

PART

I

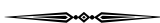


Foundations of Social Work With
Service Members and Veterans

COPYRIGHTED MATERIAL

CHAPTER

1



A Brief History of Social Work With the Military and Veterans

ALLEN RUBIN AND HELENA HARVIE

Since World War II social workers have been playing an increasingly significant role in the provision of behavioral health services to military personnel, veterans, and military families in a variety of settings. Today, the military and the Veterans Administration (VA) continue to be prominent sources of employment for social workers. Licensed social workers can work full time as uniformed military officers or as civilians for the VA and vet centers. They also can serve on a part-time or on a full-time basis as civilians who are contracted by the armed forces or the VA. In addition, they can work with military families and the veteran population as private practitioners through the military's TRICARE health insurance plan or an Employee Assistance Program (EAP) that contracts for brief therapy services for active duty military personnel. Also, military service personnel and their families, including the National Guard and Reserve, are seen by civilian social workers in community mental health agencies that contract with the VA. If you Google keywords about social work in the armed forces, you can find websites from different armed forces branches that describe what military social workers do, the prerequisites for becoming a licensed social work officer, and so on. You can find similar information about serving as a social worker in the VA at its website at www.socialwork.va.gov. The VA employs more than 13,000 social workers (Partners for Public Service, 2010) and offers a clinical training program for social work students that trains approximately 900 students per year (Department of Veterans Affairs, 2010, p. 1).

In light of the extent to which military organizations currently value social workers, you might be surprised to learn that it was not until the end of World War II that social work was officially recognized by the U.S. armed forces as a military occupation. However, the historical roots of military social work date back to much earlier times, just as the roots of the social work profession predate its emergence as a profession, as concerns about charity and how to deal with poverty have existed throughout history. Likewise, the roots of military social work in the United States can be traced back as early as 1636, when the

Pilgrims of Plymouth County stated that the care of disabled veterans was the responsibility of the colony, and the first legislation about caring for veterans was enacted (Department of Veterans Affairs, n.d.).

The more recent roots of military social work in the United States are associated with the Civil War (1861–1865), when Clara Barton, the founder of the American Red Cross, not only helped wounded soldiers medically but also assisted soldiers with finding community resources and getting information to and from family members (American Red Cross, 2011). Volunteers also visited with Union soldiers to provide support and relief during the Civil War (Raiha, 2000). However, the American Red Cross would not become an official organization until after the Civil War.

It was not until the Spanish-American War of 1898, however, when the American Red Cross as an organization provided services to members of the American armed forces at war (American Red Cross, 2011). Although the Red Cross provided mostly medical care to service members, it also provided a nonmedical service—carrying on a limited means of communication services that handled inquiries from families. The year 1898 also witnessed the birth of professional social work education, as the first social work course was offered at Columbia University (National Association of Social Workers, n.d.). Many Red Cross services were provided by social workers during the Spanish-American War; consequently, the term military social work can be conceived as originating at that time. Before 1898, citizens might have been performing social work duties, but it was not until the profession emerged that professional social workers per se did so.

WORLD WAR I AND ITS AFTERMATH

Recognition of the need for psychiatric social workers grew during World War I, when nearly 100,000 service members and veterans were admitted with neuropsychiatric disorders to military hospitals (Harris, 2000). The first psychiatric social workers had been employed in neurological clinics in 1905 as part of interdisciplinary clinical teams. Their primary role was to obtain collateral information needed by psychiatrists, relative to family background and past life experiences. Later, psychiatric social workers were in charge of preparing families for the return home of mental patients (O’Keefe, 2009). The value of psychiatric social work to the military became showcased by the Red Cross in 1918 when the first social worker was employed at the special hospital for neuroses at the U.S. Army General Hospital #30 in Plattsburgh, New York. The social worker’s duties were “to assist the medical officers by obtaining information regarding the personal, family, and community background of the soldiers under treatment, as an aid in diagnosis, treatment, and plans for aftercare” (O’Keefe, 2009, p. 1). The success of this project not only led to the increase of psychiatric social workers at this hospital, but also to the Red Cross assigning medical social workers (i.e., social workers who work in medical settings) to all hospitals.

After the war was over in March 1919, the Surgeon General asked the Red Cross to establish a social services program in federal hospitals similar to already existing psychiatric programs in civilian hospitals (Harris, 2000). While the U.S. Public Health Service had been made responsible for the care of veterans, the Red Cross assumed full

responsibility for outlining the social service program, formulating policies, recruiting personnel, and assisting in the organization of the work. By January 1920, there were social service departments in 42 federal hospitals, which mostly served veterans and service members (O'Keefe, 2009).

The Red Cross continued to carry the full responsibility for these psychiatric social services until the Veterans Bureau established its own social work department on June 16, 1926. The Veterans Bureau General Order established the social work program and outlined its organization and functions (Department of Veterans Affairs, 2010). The first year staffing consisted of 14 social workers who were placed in psychiatric hospitals and 22 who were placed in regional offices throughout the country. The first director was Irene Grant Dalymple, a pioneer in providing social work in medical settings (Department of Veterans Affairs, 2010). The early stages of the program were centered on patients suffering from psychiatric disorders and tuberculosis. Eventually, Dalymple was instrumental in getting social work services incorporated into the Veterans Bureau instead of having social services contracted by an outside organization, as had been the practice following World War I (Department of Veterans Affairs, 2010).

