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The Issue Is ... Occupational Therapists' Role on U.S. Army and U.S. Public Health Service Commissioned Corps Disaster Mental Health Response Teams

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More than 30 disasters that require an emergency response are declared each year by the federal government [Federal Emergency Management Agency [FEMA], 2007]. Several recent disasters have tested our nation's preparedness, and media attention in their aftermath has increased public awareness of disaster response. How has the profession of occupational therapy responded to this public need and what can be learned from our efforts to date? In recognition of the important contribution occupational therapy practitioners can make in times of disaster, our profession has issued a call to action that will involve practitioners in disaster preparedness, response, and recovery. In reply to this call to action, the American Occupational Therapy Association (AOTA), the American Occupational Therapy Foundation (AOTF), and the World Federation of Occupational Therapists (WFOT) have collaborated to define occupational therapy's role in crisis situations (AOTA, 2007). WFOT has developed models for disaster response and has encouraged AOTA and other member countries to develop and enact a targeted disaster response plan (WFOT, 2007). AOTF (2007) has set the goal of gaining recognition for occupational therapy as a community resource in disaster relief in its 2005–2006 and 2006–2007 strategic plans. In collaboration with the AOTA Commission on Practice, the AOTF Taskforce on Occupation in Societal Crisis prepared an official document (Scaffa, Gerardi, Herzberg, & McColl, 2006) on the role of occupational therapy in disaster preparedness, response, and recovery. The document makes a “cogent case that occupational therapy practitioners have the skills to work in disaster response” (Scaffa et al., 2006, p. 642) and presents examples of potential occupational therapy contributions. Although they have been called to become involved in disaster response, practitioners are challenged with how and where to do so. Little information has been published on the roles practitioners have actually played in disaster response, what those roles entail, and the potential barriers faced and overcome.

This article describes how we applied our disaster response skills in their roles on U.S. Army and U.S. Public Health Service Commissioned Corps (PHS) disaster mental health response teams. We present personal examples from our deployment experiences to illustrate how to address the barriers occupational therapy practitioners may face in responding to AOTA's call to action.

It was not until the early 1990s that the need to address disaster mental health was formally recognized, prompting the formation of disaster mental health networks among agencies such as the American Red Cross, the National Organization for Victim Assistance, and the International Critical Incident Stress Foundation (Everly & Langlieb, 2003). Victims of a disaster commonly experience a range of normal stress reactions such as intrusive thoughts, substantial emotional upset, nightmares and other sleep disturbances, poor concentration, or angry outbursts (Landesman, 2005; Nemuth, 2004). After the September 11, 2001, terrorist attacks on New York and Washington, DC, 44% of adults and 35% of children reported experiencing one or more symptoms of stress (Nemuth, 2004).

The Army has a long history of deploying occupational therapists on mental health teams (Ellsworth, Sinnott, Laedtke, & McPhee, 1993). For example, Army occupational therapists are members of Special Medical Augmentation Readiness Teams–Stress Management (SMART–SM) teams and provide time-limited mental health and critical incident stress management to soldiers, their families, and civilians caught in the turmoil of peacetime operations (Cozza, Huleatt, & James, 2002). Army occupational therapists are also members of Combat Stress Control detachments that deploy with the troops in the field to “maintain the health of the command” (Reyes & Hicklin, 2005, p. 483) and conduct critical incident debriefings after a soldier has been killed or injured (Gerardi & Newton, 2004).

PHS, one of the seven uniformed services, consists of health care professionals and scientists whose mission is to “protect, promote, and advance the health and safety of the nation” (U.S. Public Health Service Commissioned Corps, 2007). Occupational therapists, physical therapists, respiratory therapists, speech–language pathologists, and audiologists are commissioned in the PHS and make up the therapist category. Under the purview of the Secretary of Health and Human Services and the Surgeon General of the United States, therapist officers can be mobilized through the Office of Force Readiness and Deployment during disasters, strife, or other public health emergencies. From a roster of identified roles, therapist officers must select a role for deployment mobilization for which they are qualified. Originally, the Office of Force Readiness and Deployment did not recognize occupational therapists under its mental health provider role. Two of us (Captain Oakley and Captain Parks) successfully advocated for including occupational therapist as a qualifier for the mental health provider role, thus enabling occupational therapists to serve on PHS disaster mental health response teams (“Agency Recognizes,” 2004).

Since September 2004, PHS occupational therapists have regularly deployed as members of disaster mental health teams, typically serving for 2 weeks at time. PHS officers deploy under a variety of administrative umbrellas, including FEMA and the American Red Cross. The American Red Cross does not include occupational therapists among its mental health providers. However, because we are recognized as mental health providers by our own service, the PHS, we are able to deploy and work in that capacity with the Red Cross.

