<th>Number of Years in the Military:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Military Occupational Specialty (MOS):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number of Deployment(s):</th>
<th>Sites Deployed To:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dates of Deployment(s):</th>
</tr>
</thead>
</table>

Where will you be living upon discharge:

What are you most concerned for after separation from the military and becoming a civilian?

What have you been doing since returning from deployment? (i.e. did you go home, are you still on base, do you have a job within a military entity, etc.)

What is your overall stress level currently?

No Stress                      Crippling Stress

0 1 2 3 4 5 6 7 8 9 10
**Person:**

A person is a unique being who can take on many roles and who can participate in activities that are needed or desired within a given environment. The person consists of physical, cognitive, sensory, affective (mood & emotions), and spiritual aspects (Baptiste, 2017).

Considering your upcoming transition to civilian life, rate your level of concern with the following tasks. Scoring: 1 – not concerned, 2 – somewhat concerned, 3 – concerned, 4 – very concerned, 5 – extremely concerned, N/A – does not apply to me

**Physical**

<table>
<thead>
<tr>
<th>Physical activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Physically completing daily tasks</td>
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<td></td>
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<tr>
<td>Experiencing pain limiting daily life tasks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Demonstrating physical strength to complete daily life tasks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Demonstrating physical energy to complete daily life tasks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
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**Cognitive**

<table>
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<tr>
<th>Cognitive activity</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Making decisions</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Following directions (i.e. assembling a dresser)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Asking for help</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Using good judgment</td>
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<tr>
<td>Demonstrating logical and coherent thought</td>
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<tr>
<td>Sensory</td>
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<td>---</td>
</tr>
<tr>
<td>Experiencing various sounds</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Experiencing various lights</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Experiencing various smells</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Experiencing various visual stimuli</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Experiencing various touches</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Affective</th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying emotions and mood</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Monitoring emotions and mood</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Experiencing joy and happiness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Managing stressors</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Controlling anger and other difficult emotions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Feeling and displaying confidence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**Spiritual**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating in religious practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying personal values and beliefs</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Finding meaning/purpose/belonging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecting to something greater than self</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Raw Person Total:  

Final Score: ___________

Identify the tasks rated at 3 and above.

________________________________________________________

________________________________________________________

________________________________________________________

Explain your reasoning for rating the tasks at that level.

________________________________________________________

________________________________________________________

________________________________________________________
**Environment:**

Environment is everything that surrounds a person including living things, built structures, and natural surroundings. Environmental aspects include physical, social, cultural, institutional, and virtual (Baptiste, 2017).

Considering your upcoming transition to civilian life, rate your level of concern with the following tasks. Scoring: 1 – not concerned, 2 – somewhat concerned, 3 – concerned, 4 – very concerned, 5 – extremely concerned, N/A – does not apply to me

### Physical

<table>
<thead>
<tr>
<th>Experience</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiencing change in housing/living structure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing change in environmental climate</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Being in your physical workspace environment</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Being in a park</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being in/around water (ponds, lakes, pools, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing change in physical built environments (stores, offices, businesses, streets, sidewalks, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Social

<table>
<thead>
<tr>
<th>Connect with</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>previous friends/peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>co-workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>significant others</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</table>

7
<table>
<thead>
<tr>
<th>Topic</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecting with children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Interacting with people in your community (people in a grocery store, shopping mall, gas station, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Making new friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Being in a large crowd</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Isolating self or being isolated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Cultural</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing variation in food type</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Adapting to expectations on U.S. soil</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Experiencing changes in clothing/uniform</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Participating in rituals/ceremonies</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Experiencing behavioral expectations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Institutional</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abiding by laws/policies</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Accessing institutional systems (finances, education, and justice)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Understanding of the institutional systems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>------------------------------------------</td>
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</tr>
<tr>
<td>Navigating the institutional systems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Accessing and understanding your benefits and rights</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Virtual**

<table>
<thead>
<tr>
<th>Accessing and using technology</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessing and using social media</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Accessing and using the internet</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
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</tbody>
</table>

**Raw Environment Total:**

<p>| | | | | | |</p>
<table>
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<th></th>
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</table>

**Final Score:**

Identify the tasks rated at 3 and above.

<p>| | | | | | |</p>
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<th></th>
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</table>

Explain your reasoning for rating the tasks at that level.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
</table>
**Occupation:**

Everything we do is considered an occupation. Occupation looks different for everyone: there is a human need for occupation that relates to health and well-being and how occupation organizes time and structures life. Occupation includes self-care, productivity/work, leisure, and rest/sleep (Baptiste, 2017; Townsend & Polatajko, 2007).