WORLD WAR II AND ITS AFTERMATH

With the anticipation of World War II, the U.S. armed forces started to expand in 1940 and 1941. The contributions of social workers, however, had been mostly forgotten, and the social work specialty was not included in the expansion (O'Keefe, 2009). This was due to social work not being considered an integral part of the military medical organization.

Some of the responsibility for this state of affairs must be placed on the field of social work which had established no working relations with any of the branches of the Armed Forces before Pearl Harbor. One indication of the situation was the fact that the National Roster of Scientific and Specialized Personnel of the National Resources Planning Board did not list social work as a profession. Since psychiatry at this time also did not receive adequate recognition within the Army, psychiatric social work had neither leadership nor high-level support in the mobilization period of World War II. (O'Keefe, 2009, p. 1)

Due to this lack of recognition, the Red Cross was tasked with supplying all social workers at the beginning of World War II. "Between 1942 and 1945 about 1,000 American Red Cross psychiatric social workers were assigned to named general and regional hospitals in the United States and overseas" (Harris, 2000, p. 3).

It was not until 1942 that the military allowed service members to work as psychiatric social workers. Six enlisted soldiers in the U.S. Army who were professionally qualified as psychiatric social workers were assigned to the newly formed Mental Hygiene Consultation service at Fort Monmouth, New Jersey. "This is the first time military personnel who were trained as psychiatric social workers were utilized as psychiatric social workers in a military unit" (Harris, 2000, p. 4). On October 18, 1943, the War Department published the

Military Occupational Specialty 263 for Psychiatric Social Work Technicians. This position was defined as:

- Under supervision of a psychiatrist, performs psychiatric casework to facilitate diagnosis and treatment of soldiers requiring psychiatrist guidance.
- Administers psychiatric intake interviews, and writes case histories emphasizing the factors pertinent to psychiatric diagnoses.
- Carries out mental-hygiene prescriptions and records progress to formulate a complete case history.
- May obtain additional information on soldier's home environment through Red Cross or other agencies to facilitate in possible discharge planning.
- Must have knowledge of dynamics of personality structure and development, and cause of emotional maladjustments. (Harris, 2000, p. 5)

Even though there was a great need for psychiatric social workers, professionally trained social workers who were already enlisted soldiers could not automatically expect to be awarded the psychiatric social work occupation specialty. Most of these soldiers were drafted into the U.S. Army and already were in positions that needed to be filled, which made receiving reclassification very hard (O'Keefe, 2009). However, a noncommissioned officer in the U.S. Army could apply for reclassification as a psychiatric social worker. Ironically, the memorandum also acknowledged that Army commissioned officers or any person in the Navy, Marines, Coast Guard, Seabees, or Women's Army Corps (WAC) could not apply for reclassification. "Between 1942 and 1945, 711 enlisted men and WACs served in the role of the psychiatric social worker. These service members were assigned to induction centers, named to general and regional hospitals, station and evacuation hospitals, and combat divisions" (Harris, 2000, p. 5).

Two major professional organizations were responsible for getting a social work branch established into the U.S. Army. These organizations were the Wartime Committee on Personnel of the American Association of Social Workers and the National Committee for Mental Hygiene. The latter organization worked on behalf of social workers during World War I in collaboration with the Surgeon General (Harris, 2000). On October 19, 1942, the War Service Office of the American Association of Psychiatric Social Workers was established and continued its operations until December 1, 1945 (O'Keefe, 2009). This office was under the direction of Elizabeth H. Ross, the former secretary of the association. Through her guidance and leadership, the War Service Office became the central contact point and source of information for social workers in the military services as well as the professional resource for the Surgeon General's Office. She would also be instrumental in developing an Army psychiatric social work program (O'Keefe, 2009).

Due to the impact of these three organizations, commissioned status in the U.S. Army for social workers was finally achieved in 1945; "Major Daniel E. O'Keefe assumed the position as the first Chief of the Army's Psychiatric Social Work Branch on July 1, 1945" (Harris, 2000, p. 6). However, with the war over at the end of August, almost all of the social workers were separated from the service. Major O'Keefe was in charge only 8 months before being separated from military duty; however, he was able to begin a centrally

directed social work program. In February 1946, the Army granted the military occupational specialty for the professionally trained psychiatric social work officer (MOS 3506). Even though this was after many social workers had already separated, this assured the continuity of Army social work (Harris, 2000).

After Major O’Keefe left the service, the Surgeon General called on Elizabeth H. Ross to serve as the civilian psychiatric social work consultant until a qualified uniformed officer could be recruited and appointed (Harris, 2000). Ross was instrumental in getting social work into the military. She helped alert soldiers to possible reclassification as a psychiatric social worker and advocated on behalf of the profession to the Surgeon General. After the demobilization following World War II, there was an urgency to rebuild professional social work in the Army (Harris, 2000). There was an even greater thrust to recruit social workers with a master’s degree. The Army training program was initiated for the purpose of training psychiatric social workers to work for the Army. “The selection would be made from male graduates, students of social case-work who were enrolled in graduate schools of social work approved by the Secretary of the Army and who desired a career with the Regular Army Medical Service Corps” (Harris, 2000, p. 16).

Social Work in the Different Branches of the Armed Services

The growth of military social work during World War II and in its immediate aftermath was not the same in each branch of the armed services. As discussed earlier, that growth came primarily in the U.S. Army. The Air Force did not become its own military department until 1947. Many organizational characteristics of the Army were transitioned into the Air Force, including social work service. It was originally part of the medical service corps, but would eventually move into the Biomedical Science Corps.

