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Civilian Social Work: Serving the Military and Veteran Populations

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Abstract: This article discusses social work practice areas for civilian social workers who provide services to military service members, veterans, and their families. These practice areas include education, child welfare, domestic violence, mental health, health care, substance abuse, and criminal justice. The authors examine the impact of the contemporary military lifestyle and current military operations on service members and their families in the context of these practice areas, with the goal of compelling civilian social workers to acknowledge their responsibility to competently serve military and veteran clients. [PUBLICATION ABSTRACT]

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This article discusses social work practice areas for civilian social workers who provide services to military service members, veterans, and their families. These practice areas include education, child welfare, domestic violence, mental health, health care, substance abuse, and criminal justice. The authors examine the impact of the contemporary military lifestyle and current military operations on service members and their families in the context of these practice areas, with the goal of compelling civilian social workers to acknowledge their responsibility to competently serve military and veteran clients.

KEY WORDS: deployment cycle; mental health; military; social work; veterans

Media coverage highlighting service delivery problems at Walter Reed Army Medical Center has led to heightened public scrutiny and congressional oversight regarding the care provided to returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) service members and their families. A multitude of factors may have contributed to the breakdown of services at one of the U.S. military's premier medical facilities, and it would be shortsighted to believe that military and U.S. Department of Veterans Affairs (VA) medical facilities are solely responsible for the challenges faced by returning service members and their families.

Although U.S. military operations in the Middle East began in October 2001, clear leadership has not emerged for civilian social workers regarding their role in supporting the needs of returning service members, veterans, and their families. NASWs (2003) Peace and Social Justice policy statement includes a call to "continue using qualified professional social workers to serve the armed forces and military dependents to ensure that a high priority is given to human values and social welfare needs in those settings" (pp. 268-269). Nevertheless, the social work literature provides little practical guidance to civilian social workers on how best to serve the military and veteran populations. Social work organizations have failed to emphasize or disseminate information and tools to aid social workers in assisting a population in need of social work services. Finally, universities preparing social workers have done little to integrate content on this special population into the social work curriculum. Given that our country has been at war for nearly eight years, the deficit in guidance and paucity of research promulgated by the social work profession is alarming. As practitioners bound by a set of core principles emphasizing service, social justice, and competence, social workers must acknowledge the factors affecting the health and well-being of military and veteran families and integrate this knowledge into practice. This article describes some of the current challenges facing military and veteran clients and their families, highlighting opportunities for civilian social workers to address these challenges.

TODAY'S MILITARY

Since September 11, 2001, more than 1.5 million troops have been deployed in support of the OEF and OIF. Of those deployed, a large percentage has served multiple tours of duty, with some service members experiencing

as many as five deployments (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members [APA] , 2007, p. 9).

The reserve components of the US. military have played an integral role in deployed operations, and they continue to be called on to augment the fighting forces (Alvarez, 2007). In 1973, the Department of Defense (DoD), which had previously relied on an active duty force, embraced a "total force" policy, demanding reliance on and mobilization of six military reserve components (Reserve Forces Policy Board, 2004). The total force policy signified a departure from the traditional military structure in which almost all military families resided on or near military installations. Instead, members were now broadly distributed throughout the United States, with significant numbers living and working in civilian communities (Knox & Price, 1999). As of 2005, there were approximately 2.5 million active duty and reserve component military personnel, with reservists and National Guard members representing roughly 45 percent of the DoD's total military force (DoD, 2006a).

The military has also become increasingly diverse. Over 25 percent of active duty personnel are members of an ethnic minority group. Women represent 16 percent of the total force and are represented in 90 percent of all military job categories (APA, 2007).