Our disaster mental health work has occurred in nonclinical settings, such as shelters, schools, community centers, or the frontline of a battlefield. Our teams arrive at the disaster site during the postimpact phase. During the postimpact phase (which usually lasts from 4 to 30 days after a disaster strikes), roads may be impassable; telephone lines and cell phone towers may be downed; and businesses such as banks, hospitals, and pharmacies may be inaccessible. The

community may be without electricity, and water sources may be contaminated. Citizens are faced with the common realities of the disaster, including long lines of people waiting for basic necessities like food, water, and ice (Landesman, 2005; Young, Ford, Ruzek, Friedman, & Guzman, 2005).

Note that although we are occupational therapists, we deploy as members of a disaster response team. This is a subtle but important distinction. The goal of disaster mental health teams is to assist people experiencing normal reactions to abnormal situations by providing practical intervention designed to promote recovery, prevent the adverse impact of acute stress reactions, limit disaster-related mental health problems (e.g., posttraumatic stress reactions, depression, substance abuse), and restore psychological and social functioning (Landesman, 2005; Young et al., 2005). Assistance takes the form of advocacy, problem solving of immediate issues, stress management education about normal reactions to disaster-related stress and handling acute stress reactions, and referring those in need for further evaluation and care (Galea et al., 2002; Landesman, 2005; Waits & Waldrep, 2002; Young et al., 2005). When we deploy as members of disaster mental health teams, we have found that the goal of each team, facilitating normalization of the situation, is the same, but how our role is implemented depends on the circumstances encountered at the site. The following paragraphs provide examples of our recent mental health disaster deployments.

September 11, 2001

In response to the September 11, 2001, terrorist attacks, Army occupational therapists deployed as part of a SMART–SM team to the Pentagon. In the traumatic situation, soldiers and civilians at the Pentagon wanted to tell their stories. The Pentagon workers whose offices were close to the impact site lost all their belongings, including computers, files, personal effects, and reference books. The victims of the Pentagon attack were subsequently relocated to Crystal City, Virginia, a few miles away, while the impact area was being rebuilt. They experienced a variety of new frustrations, such as longer commutes and parking garage fees. They also dealt with not knowing when meetings were held at the Pentagon and not having computer access during construction of new office areas. Beyond the mundane daily frustrations, Pentagon workers were grieving for lost friends and coworkers. Using an instructive approach, SMART–SM team members gave clients an opportunity to discuss their experiences in a supportive environment and educated them about the wide variability of normal reactions to such an abnormal situation (Cozza et al., 2002). They made basic mental hygiene recommendations, encouraging maintenance of adequate sleep, eating, and fitness schedules and advising those affected to limit their exposure to media coverage (Cozza et al., 2002). The team emphasized the benefits of relaxation techniques and the importance of receiving and giving social support during a uniquely devastating and traumatic time in the United States' history. Many times, an effective intervention was simply giving someone permission to address his or her personal needs by relaxing and playing despite the chaos.

Iraq Intervention

As members of Combat Stress Control detachments, Army occupational therapists deployed to Iraq provided critical incident stress counseling to survivors or witnesses of traumatic events, thereby preventing emergence of protracted grief reactions or post-traumatic stress disorder. The therapists received feedback from soldiers that they were well suited to this role on the basis of their skills in listening, empathizing, and offering reassurance with practical methods to assist victims in getting back to a “new” normal. Occupational therapists were comfortable talking about roles with soldiers, which served as an opening to discuss the importance of seeking mental health assistance, if needed. If soldiers stated they were having nightmares, anxiety attacks, or difficulty sleeping, a therapist could emphasize the importance of discussing

the event. Time was also spent discussing the reality that while deployed, roles could not be changed, but to decrease stress, soldiers could use health-promoting activities such as exercising, getting adequate sleep and nutrition, and limiting caffeine intake.

Florida Hurricanes 2004

After three hurricanes struck Florida in the summer of 2004, PHS occupational therapists deployed with mental health teams to numerous disaster relief sites. One such deployment was to an emergency “megashelter” in Orlando established for older adults with special needs who had been evacuated from nursing homes, assisted living centers, and private homes within an approximate 100-mile radius of the shelter. Many of the residents required medical care, including electronic support devices (e.g., oxygen) to maintain life, several walked using assistive devices, quite a few used wheelchairs, and many had experienced repeated moves from shelter to shelter during evacuation from their homes.