Initially, social workers were assigned to larger medical facilities with the senior social worker being designated as the Chief of Social Work Service. However, by the early 1970s, it was common for a single social worker to be assigned to a small medical facility, sometimes as a member of a multidisciplinary mental health team or, on occasion, as the only mental health provider. (Jenkins, 2000, p. 28)

Social work in the Air Force would grow from six initial commissioned social work officers in 1952 to 225 at the peak of expansion in 1988 (Jenkins, 2000).

In the Navy, a variety of medical and administrative personnel provided social work services in naval medical treatment facilities. The Navy Relief Society was one of the largest social services agencies to provide social support, and World War II was the first time that the Navy Relief Society provided social workers to assist Navy families. However, most professional social work activities were confined to training volunteers who provided the social services (United States Navy Medical Service Corps), and it was not until the Vietnam War era that military social work in the Navy burgeoned (as is discussed later).

THE KOREAN WAR AND THE START OF THE VIETNAM WAR: 1950–1970

During the 1950s and the 1960s a mix of long periods of conflict overseas led to the expansion of military social service provisions. The Korean and Vietnam Wars drew on the lessons learned in World Wars I and II, which led to an increase in social services to service members and their families. The growing field of social work found itself in many different areas of the military and the veteran community. From the stockades to family advocacy, social workers solidified their worth to the military.

During these two wars, social workers would be deployed with Mental Hygiene units to combat zones and continued to work in medical settings (Daley, 2000). Social workers would also work in mental health facilities and community service organizations (Daley, 2000). By the time the Vietnam War ended, the military community would forever be changed.

Stockades

Since the military is a microcosm of society, many of its systems mirror those in civilian society. During the 1950s and 1960s one such system became increasingly worrisome. The military penal system struggled with whether to punish or rehabilitate its offenders (Harris, 2000). Colonel William C. Menninger, MC, chief of the department of neuropsychiatry and neurology of the Surgeon General's office stated:

Rehabilitation should be our first aim in dealing with military offenders, recognizing that some members who are potentially unsalvageable should be separated from the group. The first step on a man's arrival should be psychiatric and social evaluation to determine the nature of the problem and the most promising steps to take in his rehabilitation. To accomplish this mission, every member of the staff from the commander to guard must know and apply the principles of mental hygiene. (Harris, 2000, p. 12)

However, the treatment options for rehabilitation were slow to be integrated and implemented into the stockades. Mental hygiene units had always been a part of the stockades in some fashion, but they often lacked certain characteristics to make them successful. For instance, they rarely included the total prisoner population and they never represented a real, cooperative combined effort between the psychiatric personnel and the military commanders (Harris, 2000).

In September 1957, the first real effort to screen prison inmates took effect. Army Regulation 210–181 introduced the Army Stockade screening program, which made “provisions for the early identification of maladjusted soldiers and, if possible, the use of remedial efforts to render these individuals useful to the service” (Harris, 2000, p. 13). The psychiatric evaluations were conducted within the first few days of confinement and were most effectively conducted by social work personnel under the supervision of the psychiatrist (Harris, 2000). This screening program was hailed as a major achievement in military corrections, and was part of an organized effort to make the stockade a rehabilitation center rather than a place to isolate offenders—or what some had come to believe as a source of free labor (Harris, 2000).

However, there were several criticisms of these early rehabilitation efforts. One criticism pertained to the large variety of programs being implemented in the stockades facilities and whether these programs were effective. Most programs focused on the classical one-on-one psychotherapeutic relationship or a variety of group treatments. Another criticism was that social workers were being used to screen new inmates instead of being a larger part of the treatment process (Harris, 2000). Although they participated in individual treatment, many social workers felt the need to work on improving the military community as a whole (Harris, 2000).

In 1968, the Correctional Training Facility (CTF) was established in Fort Riley, Kansas. The purpose of this facility was to provide the training and assistance necessary to treat military offenders and return them to duty or to an honorable discharge (Harris, 2000). Social workers played a significant role in the development and implementation of the CTF and its programs.

Army Community Service (ACS): The Beginnings of the Family Advocacy Program

During the years between World War II and the Vietnam War, the demographics of the military changed dramatically.

In 1940 there were 67,000 families in the Army. By 1965, there were about 450,000 families with over 1,300,000 million dependents. In 1940 enlisted men were required to obtain their superior's permission to marry. By 1965, 60% of the enlisted men were married and 80% of the officers. However, one consequence was that over 100,000 wives were separated from their husbands due to military duties. (Harris, 2000, p. 14)

Commanding officers were getting an increasing number of reports of problems from their troops in regard to family problems. These problems ranged from chronic financial problems to physical or mental health problems with children. These problems were leading to difficulties in retention of good soldiers and regular troop morale (Harris, 2000). A 2-year study was conducted to research these complaints and how the Army could aggressively address these problems. The study's findings led to the development of the Army Community Service (ACS) program, which was first started at Fort Dix in New Jersey, Fort Benning in Ohio, and Fort Lewis in Washington. The program later was established at all installations in which more than 500 military personnel were stationed.

The mission of the ACS program was to establish a centrally located service that would provide information, assistance, and guidance to members of the Army community in meeting personnel and family problems beyond the scope of the family's own resources. The program had to be recognizable and responsive to the needs of military personnel and their families. It was created with the intention of reducing hours consumed by command-personnel problems and soldiers seeking assistance for complex personal problems and domestic disputes. Another aim was to improve personnel retention by increasing career satisfaction. "Some of the services that were provided included information and referral for financial assistance, availability of housing, transportation, relocation of dependents, medical and dental care, legal assistance, and more complex family and personal issues" (Harris, 2000, p. 15).