More than 160,000 female soldiers have been deployed to Iraq and Afghanistan, as compared with 7,500 who served in Vietnam and the 41,000 who were dispatched to the gulf war in the early '90s. Today one of every 10 U.S. soldiers in Iraq is female. (Corbett, 2007)

THE DEPLOYMENT CYCLE

Deployment describes a service member's time spent away from his or her home base in support of a military operation, and it involves three phases: predeployment, deployment, and postdeployment. From notification of an impending deployment to homecoming and reintegration, deployment entails physical, emotional, and mental distress in the form of physical and environmental stressors, high operating tempo, long work hours, and separation from family (Hosek, Kavanagh, & Miller, 2006). Because of overall decreases in military manpower following the end of the Cold War, multiple deployments, decreased time between deployments, and extended deployments have become typical features of military deployment, which can cause increased stress on service members and their families (Hosek et al., 2006). Each phase of the deployment cycle is characterized by a collection of unique stressors for both the individual service member and the family system.

Predeployment

This is a time of preparation, during which the service member is engaged in mission training. Although family members may want to spend time with the service member, their expectations may be unrealistic in light of training demands. The anticipation of deployment may create anxiety and begin to disrupt family functioning.

Deployment

While deployed, service members face the stress of a combat zone in addition to worries about the well-being of their families. Deployment requires the spouse at home to manage most family matters in addition to helping children to cope with the absence of the deployed parent and the threat of injury to or death of that parent.

Postdeployment

Postdeployment, families must adapt to the change in family structure by renegotiating roles and responsibilities, which can be a complex and anxiety-provoking task. Injuries may exacerbate the complicated stressors that service members and their families experience. In addition to obvious physical injuries, the family must cope with those injuries that are less readily apparent, such as traumatic brain injury (TBI), depression, or posttraumatic stress disorder (PTSD).

Although various forms of counseling and behavioral health services are provided by military and veteran systems to service members to assist with the impact of deployment, services may not always be easily accessible. Whereas an active duty contingent typically returns to an area replete with support units, National Guards and Reservists are widely dispersed, often in areas without sufficient military infrastructure to support adequate reintegration. Often, the only military support facility available to reservists is the drill center, whose

primary purpose is to provide logistical support for training and mobilization. In some cases, a reservist may not live in the state in which his or her unit drills. Consequently, continuity of services and ability to connect with others who have had similar experiences are compromised (DeAngelis, n.d.). Isolation is the enemy of healthy reintegration, and for many members of the National Guard and Reserves, the risk of isolation is considerable.

MILITARY CULTURE

Military life is characterized by mobility and an emphasis on mission readiness. Service members are expected to be prepared to do their job at any time, in any location. Military families are charged with the difficult task of balancing military demands with family needs, a process that amplifies family stress when a service member is deployed to a dangerous area. In contrast to the civilian sector, the military, in the name of mission readiness, is highly involved in the personal lives of those who serve and is often concerned with intimate details, such as marital discord, substance use, and mental and physical health. These factors can be considered in determining a service member's fitness for duty.

The military provides programs and services specifically for service members and their families, and many of these are located on military installations. Although installation services may enhance connection to the military community, they may also promote isolation of military service members and their families, who may be unfamiliar with the resources in the surrounding civilian community. In some cases, service members may not access military support services because of fear of career consequences. For these members, the risk of isolation is even greater. Frequent relocation may also inhibit service members and their families from accessing community resources, developing civic commitment, or fostering social ties within the civilian community (Bedics & Doelker, 1986).

MILITARY FAMILIES

Among the unique factors affecting the military family's biopsychosocial functioning are long periods of separation, which may involve intermittent single parenting and reintegration challenges; service members' physical injuries or mental health problems; frequent relocation; financial strain; children's emotional and behavioral reactions to a deployed parent's absence, injury, or death; and possible limited access to resources, depending on the family's geographic location. A military family's ability to cope with these challenges will vary. In some cases, the challenges may lead to maladaptive responses, including domestic violence, child abuse or neglect, and children's social and academic decline.

Domestic Violence

In fiscal year 2005, there were almost 16,000 reports of spousal abuse made to the DoD Family Advocacy Program (FAP), which coordinates the military's response to family violence (DoD, 2006b). Military couples' relationships may be threatened by the effects of combat experiences, which pose challenges to family cohesion, expressiveness, intimacy, and relationship adjustment and may increase the risk of interpersonal violence (Jordan et al., 1992). In Taft et al.'s (2005) study of military veterans, PTSD was associated with partner violence for one-third of the study participants.