The megashelter was a cavernous space with concrete floors and an unfinished ceiling located near the loading docks of the Orlando Convention Center. Row upon row of cots and hospital beds were brought into the space to accommodate residents and their caregivers. PHS occupational therapists were part of a team that secured an area within the shelter and established an activity center to provide residents and their caregivers structure, continuity, and an opportunity to socialize and engage in valued leisure activities. To elicit information about interests, hobbies, and favorite occupations of greatest interest to the residents, an occupational therapist designed and administered an activity questionnaire to residents and their caregivers. The information obtained from the questionnaire was collated to guide the team in procuring supplies that were donated through direct contact with local area merchants. The most popular activities included chair aerobics, bingo, tournament Scrabble, movies, walking group, relaxation group, and puzzles. For those residents who were unable to come to the activity center, one-on-one activity sessions were provided at their bedsides. To alleviate distress and confusion and to enable the residents and their caregivers to become familiar with their environment and the events of the day, the team made and distributed a daily activity schedule and a “map” of the shelter and posted signs directing residents to bathrooms and other important locations.

Hurricane Katrina 2005

In September 2005, after Hurricane Katrina, a PHS occupational therapist was deployed to Gulfport, Mississippi, as a member of the 10-person FEMA Disaster Mental Health Team. The team’s mission was to meet with first responders, caregivers, and service providers, many of whom had witnessed trauma or were victims of loss themselves. The team’s aim ultimately was to communicate to their contacts and clients a sense of mastery over the circumstances to mitigate the damage and reverse its effects as efficiently as possible. When the team was contacted by the chaplain for the state of Mississippi National Guard, it was to communicate a request from the commander of a guard unit with more than 200 soldiers who had been on orders for deployment to Iraq just before Hurricane Katrina’s landfall. With the hurricane’s devastation and aftermath, the guard unit’s planned shipment to Iraq was cancelled, and the unit was temporarily reassigned to assist with clean up in their area of Gulfport. After a few days, the shipment opportunity came up again, and volunteers for the Iraq duty were invited to volunteer. More than 100 of the original 250-soldier unit came forward to volunteer.

The unit’s commander requested the FEMA Disaster Mental Health Team to provide a one-on-one opportunity for each of his soldiers to talk about their experiences during the storm. Many had lost vehicles, homes, and even neighbors or family members. By offering each soldier a chance to talk about traumas and losses, members of the Disaster Mental Health Team were able to contribute to the post-Katrina healing process. They also helped the commander

to identify specific people whose emotional reactions were so detrimental as to make their deployment to Iraq inadvisable at the time.

Similar opportunities to talk through reactions to the hurricane were subsequently offered to the staff members of a center for the adults with mental retardation and a mental health center featuring programs for adults and children with problems of substance abuse, mood disorders, and other major psychiatric illnesses. Both assignments came as requests from the facilities' directors, asking for trained professionals (the Disaster Mental Health Team included two occupational therapists) to talk with any staff members who wanted to discuss what they had been through during the hurricane and its immediate aftermath. In both cases, the facilities' staffs were struggling with their own enormous personal losses while trying to carry on in the roles they were employed to play on a daily basis with their residents and clients.

Conclusion

It is clear that although occupational therapy practitioners have the potential to become members of disaster mental health teams, they face barriers to doing so. First, it is critical that occupational therapy practitioners augment their skills with additional training in disaster mental health response. Second, when serving on disaster mental health response teams, occupational therapy practitioners must be aware that they can use their occupational therapy skills but must do so within the overarching disaster mental health team role guidelines. Finally, the Red Cross does not recognize occupational therapy as a profession credentialed to serve on its disaster mental health response teams. Nevertheless, both the U.S. Army and the U.S. PHS Commissioned Corps recognize the value of including occupational therapists on disaster mental health teams. Although our disaster roles are usually quite different from the roles we routinely play in our daily work in a hospital or clinic, our experience as occupational therapists has prepared us well for work on disaster mental health teams. Our occupational therapy training along with our additional online and classroom training in disaster mental health allowed us to apply essential clinical skills we use every day to disaster situations. In disasters, we bring practical skills to communities in need. The skills include our ability to provide education about normal reactions to abnormal situations, to encourage resumption of usual daily routines including basic self-care as soon as possible, to answer questions about factual aspects of the disaster, and to allow people to tell their stories if they so choose. We act to ensure that those involved in the disaster do not perceive themselves as banished from society and, by doing so, we embody a message of hope and resiliency rather than pathology and despair.

In our experience, occupational therapists can serve not only as essential members of disaster mental health teams but also as effective team leaders. As evidence of the latter, we are proud to report that Major Caswell is Commander of the 85th Medical Detachment, Combat Stress Control. She leads a 42-member team consisting of psychiatrists, psychiatric nurses, social workers, psychologists, occupational therapists, and mental health specialists currently serving with the troops in Iraq.

In a guest editorial on occupational therapy in times of disaster, Gretchen Stone (2006) queried, "Are occupational therapists prepared to respond? Are occupational therapists essential during and in the aftermath of a disaster?" (p. 7). From our direct experience, we confidently respond "Yes" to her questions. We are essential, we are prepared, and we do respond. ▲

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