In the beginning, 42 social work officers and 19 social work enlisted personnel were assigned. This assignment was the first time social workers, as a group, were called on to extend their knowledge and skills outside of the medical service. In addition to professional staff, the ACS relied heavily on volunteers. The concept of ACS started with the hope that its foundation would be a volunteer corps of Army wives who would support a small nucleus of military and civilian supervisors (Harris, 2000). Two wives who played a major role in the beginning of ACS were Beatrice Banning Ayer, the wife of General George S. Patton, and Dorothy Rennix, the wife of General Harold K. Johnston, the Army Chief of Staff from 1964 to 1968.

“By November 1966, over ninety ACS centers had been established worldwide, with over 132,000 individuals having received assistance at these centers” (Harris, 2000, p. 15). ACS centers were also established at major medical facilities, including Walter Reed Army Medical Center in Washington DC, Fitzsimmons General Hospital in Colorado, and Valley Forge General Hospital in Pennsylvania. Social workers played a major role in implementing and establishing ACS programs in medical centers across the globe (Harris, 2000). A major milestone was achieved on January 16, 1967, when an ACS branch was established in the Personnel Services Division of the Army Deputy Chief of Staff of Personnel. This achievement solidified the ACS program within the Army community, and the ACS program would become the foundation for the family advocacy program, an important development for military social work, as is discussed in more depth later in this chapter.

After the Vietnam War to the End of the Cold War

The end of the 1960s and early 1970s was a great period of change in society, and the military was no different. The Great Society carried out by President Lyndon B. Johnson increased awareness of poverty, racial tensions, and domestic issues including child abuse and domestic violence. This awareness brought a significant change in the military social services, including the creation of the Navy social work program.

The Red Cross decided to cease its contribution to the psychosocial services, due to the increasing need for professional trained mental health professionals during the Vietnam War. The magnitude of service members and family members that needed services also was too much for the organization to sustain on its own. When the Red Cross ceased its contribution in the 1970s, a temporary decline in social work services occurred in naval medical treatment facilities, and other health professionals had the burden of filling the void of social workers. However, before the Red Cross withdrew, several civilian psychiatric social workers had laid the foundation for an official social work program in the Navy. Eventually, the concern about the large number of prisoners of war (POWs) and personnel listed as missing in action (MIA) provided a catalyst for increasing the role of social work in the Navy (United States Navy Medical Service Corps, 2000). In 1972 a Center for Prisoner of War Studies was established at the Naval Health Research Center in San Diego, California. Its research concluded that strong outreach services, collaboration with other agencies, and mental health consultation were necessary to assist returning POWs and their families. This led to social workers being employed at several Navy treatment facilities. The social workers coordinated community services and facilitated the transition for repatriated POWs and their families. At these treatment facilities, programs were

initiated to help families and children deal with service members returning home by providing individual and family counseling (U.S. Navy Medical Service Corps, 2000).

Other developments during the 1970s that increased the role of social services in the Navy included the establishment of Naval drug rehabilitation centers in 1971, family advocacy programs in 1976, and the Navy family service center system in 1978. At their start, however, these programs were created with few social workers. For example, only 29 civilian social workers were employed in naval hospitals. The other branches of the armed forces had comparatively robust social work programs, with a ratio of one military or civilian social worker for every 15 physicians. But the ratio in the Navy was only one civilian social worker to 170 physicians (U.S. Navy Medical Service Corps, 2000, p. 25). Those civilian social workers were responsible not only for caring for sailors in the Navy, but also for U.S. Marines.

This dearth of social workers led to increasing problems in caring for sailors and Marines, and the use of social workers in the Navy got a boost in 1979 when the Bureau of Medicine and Surgery approved a request to recruit and commission thirteen social workers in the Medical Service Corps. Consequently, in January 1980 the Navy's first uniformed social worker was commissioned as a lieutenant (junior grade) and was assigned to establish a department of social work at the Naval Regional Medical Center in San Diego (U.S. Navy Medical Service Corps, 2000). By the end of 1980, there would be 11 more uniformed social workers in the department. Another boost in 1979 occurred with the establishment of the Navy's first Family Service Center. Over the next 5 years, social work in the Navy would continue to grow in medical treatment facilities, drug and alcohol rehabilitation centers, family advocacy programs, and expanded clinical services with individuals, families, and groups (U.S. Navy Medical Service Corps, 2000).

Family Programs

As Jesse Harris discusses in Chapter 18 of this book, perhaps the most important factor contributing to the growth of military social work is the stress experienced by the families and children of active duty service members and veterans and the recognition by military commanders of the impact of family stress on the military mission. One of the largest programs to serve military families is the Family Advocacy Program (FAP), which, as mentioned earlier, emerged during the Vietnam War era. Its predecessors were family violence prevention programs, which concentrated primarily on child abuse. Although the initial focus of these programs was on the medical aspects of child maltreatment, the prevention and education foci soon followed (Nelson, 2000).

Many civilians believed that child abuse was an epidemic taking over the military community. However, at the time there was no central database to correlate that fact or deny it. Later studies would show that child abuse was actually less in the military than in the regular population during the 1970s (Nelson, 2000). However, this stigma continued to persist and led to passage of Public Law 93-247, "Child Abuse Prevention Treatment Act."