According to the U.S. Army, Battlemind is the "soldier's inner strength to face fear and adversity with courage" (Walter Reed Army Institute of Research, 2006, p. 2), requiring targeted aggression and key skills such as discipline and cohesion. Although Battlemind is critical in a combat zone, inability to moderate aggression postdeployment may result in misplaced, inappropriate aggression and lead to family violence (Walter Reed Army Institute of Research, 2006). Social workers should be familiar with the impact of Battlemind and military culture on families, and with the policies that govern the military's response to domestic violence.

In 2000, Congress established the Defense Task Force on Domestic Violence (DTFDV), which was charged with examining DoD's response to domestic violence and providing recommendations for improvement. Implementation of the vast majority of DTFDV recommendations has improved victim services, offender accountability, and violence prevention efforts in the military. Civilian social workers who provide services to victims of domestic violence should be cognizant of the military's domestic violence policy changes and the

opportunities to promote a coordinated community response to domestic violence (DoD, 2003). Implementation of the DoD restricted reporting policy for incidents of domestic abuse, which provides victims of domestic abuse with confidential reporting options, was a key outcome of the DTFDV report. Whereas reporting domestic violence once automatically prompted command notification and a law enforcement investigation, victims now have the option to report abuse confidentially and obtain victim advocacy and safety planning services (DoD, 2007). Confidential reporting options represent a significant cultural change in the military environment, providing victims with the time to make a decision about whether they want to report abuse. Social workers should be familiar with the military's restricted reporting policy to be able to inform and more effectively serve victims who seek services or shelter in civilian agencies.

In addition to confidential reporting options, DoD also implemented several other significant domestic violence policy changes. Present DoD (2007) policy requires military law enforcement agencies to formally coordinate their response to domestic violence with civilian law enforcement agencies and legal authorities through memoranda of understanding (MOUs). Because many military families live in civilian communities, local law enforcement is often charged with responding to domestic violence calls, and the local district attorney's office is often involved in the prosecution of alleged abusers. In the absence of formal agreements that clarify jurisdictional responsibilities and matters of information sharing, the criminal and legal processes may become disjointed, and the involved parties may not be referred to appropriate resources. Social workers involved in the domestic violence practice area should be aware of any MOUs with the military that exist in their communities. Social workers can also capitalize on the coordinated community response movement by advocating for additional collaboration between military and civilian communities, such as MOUs that address the emergency shelter needs of military-affiliated victims of abuse.

Social workers working with victims of domestic violence who are affiliated with the military system should also be familiar with transitional compensation, which provides financial benefits to the families of service members who have been discharged for child abuse or domestic violence (DoD, 1995). It is important to note that the service member abuser's separation documents must indicate "child abuse" or "domestic violence" as a reason for separation for family members to receive this benefit.

Child Abuse and Neglect

Deployment of a service member can lead to increased parenting stress and, in some cases, compromise parents' ability to appropriately care for their children. Gibbs, Martin, Kupper, and Johnson (2007) found that the overall rate of child maltreatment by Army wives during their husbands' deployments was more than three times the rate of child maltreatment by wives while their husbands were not deployed. The elevated rate of child maltreatment during times of deployment was particularly pronounced for child neglect. This research represents the first national study of child maltreatment perpetrated by the wives of soldiers during the soldiers' deployment, and it highlights the specific effect of deployment on the civilian spouses and children of deployed soldiers.

Although all suspected cases of child maltreatment require a report to Child Protective Services (CPS), military installations also use FAP to prevent child abuse and respond to allegations of child abuse in military families. Whereas CPS has jurisdiction over the civilian investigation of cases and custody decisions, FAP remains involved with families suspected of abuse and works with military leadership to address the intervention needs of families. Military commanders have jurisdiction over service members and may impose their own treatment requirements and disciplinary actions. If FAP and CPS disagree about the severity of a case, the military community can use its own strategies to respond to suspected maltreatment. If, for example, CPS does not remove a child from the home but FAP has assessed the case as high risk, military leadership can force separation by removing an alleged service member abuser from the home. In addition, FAP provides primary and secondary prevention programs and treatment to victims and abusers, resources that may be used by and integrated into the civilian infrastructure.