Considering your upcoming transition to civilian life, rate your level of concern with the following tasks. Scoring: 1 – not concerned, 2 – somewhat concerned, 3 – concerned, 4 – very concerned, 5 – extremely concerned, N/A – does not apply to me

### Self-Care

<table>
<thead>
<tr>
<th>Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completing dressing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Completing bathing/showering</td>
<td></td>
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<tr>
<td>Completing toileting and toilet hygiene</td>
<td></td>
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<tr>
<td>Completing personal hygiene and grooming</td>
<td></td>
<td></td>
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<tr>
<td>Managing and maintain your health</td>
<td></td>
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<tr>
<td>(medication management, etc.)</td>
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<tr>
<td>Completing meal preparation and clean-up</td>
<td></td>
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</tbody>
</table>

### Productivity/Work

<table>
<thead>
<tr>
<th>Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing your finances</td>
<td></td>
<td></td>
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<tr>
<td>Participating in driving and community mobility</td>
<td></td>
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<tr>
<td>Taking care of others and pets</td>
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<td></td>
</tr>
<tr>
<td>Activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
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<tr>
<td>-------------------------------------------------</td>
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</tr>
<tr>
<td>Establishing and managing your home</td>
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<tr>
<td>Completing your shopping</td>
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<tr>
<td>Participating in educational experiences</td>
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<tr>
<td>Demonstrating adequate job performance</td>
<td></td>
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<tr>
<td>Identifying employment interests and pursuits</td>
<td></td>
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<tr>
<td>Seeking and acquiring employment</td>
<td></td>
<td></td>
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<tr>
<td>Preparing and adjusting to retirement</td>
<td></td>
<td></td>
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<tr>
<td>Exploring and participating in volunteerism</td>
<td></td>
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<tr>
<td>Communicating with co-workers, teachers, bosses, etc.</td>
<td></td>
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</tr>
</tbody>
</table>

**Leisure**

<table>
<thead>
<tr>
<th>Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuming hobbies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finding meaningful activities to engage in</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Exploring and participating in leisure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socializing in community</td>
<td></td>
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<tr>
<td>Socializing with family</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Socializing with peers/friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tbody>
</table>

### Rest/Sleep

<table>
<thead>
<tr>
<th>Falling and staying asleep</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Experiencing nightmares/flashbacks</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Establishing a healthy sleep routine</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relaxing and resting</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Raw Occupation Total:**

|  |  |  |  |  |  |  |

**Final Score:** ____________

**Identify the tasks rated at 3 and above.**

________________________________________________________________________

________________________________________________________________________

**Explain your reasoning for rating the tasks at that level.**

________________________________________________________________________

________________________________________________________________________

**What resources or supports do you know of or plan to utilize when leaving the military?**

________________________________________________________________________

________________________________________________________________________
Clinical Reasoning/ Observations

Subjective (observed mood, behavior, attention):

Objective (check all completed):
☐ Completed screening tool
☐ Discussed and identified access to resources
☐ Discussed and identified access to supports
☐ Provided additional resources
☐ Other (please describe):

Assessment (clinician’s assessment; barriers to transition; readiness for transition):

Plan (recommendations, next follow up):
Appendix B

Scoring & Interpretation

Refer to manual for complete scoring instructions. If the scores are higher than the recommended referral score, the administrator is encouraged to use their professional judgment and observation skills to determine if the veteran would benefit from a referral. If the administrator identifies more than five barriers in the veteran’s life during their observation, the administrator is encouraged to make a referral to occupational therapy.

Person: If the final score is 20 or greater, this indicates the need for a referral.

OR

Environment: If the final score is 23 or greater, this indicates the need for a referral.

OR

Occupation: If the final score is 23 or greater, this indicates the need for a referral.

<table>
<thead>
<tr>
<th>Raw Task Totals</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person: 25 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment: 28 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation: 28 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reference


Appendix C

Referral Form
(Send a copy of the screening, scores, and scoring/interpretation page to referred practitioner)

Veteran Name:

DOB:

<table>
<thead>
<tr>
<th>Raw Task Totals</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person: 25 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment: 28 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation: 28 Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reason for Referral: ____________________________________________________________

Does the veteran have access to technology?  YES  NO
Would he/she be interested in receiving services via Telehealth?  YES  NO
If NO, what barriers are identified?