This legislation authorized federal grants to states to develop and strengthen child abuse prevention and treatment programs, exclusively to states with an established system for reporting and investigation of incidents of suspected

child abuse. The act also established the National Center on Child Abuse and Neglect (NCCAN), which was to become a strong advocate for programs in the DoD. (Nelson, 2000, p. 54)

Following the passage of this legislation, there was increased pressure on the Department of Defense (DoD) to create its own identification and treatment program. However, the DoD was reluctant and encouraged civilians that were working with the military to take charge of this program (Nelson, 2000).

In 1975, the Air Force became the first service to establish a child advocacy program (Nelson, 2000), and each service had its own child advocacy program by the end of 1976. In addition, the Navy included spouse abuse in its program (Nelson, 2000). However, none of these programs was directly funded or given high priority, because all staff assigned operated as additional or collateral duties (Government Accountability Office [GAO], 1979). Nelson (2000, p. 55) observed, "As such, the programs were little more than administrative mechanisms to formalize the existing structure. Any additional resources to fight child abuse or for prevention were not available at this time."

The catalyst that changed the direction of child advocacy in the military was a 1979 Government Accountability Office report, "Military Child Advocacy Programs: Victims of Neglect," which documented the need for overall DoD guidance in implementing military family violence programs. This report stated that child advocacy programs were inconsistent among the different services, were not properly funded, and were not in proper positions of the military installation level. This report also stated that the programs were understaffed and needed a unified and consistent DoD policy, greater resource allocation, and expanded education and training (Government Accountability Office, 1979). In response to this report, the DoD established the Military Family Resource Center. The first DoD directive on family violence was published, and funding was appropriated for the military family advocacy programs (Nelson, 2000).

The Military Family Resource Center (MFRC), established in October 1980, was the sole mission of the Armed Services YMCA (ASYMCA). It was created to "provide information and technical assistance to professionals serving military families, facilitate inter-service and inter-disciplinary cooperation, maintain liaison with other federal and civilian agencies serving families, and provide fiscal oversight to all of the military family violence programs" (Nelson, 2000, p. 56). Even though it was initially conceptualized as a place to share information, it became the vehicle to manage program development and training. It also acted as a catalyst for the development of prevention and family support programs (Nelson, 2000). By 1990, the ASYMCA relinquished control of the MFRC; however, it served a vital role in creating and implementing a place for family advocacy in the armed forces.

In 1981 the DoD issued a directive that expanded the scope of child advocacy programs to include spouse abuse and established a set of common definitions for each service. This directive shifted the focus from just child advocacy to family advocacy. It required each service to set up its own program for prevention, identification, reporting, treatment, and follow-up of child and spouse abuse. The Family Advocacy Program (FAP) initially was met with hesitation in the Department of Defense, because it was unclear how it could aid DoD's main mission of supporting active duty forces (Nelson, 2000). However, by fiscal

year 1983, FAP funds were directly appropriated to DoD. “The centralization of family maltreatment funding was a key in consolidating individual and uncoordinated service activities into a coherent DoD program” (Nelson, 2000, p. 57), which was recommended in the GAO report of 1979. In 1987, the first standardized central registry reporting requirements for reporting child and spouse abuse was created (Nelson, 2000).

Currently, the FAP’s mission is to prevent, identify, intervene, and treat all aspects of child abuse, neglect, and spouse abuse (Nelson, 2000). FAPs are also designed to support the integrity of the family unit without compromising the victim, and they collaborate with state and local civilian child protective services. They also work to make the family unit stronger by providing services and programs that include training and education and primary and secondary prevention programs that range from advocacy for nonviolent communities to programs targeted to at-risk populations (Nelson, 2000).

Social workers were instrumental in the creation and development of the FAP. Civilian social workers led the way, but control was quickly given to uniformed social workers. Early programs were managed by social workers, who were generally assigned as mental health officers. The role of the child advocacy officer was an additional duty, and workers consequently had to balance numerous competing demands. These demands included command-directed evaluations, counseling, and consulting, as well as the evaluation, treatment, and case management of child abuse cases. Unfortunately, this meant that child abuse cases were not always the highest priority (Nelson, 2000). It would not be until the late 1980s and early 1990s that child advocacy would be the sole job of a social worker.

Substance Abuse Programs

As discussed in Chapter 12 of this book, substance abuse became a large problem for the military during the Vietnam War, as service members were returning from Vietnam addicted to opiates, heroin, and/or marijuana. Consequently, Public Law 92–129 was enacted in 1971, which mandated a program for the identification and treatment of drug and alcohol dependent individuals in all branches of the armed services. Military substance abuse prevention programs parallel civilian Employee Assistance Programs (EAP), however, unlike civilian programs, which aim for economic benefits, military programs are aimed at assuring force readiness (Newsome, 2000).

The primary treatment model in the early stages was the 12-step model of Alcoholics Anonymous. Both inpatient and outpatient programs relied heavily on a 12-step treatment model, and the main criterion to be a provider was to be “in recovery” oneself. This criterion led to a paraprofessional work force, which continued into the 1980s. Each branch viewed the counselor role differently. Both the Army and Navy used individuals in recovery, but the Army established the counselor role as a specific duty, while the Navy had the counselor as an extra duty, with the individual maintaining their regular Navy position. All rehabilitative services were provided by paraprofessional counselors assigned to a multiservice agency called *Social Actions*. This agency also addressed employee relations, racial relations, and equal opportunity issues. The Air Force combined an initial assessment from a Social Actions counselor and then a medical consultant. Active duty social workers primarily filled the roles of the medical consultant, and they were mostly assigned to base mental health clinics (Newsome, 2000).