Several opportunities for military- civilian collaboration exist within the area of child abuse. Child welfare social workers should seek collaborative relationships with local military FAPs, which have valuable information about military families that may better inform child welfare decisions. CPS social workers should also understand and capitalize on the resources available to FAP on military installations. In particular, CPS workers should be familiar with the role of command and its authority over service members. Finally, collaboration in the review of child abuse-related fatalities can enhance prevention and intervention efforts.

Children's Mental Health

There are approximately 1.2 million dependent children associated with the active duty force and 700,000 associated with the National Guard and Reserve forces (APA, 2007) . In addition to the risk of child abuse and neglect, the military lifestyle may also lead to other challenges for children, including behavioral and academic problems, stress from potential relocation as often as every three years, anxiety related to the deployment cycle, and problems coping with a parent's death or combat-related injuries. Each phase of the deployment cycle has a specific effect on children's emotional state, and children's responses may vary by age and developmental stage (APA, 2007). Civilian social workers should understand the constellation of factors affecting the mental health of children of military families and be prepared to address the effects of these factors in a variety of settings. In addition, there are a number of resources available to children of military families, and these may be accessed by civilian social workers serving these children.

School Social Work

Civilian school social workers, in particular, play a vital role in addressing the needs of military children, for approximately 80 percent of the children of active duty service members are educated in civilian schools. The unique stressors facing children in military families can significantly affect academic performance and social functioning (National Military Family Association, 2006). Relocation and school transition require rapid adjustment to new environments, routines, curriculums, teachers, and friends. In some cases, differences in academic requirements may cause military children to be retained in the same grade (Strobino &Salvaterra, 2000). The deployment cycle may further stress children, who may experience fear and adjustment issues because of the prolonged absence of a parent, especially when deployment is to a combat zone.

Civilian school social workers, who interface between students' school and family lives, can improve the experience of military children by recognizing the unique challenges these children face while helping to strengthen their sense of connection to the school. Social workers are in a unique position to establish or make available resources in the school and community that will facilitate adjustment without academic detriment and to educate school personnel about the issues military children face (Strobino &Salvaterra, 2000). Social workers can also capitalize on the expertise of military school liaison officers, who are charged with reducing the impact of the mobile military lifestyle on children and providing support services to military families to facilitate transitions. Military school liaison officers are available at military installations throughout the United States.

WOUNDED SERVICE MEMBERS

The DoD reports that over 25,000 service members have been injured in combat since the onsets of OEF and OIF (DoD, Statistical Information Analysis Division, 2007). When nonhostile injuries (that is, vehicular and in-country training accidents) are included, this number more than doubles to nearly 53,000 (Gamboa, 2007). Many of these injuries would have been fatal in earlier combat situations, but contemporary helmets and body armor, advances in battlefield medicine, and swift evacuations to hospitals have prevented death. The 98 percent survival rate among service members injured in Iraq is higher than that in any previous war (Kilbride, 2007). This progress, however, means that more service members return home with grave injuries that transform their lives: damaged brains and spinal cords, vision and hearing loss, disfigured faces, amputated limbs, and psychological problems such as depression and PTSD. These injuries often require comprehensive inpatient and outpatient rehabilitation services, and the steady support of medical and social service professionals throughout each step of the recovery process is critical.

Since 2004, the U.S. Government Accountability Office has issued numerous reports documenting the conditions facing OEF and OIF service members and veterans. This work has shown that service members injured in combat face "an array of significant medical and financial challenges as they begin their recovery process in the health care systems of DoD and the [VA]" (Bascetta, 2007). The media coverage of conditions at Walter Reed Army Medical Center revealed that service members are experiencing a host of health care challenges when they return from war: The medical disability rating process does not meet the needs of injured service members and veterans, case management throughout the DoD and VA is uncoordinated and understaffed, and access to benefits is often hindered by bureaucratic and lengthy claims processes (Priest & HuU, 2007a, 2007b, 2007c; Span, 2007). Although the survival rate of this war represents advances in military medicine, medical and social service systems are saturated and struggling to meet the needs of the injured population.