Please add together the scores from each transaction and place scores here:
Person & Environment: __________________
Environment & Occupation: _____________
Occupation & Person: _________________

Additional Comments: _________________________________________________________

________________________________________
Print Name

__________________________   _______________________
Signature                        Date
FROM HERE TO THERE: AN OCCUPATIONAL SCREENING TOOL FOR TRANSITIONING SOLDIERS

Presented By: Bailey Fruit, MOTS & Hannah Williams, MOTS
Advisor: Cherie Graves, OTR/L

OBJECTIVES

Audience will:
- Recognize barriers to community reintegration for veterans
- Understand the purpose of the developed tool
- Understand the implications for the use of the tool
- Understand the use and application of the Person-Environment-Occupation (PEO) model
LITERATURE REVIEW

- Community reintegration
- First 1-2 years are crucial
- Reintegration challenges
  - Social support
  - Home life
  - Education or employment

(Cogan, 2014; Malocco & Smith, 2014; Pease, Bilkera, & Gerard, 2016; Sayer et al., 2010; Seal et al., 2008)

LITERATURE REVIEW: HISTORICAL OVERVIEW

- World War I
  - Intelligence Testing
- World War II
  - Medical Survey Program
  - Neuropsychiatric Screening Adjunct
- Korean War
  - Satisfaction Screening Tools
- OEF/OIF
  - Afghan & Iraq Post-Deployment Screen
  - Military to Civilian Questionnaire (M2C-Q)
  - Deployment Risk & Resilience Inventory (DRRI)

(Ritchie & Cardona, 2007; Sayer et al., 2011; Seal et al., 2008; Vogt, Proctor, King, King, & Vasterling, 2008)
PROBLEM

1. Large influx of soldier back onto U.S. soil with conclusion of OEF/OIF
2. Occupational challenges become apparent during reintegration
3. Appropriate Resources
   - Screenings currently implemented
   - Reintegration resources from the military
   - Community resources after separation

[Pogran, 2014; Kashliwa, Sweetman, & Helgeson, 2017; Maluccio & Smith, 2016; Pease, Billica, & Gerard, 2016; Sayer et al., 2010; Seal et al., 2008]

PURPOSE

- Identify gaps in the transition process
- Identify individual barriers and challenges
- Address the need for...
  - Additional services
  - Resources
  - Training
METHODOLOGY

- Literature review
- Identify problem areas
- Chose OT model
- Create screening tool
- Create manual
- Shared screening tool

THEORETICAL MODEL:
PERSON-ENVIRONMENT-OCCUPATION (PEO)

<table>
<thead>
<tr>
<th>Person</th>
<th>Physical, Cognitive, Sensory, Affective, Spiritual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Physical, Social, Cultural, Institutional, Virtual</td>
</tr>
<tr>
<td>Occupation</td>
<td>Self-Care, Productivity/Work, Leisure, Rest/Sleep</td>
</tr>
</tbody>
</table>
PRODUCT: MILITARY COMMUNITY REINTEGRATION SCREEN (MCRS)

- Demographic information
- Domains
  - Sub-domains
  - Tasks
- Individualized concerns
- Resource and supports
- Clinical reasoning/observations
- Scoring & interpretation
- Referral

PRODUCT: MCRS MANUAL

- Preface
- Author Affiliations
- Introduction
- Features
- Theoretical Basis
- Development of the MCRS
- Administration
- Case Example
- Scoring/Interpretation
- Referral
- Follow-up
- Short Form
- OT Implications
- References
CONCLUSION

- Research and present gaps to military community reintegration
- Identified the purpose
- Demonstrated the development and methodology
- Introduced the application of PEO
- Explained the MCRS and accompanying manual
- Identified limitation and areas for future research
REFERENCES

(A complete list of references available upon request.)


QUESTIONS?

MCRS
THANK YOU
Appendix D

Poster Presentation

Abstract

Literature Review

Contribution to Practice

Limitations & Recommendations

Appendix

References

Appendix A

Appendix B

Appendix C

Appendix D

Appendix E

Appendix F

Appendix G

Appendix H

Appendix I

Appendix J

Appendix K

Appendix L

Appendix M

Appendix N

Appendix O

Appendix P

Appendix Q

Appendix R

Appendix S

Appendix T

Appendix U

Appendix V

Appendix W

Appendix X

Appendix Y

Appendix Z

Appendix AA

Appendix BB

Appendix CC

Appendix DD

Appendix EE

Appendix FF

Appendix GG

Appendix HH

Appendix II

Appendix JJ

Appendix KK

Appendix LL

Appendix MM

Appendix NN

Appendix OO

Appendix PP

Appendix QQ

Appendix RR

Appendix SS

Appendix TT

Appendix UU

AppendixVV

Appendix WW

AppendixXX

Appendix YY

Appendix ZZ
References


https://www.army.mil/article/6829/battlemindprepares_soldiers_for_combat_returning_home


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