PTSD

In 1980 posttraumatic stress disorder (PTSD) was officially recognized as a diagnosis in the *DSM-III* (Lasiuk & Hegadoren, 2006). Although military trauma stress reactions were known by other names in earlier wars, as discussed in Chapter 6 of this book, it was not until the late 1960s and 1970s that veterans started to fight to have mental health viewed as an injury from combat. Before PTSD was an official diagnosis, veterans were unable to receive disability compensation for their PTSD symptoms (Lasiuk & Hegadoren, 2006). This new diagnosis led to an increase in mental health social workers at veterans hospitals and at mental health clinics in the military (Daley, 2000). However, this was also a period of decline for uniformed social workers working in mental health clinics in the military. Uniformed social workers were expanding their expertise to family advocacy and substance abuse programs, which caused them to lose their footing in mental health clinics (Daley, 2000).

The Veterans Administration

The Veterans Administration increased many of its services during this time period as well. After the passage of the Veterans Health Care Amendments Act of 1979, the VA set up a network of Vet Centers across the country, separate from other VA facilities. In response to Vietnam veterans' special needs, the Vet Centers at first were limited to just Vietnam veterans; however, they later expanded to serve all veterans (Department of Veterans Affairs, NA).

In 1975, in response to an increasing number of elderly veterans and their special needs, the VA began to train interdisciplinary teams of health care specialists. In the late 1980s, the VA began to take a special interest in helping homeless veterans and chronically mental ill patients (Department of Veterans Affairs, NA). Many of the professional staff positions for serving these new target populations were filled by social workers.

The Persian Gulf War Until 9/11

The 1990s was a period of expansion and a period of transition for military social work. After the end of the Cold War and the Gulf War of 1990–1991 (known as Operation Desert Shield/Desert Storm), many social work–led programs increased in funding and in size. The family advocacy program expanded greatly during this time period. So did the social work role within the military, in general, and in veterans hospitals. The Navy was an example of this expansion. “During Operation Desert Shield/Storm, social workers were deployed for the first time to a combat zone on board hospital ships *Comfort* and *Mercy*, and Fleet Hospital Five. They provided counseling and referral services, and mental health support” (U.S. Navy Medical Service Corps, 2000, p. 26).

Family Advocacy Programs

The family advocacy program's budget grew fourfold between 1988 and 1993—from \$14.2 million to \$62.2 million. The personnel in the FAP worked extensively to ensure standardization in reporting and training policies and extended prevention programs. All of these prevention programs were supported by funding including a New Parents Support Program, which was given \$20 million in 1995 (Nelson, 2000).

Toward the end of the 1990s, increasing funding and resources were being taken away from the FAP. This was due to the drawdown of the military. By 1995 the DoD had approximately one third fewer active duty service members than just 5 years earlier, with the closing of numerous installations, particularly those that were overseas, and with the movement toward home basing. Even with this drawdown, however, by 1998 the FAP was a large, comprehensive, multidisciplinary operation funded at over \$100 million per year and employing more than 2,000 staff, which provided a wide range of intervention and prevention services (Nelson, 2000).

Substance Abuse Programs

Substance abuse programs also experienced a change and growth in the 1990s. An increased focus on outpatient treatment instead of brief inpatient stays was becoming popular in the civilian society, which was affecting how the military treated substance abuse. The move to outpatient facilities led to a reduction of inpatient treatment facilities, which helped the DoD during a time when they were looking to make budget cuts (Newsome, 2000).

Due to the change from discretionary referral to mandated referral, service members were receiving treatment for alcohol abuse before they qualified for the *DSM* diagnosis. Military substance abuse prevention and treatment program managers, many of whom were social workers, were responsible for ensuring the lowest possible illegal drug use to maximize operational readiness in the armed forces. This responsibility meant that counselors had to develop skills for detecting early levels of alcohol abuse disorder. The use of screening instruments with well-established sensitivity and specificity, such as the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT), would prove to be critical in the accuracy of early assessments (Newsome, 2000).

Illegal drug use also became a large focus in the 1990s. In the early 1980s, service members could be treated for illegal drug use under the Limited Privilege Communication Program; however, in the mid-1980s a "zero tolerance" policy was implemented, in which any report of illegal drug use—whether by self or by others—could result in administrative discharge and perhaps even criminal prosecution (Newsome, 2000).

In 1998 the Air Force implemented the Alcohol and Drug Abuse Prevention and Control (ADAPT) program, which allowed individuals who self-identified as using illegal drugs could be granted limited protection from criminal prosecution (Newsome, 2000). Treatment by the VA was granted to those individuals who came forward as long as they agreed to an administrative discharge. The establishment of ADAPT was the first time that efforts to assess outcomes were implemented. One of the requirements of the program included 3-, 6-, and 12-month follow-up assessments to evaluate behavior and duty performance (Newsome, 2000). Social workers and other behavioral health professionals were in charge of conducting these follow-up sessions, and in charge of treating service members addicted to illegal substances.