Movement from the point of battlefield injury (whether physical, psychological, or a combination of the two) through levels of care abroad and within the United States is a "complex process involving the interplay of personal endurance, military and medical leadership, technology and communications and networks of civilian and military caregivers, supporters, and communities" (Center for the Study of Traumatic Stress, n.d.-a). In December 2003, the Secretary of the Army approved a plan to expand medical services for National Guard and Reserve personnel to their communities. Known as Community Based Health Care Organizations (CBHCOs), the goal of this initiative is to expedite the return of service members while leveraging medical capacity within soldiers' communities. There are currently eight regional CBHCOs operating throughout the United States, providing case management to over 3,300 service members (Baker, 2007). Approximately 50 percent of service members receive care through local military and VA treatment facilities, whereas the other 50 percent receive care through military health system (TRICARE) network providers. During a service member's recovery within a CBHCO, active duty registered nurses remotely manage his or her medical care in conjunction with medical providers and social workers.

THE SIGNATURE INJURY

Improvised explosive devices (IEDs) are largely responsible for the signature injury of the Iraq war: TBI. In 2005, the DoD reported that approximately 65 percent of OEF and OIF service members wounded in action sustained injuries from blasts and fragments from IEDs, land mines, and other explosive devices (Bascetta, 2007). "For the first time, the U.S. military is treating more head injuries than chest or abdominal wounds" (Glasser, 2007, p. B1). Approximately 28 percent of troops medically evacuated from combat are sustaining TBIs (McIntire Peters, 2007). Moreover, "88 percent of patients who sustained traumatic brain injuries did not have penetrating head wounds, meaning their injuries were not always apparent to others or even to themselves" (McIntire Peters, 2007, p. 30). The complexity of treating brain-injured troops is taxing an already overburdened military and veteran health care system, and the cost of these injuries to society is staggering. Bilmes and Stiglitz (cited in McIntire Peters, 2007) have estimated the cost of treatment for brain injury at \$14 billion if U.S. troops are withdrawn from Iraq by 2010.

Military and VA health care providers are learning that significant neurological injuries should be suspected in any troops exposed to a blast, regardless of their proximity. As soldiers who walk away from IED blasts discover, they often suffer from "memory loss, short attention spans, muddled reasoning, headaches, confusion, anxiety, depression, and irritability" (Glasser, 2007, p. B5). Significant behavior and personality changes resulting from TBI also have a significant impact on family members and caretakers. A study of returning veterans with TBI found that families of service members need more support than they are receiving (VA, Office of Inspector General, 2006). As a result of TBI, symptoms of aggression, irritability, and emotional instability also frequently contribute to family turmoil, which may interfere with therapy and recovery. Although families assisting in the recovery of a wounded service member are likely to deny their own needs, it is essential to acknowledge and address these less visible wounds. A strong, healthy support system, reinforced by the

community, creates an environment that is conducive to healing and effective reintegration (Cantrell & Dean, 2005). Civilian social workers must be aware of the military experiences of their clients to appropriately consider the impact of these experiences on biopsychosocial functioning.