The Veterans Administration

In the 1990s the VA focused its attention on caring for veterans of the Persian Gulf War. Many Gulf War veterans were returning home with chronic illnesses that could not be linked to a specific cause. This unknown cause of their illnesses led the VA to conduct

many research studies and to change its policy on how service connected compensation is determined (Department of Veterans Affairs, n.d.).

Female veterans were also becoming a large proportion of the veteran population during the 1990s. In response to this growth “the VA expanded medical facilities and services for women and increased efforts to inform them that they are equally entitled to veterans benefits. The Veterans Health Care Act of 1992 provided authority for a variety of gender-specific services and programs to care for women veterans” (Department of Veterans Affairs, n.d.).

The first VA center dedicated to women opened in November 1994. Its mission was to ensure that women veterans had the same access to VA health care and benefits as did male veterans and that the VA was responsive to the gender specific needs of women veterans. It also aimed to improve awareness of women veterans’ benefits and eligibility criteria (Department of Veterans Affairs, n.d.).

The VA also made strides to protect women against sexual assaults. After the Tailhook scandal, which involved multiple midshipmen from the Navy assaulting multiple females, Congress began to take notice of how sexual harassment and sexual assaults were hurting female veterans. According to the VA website,

In July 1992, a series of hearings on women veterans’ issues by the Senate Veterans Affairs Committee first brought the problem of military sexual trauma to policy makers’ attention. Congress responded to these hearings by passing Public Law 102–585, which was signed into law in November of 1992. Among other things, Public Law 102–805 authorized health care and counseling to women veterans to overcome psychological trauma resulting from experiences of sexual assault or sexual harassment during their military service. Later laws expanded this benefit to male veterans as well as female veterans, repealed limitations on the required duration of service, and extended the provision of these benefits until the year 2005. (Street & Stafford, 2004)

Military sexual trauma is a large focus in the VA, and the benefits for females and males that suffer from it continued to grow into the next decade. Social workers often work as sexual trauma counselors and military sexual trauma coordinators to help veterans suffering from military sexual trauma.

The Global War on Terrorism

On September 11, 2001, the United States was forever changed. Before 9/11, the military community believed it was going to increasingly drawdown its size and scope (Daley, 2000). However, after 9/11 the military increased in size to fight the Global War on Terrorism, which includes Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom in Iraq, which later became Operation New Dawn, (along with various counter terrorism operations in other countries). This was the first time since Vietnam that the U.S. military was in a prolonged war, and with a prolonged war comes changes in the social environment of the military. There were no “front lines” in these wars, so female service members were in combat situations that they had not been a part of in previous wars. This female equality shined a light on the abilities of women, but it also

demonstrated how female service members could be in danger from their own colleagues through sexual harassment and assault (Hyun, Pavao, & Kimmerling, 2009).

Also during these wars, the military community took greater notice of suicides, when the amount of suicides began to outnumber the amount of combat casualties in a single year (Donnelly, 2009). The policy of Don't Ask, Don't Tell regarding open homosexuality in the service was overturned. In addition, the signature wound of these two wars, traumatic brain injury, was brought to the public's attention. All of these events have resulted in a period of increasing change within the military, and an increasing role for military social workers. Military social workers are now working in behavioral health units, combat operational stress control detachments, and warrior in transition units, which focus on injured returning troops and their transition into civilian society.

Sexual Assault

The 2000s saw the creation of the Sexual Assault Prevention and Response Office (SAPRO). Directive 6495.01 was created on October 5, 2005. This directive outlined the responsibilities of SAPRO and created the first agency to monitor and report on the sexual assault cases that take place in the military. This directive was DoD-wide and was created for each branch of the armed forces. The goal of this program was to eliminate sexual assaults that take place in the military (Department of Defense, 2005). Social workers and other behavioral health providers are often employed as sexual assault response coordinators and often volunteer as victim advocates in the military.

Another change was in how the military viewed the sexual assault of men. There is a much greater number of men in the military than women, yet, the number of reported military sexual traumas is about the same actual number for men as for women (1% of males reporting within the male military population versus 20 to 40% of female reports in the female military population) (Hyun et al., 2009; Kelly et al., 2011).

The VA took steps to combat the aftereffects of sexual assault. "A series of VA directives mandated universal screening of all veterans for a history of military sexual trauma and mandated that each facility identify a Military Sexual Trauma Coordinator to oversee the screening and treatment referral process" (Street & Stafford, 2004, p. 68). These positions were often filled with social workers.

Suicide Prevention

As mentioned earlier, during the Global War on Terrorism, suicides drew increased attention in the military. The vice chief of staff of the Army, General Peter Chiarelli, took a special interest in this problem, and he made it his personal mission to eliminate suicides in the military. One program that was implemented was a national call center for active duty service members and veterans, which was created in 2007. "Since its launch, the Veterans Crisis Line has answered more than 500,000 calls and made more than 18,000 life-saving rescues. In 2009, the VA added the anonymous online chat that has since helped more than 28,000 people" (Department of Veterans Affairs, 2011, p. 1). This call center is staffed with professionals specializing in crisis intervention and mental health techniques (Department of Veterans Affairs, 2011). Social workers often work as crisis intervention counselors at VA hospitals and in behavioral health departments at military medical treatment facilities.

Military Social Work Today

Social workers today are required to have at least a master's degree to work with veterans and to serve in the military. In recent years, the DoD has preferred that social workers have 2 years' postgraduate experience and/or a license to practice independent clinical social work before serving in the armed forces. However, each branch has created an internship for recent master-level social workers to help them obtain their clinical licensing while in the service (Department of Veterans Affairs, 2010).