SERVICE MEMBERS' MENTAL HEALTH

Although physical injuries may be easily identified for treatment, mental and emotional damage is often invisible until it manifests in an associated behavior. However, the stigma associated with mental health treatment is a deterrent to military members seeking care. Regrettably, a landmark study published in the *New England Journal of Medicine* demonstrated that fear of being stigmatized was "disproportionately greatest among those most in need of help from mental health services" (Hoge et al., 2004, p. 20). Subsequently, the Army has become more aggressive in its attempts to destigmatize treatment and make it more accessible to soldiers (Army Mental Health Advisory Team, 2005). The other military services have also taken steps to ensure that service members perceive feasible options for addressing the strain of combat and other deployment pressures. Although progress has been made, Medicare and TRICARE actually reduced provider reimbursement rates in April 2007, which may force mental health providers to discontinue care for individuals with Medicare or TRICARE benefits, further limiting access to care for a population in critical need of services (Norman, 2007). When mental health issues are not addressed, the results may be deadly. In December 2006, the Army released the results of the Mental Health Advisory Team III Report (MHAT III). The MHAT III examined the behavioral health care requirements of the then most current deployment of soldiers (2004-2006). Of note in this report was the suicide rate, which showed a moderate increase to 19.9 per 1,000,000 from 18.8 per 1,000,000. The leading suicide risk factors were problems with relationships at home and in combat, followed by legal actions, issues with fellow soldiers and commanders, and dissatisfaction with duties (Army Mental Health Advisory Team, 2005). The latest suicide prevention effort deemed "safe" by service members is a Web-based program that allows them to ask questions regarding mental health anonymously (Berton, 2007). Of the 103,788 OEF and OIF veterans seen at VA health facilities for the first time following their service in Iraq, approximately 25 percent received a mental health diagnosis, and more than half of those were dually diagnosed. The percentage increased to 31 percent when psychosocial diagnoses were included in the sample. The diagnosis most prevalent in the VA cohort was PTSD, which accounted for more than half of the diagnoses (Seal, Bertenthal, Miner, Saunak, & Marmar, 2007). The connection of military conflict with mental health issues has been extensively researched since the Vietnam conflict, and connections have been made between exposure to combat and an increased risk of "PTSD, major depression, substance abuse, functional impairment in social and employment settings and the increased use of healthcare services" (Hoge, Auchterlonie, & Milliken, 2006, p. 1023). Without treatment and support, PTSD-related stress may lead to divorce, substance abuse, family violence, unemployment, behavioral problems in children, and other related issues that can have a lasting, detrimental effect on family life and society.

Findings suggest that women who have suffered military sexual trauma (MST) are at an even greater risk of developing PTSD (Street & Stafford, 2004; Yaeger, Himmelfarb, Cammack, & Mintz, 2006), major depressive disorder, and increased substance use (Street & Stafford, 2004). Wartime stress has been associated with increases in sexual harassment and assault rates (Street & Stafford, 2004), and a 2003 DoD report examining women seeking care through the VA indicated that one-third of the female veterans had experienced rape or attempted rape during their time in service (Corbett, 2007). Although MST is more prevalent among women, men have also reported rape and attempted rape (Street & Stafford, 2004). The Iraq War Clinician Guide suggested that social workers include specific questions related to MST on assessments to ensure appropriate identification and treatment (Street & Stafford, 2004).

When providing services to those who have deployed to combat zones, it is important to look for signs of distress, such as "nightmares or other forms of sleep disorder; hypervigilance, jitteriness or overexcitement; and avoidance or social withdrawal" (Center for the Study of Traumatic Stress, n.d.-a). Traumatic events that

contribute to the development of PTSD include sexual trauma, seeing dead bodies, being injured, killing others, seeing others killed, and having friends killed (Hoge et al, 2004). Comprehensive assessments of clients, both men and women, should include questions regarding military service and trauma prior to military service.

REINTEGRATION CHALLENGES

Healthy reintegration can be a daunting task, and some veterans succumb to the stressors of their military experience. When service members come home, many face significant financial, professional, and personal hurdles. These returning service members, many already low income by virtue of their modest military pay, are at risk of poverty and homelessness. A percentage of these individuals may be found in jails, shelters, and treatment programs across the nation.

Incarceration

Although the data available on incarcerated veterans predate OEF and OIF, they do provide insight into the risk of incarceration for returning service members from OEF and OIF conflicts. Approximately 20 percent of veterans in prison or jail have reported seeing combat duty. The Bureau of Justice Statistics (BJS) (2000) reported that veterans incarcerated in federal prisons (13.2 percent) are more than twice as likely as nonveteran federal prisoners (6.4 percent) to report mental illness problems. Veterans are also more likely than nonveterans to report traits of alcohol abuse and dependence. The crimes committed by veterans that led to their incarceration were more violent in nature, overall, than those committed by nonveterans. About 35 percent of the veterans in state prison were convicted of homicide or sexual assault, compared with 20 percent of nonveteran offenders. Veterans (30 percent) were more likely to be first-time offenders than were nonmilitary offenders (23 percent), suggesting the possibility of combat-related triggers as a factor contributing to criminal activity (BJS, 2000) .

Substance Abuse

The stigma that inhibits treatment-seeking behavior may lead some veterans to attempt to cope independently with their fears and trauma (Center for the Study of Traumatic Stress, n.d.-b). In the absence of treatment, drugs and alcohol may provide respite from the nightmares and flashbacks that are vivid reminders of the horrors of combat. However, although drugs and alcohol may temporarily distract some veterans from frightening memories, substance abuse can exacerbate the severity of a mental health condition or lead to other consequences, such as financial and legal problems. For those still on active duty, the process of "self-medicating" and resulting instances of misconduct (for example, driving under the influence) can have disastrous effects. The impact of substance abuse has been cited as a possible factor in the less than honorable discharges of 1,019 combat Marines from active duty since the Iraq War began (Zoroya, 2006) . It is important to note that military discharges due to misconduct render service members ineligible for medical and other VA benefits. When working with individuals discharged under these circumstances, social workers will need to draw on local resources to provide services.

Homelessness

Although veterans make up 12.6 percent of the U.S. population, they make up 18.7 percent of the homeless population, 33 percent of which served in a war zone (U.S. Department of Housing and Urban Development, Office of Community Planning and Development, 2007). The risk of homelessness is two to four times greater for female veterans than it is for nonveteran females (Gamache, Rosenheck, & Tessler, 2003). The VA has reported that 45 percent of homeless veterans suffer from mental illness, and 70 percent of the homeless veteran population wrestles with substance abuse problems (VA, n.d.). With the extended duration of OEF and OIF and the prevalence of reported mental health concerns, the veteran homeless population will likely continue to grow. The VA currently estimates that almost 200,000 veterans are homeless nightly, and approximately 400,000 will be homeless at some point during the course of a year. In addition to mental illness and substance abuse, lack of affordable housing, lack of livable income, lack of access to health care, war injuries, unemployment, and breakdown of family and social support also contribute to homelessness (Stewart, 2004;

VA, n.d.). Proactive programs that identify individuals and their families who may be at risk may help to arrest the rising rate of homelessness among veterans. Collaborative programs between the VA and local providers can help to expand the range of services available to this population. It is likely that civilian social workers will encounter homeless individuals who have a military background, which will necessitate an understanding of the experiences that contribute to their homelessness and the resources available to such individuals from both military and civilian systems.

FINANCIAL CONCERNS

Although the vast majority of service members are able to meet their financial obligations, 10.2 percent of the total enlisted force receives some form of government assistance, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (U.S. Government Accountability Office, 2000). Deployment demands special financial considerations, such as the stateside spouse's assumption of responsibility for financial management, including banking, bill paying, and tax preparation, tasks with which the spouse may be uncomfortable or ill-prepared to manage. Furthermore, military families are often targeted by payday lenders. There is evidence to suggest that these lenders select locations with high concentrations of military personnel, clustering near military bases. Predatory lenders trap borrowers in a cycle of debt by charging exorbitant fees; annual interest rates can be 400 percent or higher. Predatory lending results in \$80 million in abusive fees to military families each year (Tanik, 2005). Although a 2007 federal regulation prohibits payday loans and car title loans to service members and limits the amount of interest that may be charged to military borrowers, the financial strains on military families remains a challenge. It is important that social workers understand this regulation and connect families with financial counseling and budgeting assistance prior to and during deployment to help prevent financial hardship and undue stress.

The accounting systems for the National Guard and Reserve forces are complicated and at times unable to track the duty status of injured members. Injured service members have been dropped from active duty rolls, resulting in a loss or gap in pay and benefits (U.S. Government Accountability Office, 2007). In some families, deployment means a pay cut, because junior enlisted pay may fall well below a reservist's civilian pay (APA, 2007). For service members who own businesses, multiple deployments may result in loss of clients or inability to sustain the business. The Uniformed Services Employment and Reemployment Rights Act of 1994 (EL 103-353), a policy with which civilian social workers should be familiar, provides specific guidelines governing employment, reemployment, and retention for deployed reservists to prevent discrimination (see Employer Support of the Guard and Reserve, n.d.).