The role of social work has evolved in the VA. It now has treatment responsibilities in all patient care areas. These include helping VA patients and families maximize their level of adjustment and coping, as well as promoting vocational and psychosocial rehabilitation (Department of Veterans Affairs, 2010). Social workers are part of multidisciplinary teams. They participate in the development and implementation of treatment approaches. They work with acute/chronic medical conditions and hospice patients, and are responsible for care through admission to follow-up services. They coordinate discharge planning and provide case management services (Department of Veterans Affairs, 2010). Social workers continue to be included in serving almost all VA target populations, including the veterans from the Global War on Terrorism, the homeless, the aged, the mentally ill, and the families that care for them.

The Department of Veterans Affairs is affiliated with more than 180 graduate schools of social work. As mentioned at the beginning of this chapter, it “operates the largest and most comprehensive clinical training program for social work students—training 900 students per year” (Department of Veterans Affairs, 2010, p. 1). In 2010, the VA employed more than 13,000 social workers, and it is increasing its numbers every year (Partners for Public Service, 2010).

CONCLUSION

This chapter presented a brief look at the historical roots and the growth of social work within the military and the Veterans Administration. From its early roots of medical social work in the Civil War to the Global War on Terrorism, social workers have been caring for America's wounded veterans. Social workers have been instrumental in implementing many different social reform programs in the military, including the family advocacy program, substance abuse programs, and the Sexual Assault Prevention and Response Office. Over the past 100 years, social workers have expanded the area of practice from purely mental health and medical fields of practice into many different areas, and will probably continue to do so long into the future.

REFERENCES

- American Red Cross. (2011). *Military and Red Cross partnership*. Washington, DC. Retrieved from <http://www.redcross.org/portal/site/en/menuitem.d8aaecf214c576bf971e4cfe43181aa0/?vgnextoid=b9681b655eb3b110VgnVCM10000089f0870aRCRD&vgnnextfmt=d>
- Daley, J. (2000). Military social work practice in mental health programs. In J. Daley (Ed.), *Social work in the military* (pp. 123–136). Binghamton, NY: Haworth Press.

- Department of Defense 6495.01. (2005). *Sexual assault prevention and response program*. Washington, DC.
- Department of Veterans Affairs. (n.d.). *Veteran's affairs: A history in brief*. Washington, DC. Retrieved from www.va.gov/opa/publications/archives/docs/history_in_brief.pdf
- Department of Veterans Affairs. (2010). *History of Veteran's Administration social work*. Washington, DC. Retrieved from <http://www.socialwork.va.gov/about.asp>
- Department of Veterans Affairs. (2011). *Suicide prevention*. Washington, DC. Retrieved from http://www.mentalhealth.va.gov/suicide_prevention/index.asp
- Donnelly, James. (2009). More troops lost to suicide. *Congressional Quarterly*. Retrieved from: <http://www.congress.org/news/2009/11/25/rising_military_suicides?referrer=bk>
- Government Accountability Office. (1979). *Military child advocacy programs: Victims of neglect*. Washington, DC: Author.
- Harris, J. (2000). History of army social work. In J. Daley (Ed.), *Social work in the military* (pp. 3–22). Binghamton, NY: Haworth Press.
- Hyun, J. K., Pavao, J., & Kimerling, R. (2009). Military sexual trauma. *PTSD Research Quarterly*, 20, 1–8.
- Jenkins, J. (2000). History of air force social work. In J. Daley (Ed.), *Social work in the military* (pp. 27–48). Binghamton, NY: Haworth Press.
- Kelly, V. A., Skelton, K., Meghna, P., & Bradley, B. (2011). More than military sexual trauma: Interpersonal violence, PTSD and mental health in women veterans. *Research in Nursing & Health* 34(6), 457–467.
- Lasiuk, G., & Hegadoren, K. (2006). Posttraumatic stress disorder part I: Historical development of the concept. *Perspectives in Psychiatric Care*, 42(1), 13–20.
- National Association of Social Workers. (n.d.). *Social work history*. Washington, DC.
- Nelson, J. (2000). Development and evolution of the family advocacy program in the department of defense. In J. Daley (Ed.), *Social work in the military* (pp. 51–66). Binghamton, NY: Haworth Press.
- Newsome, R. (2000). Military social work practice in substance abuse programs. In J. Daley (Ed.), *Social work in the military* (pp. 91–106). Binghamton, NY: Haworth Press.
- O'Keefe, D. (2009). Psychiatric social work. In *Neuropsychiatry in World War II*. Washington, DC. Retrieved from http://history.amedd.army.mil/booksdocs/wwii/NeuropsychiatryinWWII_Voll/default.htm
- Partners for Public Service. (2010). *Social work jobs in the federal government*. Washington, DC. Retrieved from <http://www.makingthedifference.org/federalcareers/socialwork.shtml>
- Raiha, N. (2000). Medical social work in the U.S. armed forces. In J. Daley (Ed.), *Social work in the military* (pp. 107–122). Binghamton, NY: Haworth Press.
- Street, A., & Stafford, J. (2004). Military sexual trauma: Issues in caring for veterans. In *Department of Veterans Affairs & National Center for PTSD (2004) Iraq War Clinician's Guide*. Washington, DC.
- United States Navy Medical Service Corps. (2000). History of navy social work. In J. Daley (Ed.), *Social work in the military* (pp. 23–26). Binghamton, NY: Haworth Press.