Military members who struggle with multiple deployments and resulting mental health problems may be unable to maintain employment once they return from combat. They may become isolated, begin using alcohol and drugs, or have a difficult time finding meaning in a predeployment job. If the primary wage earner for a family is unable to work, financial strains become paramount. While the service member is seeking treatment, these families may need to apply for Temporary Assistance for Needy Families, WIC, or Medicaid. Veterans should also explore programs provided by the VA and nonprofit agencies focused on assisting the transition to civilian life through vocational rehabilitation, job placement, and financial management assistance.

ACCESSING BENEFITS

Civilian social workers in all practice areas should be aware of benefits and services available to military service members and their families and the regulations governing access to services. Both the military, through DoD's TRICARE insurance network, and the VA, through nationwide Vet Centers, have well-established systems in place to address health care and transition issues. In addition, numerous professional and charitable organizations provide specific benefits for veterans and their families that supplement those provided by the DoD and the VA.

Veterans Health Administration Directive 2002-049 delineates specific VA health care privileges for combat OIF and OEF veterans. "Many activated reserve and National Guard personnel lose routine access to military health

care and assistance as soon as they leave active duty, and may require VA services immediately" (VA, Veterans Health Administration, 2002, p. 1). The window of opportunity to access these benefits is limited to two years from the date of discharge from the military. However, symptoms of some mental health conditions such as PTSD may not always present within the period of eligibility stipulated by the VA. Veterans may also be experiencing feelings of stigma, denial, or anger toward the military that will prevent them from seeking care from government agencies (Clay, 2006). When working with the veteran population, community providers must consider veteran eligibility requirements. The burden of responsibility falls on the veteran to apply for benefits, and many veterans may not be aware of the eligibility requirements or the implications of enrollment rules (for example, the need to enroll within a specific period).

A family focused on a wounded service member's recovery may neglect their financial well-being, which may be strained by injury-related expenses. However, Social Security Disability Insurance (SSDI) may alleviate financial distress. Children are also eligible for benefits amounting to approximately 150 percent to 180 percent of the guardian's benefit (U.S. Social Security Administration, 2007). Military personnel are the only professionals eligible to receive SSDI benefits while still employed. Service members should submit claims as soon as possible to activate the benefit.

COMMUNITY-BASED SERVICES

No single organization can meet all of the needs of service members and veterans. Community outreach programs, town hall meetings, and formal partnership agreements have prompted organizations such as DoD to emphasize the critical role of nonprofit agencies, veteran service organizations, and other nongovernmental organizations in providing assistance to military families and veterans.

In March 2006, the U.S. Substance Abuse and Mental Health Services Administration in partnership with Therapeutic Communities of America, hosted the National Behavioral Health Conference on Returning Veterans and Their Families in Washington, DC. The goal of the conference was to provide federal, state, and private-sector providers with information on and strategies for assisting veterans and their families with reintegration issues and evidence-based approaches to preventing and treating mental health disorders, substance abuse, suicide, and co-occurring disorders. Private-sector professionals were identified as playing a key role in the effort to address the needs of returning veterans, and conference proceedings placed significant emphasis on promoting awareness and increasing the participation of community mental health providers with regard to veterans' issues (Clay, 2006).

Heroes to Hometowns, a DoD-sponsored transition program, facilitates the reintegration of severely injured service members throughout the United States by establishing state and national networks that identify and coordinate resources before service members return to their local communities. Recently, Heroes to Hometowns established and identified charter committees for every state to mobilize local support in a more consistent manner. These charter members include the American Legion's State Adjutants, State Directors of Veterans' Affairs, and the National Guard Joint Force Headquarters' State Family Program Directors. Each charter member is

uniquely able to contribute to overall support with the ability to tap into their national, state, and local support systems to provide essential links to government, corporate and nonprofit resources at all levels and to garner the all important hometown support. (Heroes to Hometowns, n.d.)

IMPLICATIONS FOR CIVILIAN SOCIAL WORK PRACTICE

It is insufficient to assume that the care of service members, veterans, and their families will be adequately provided for by military and governmental systems. This article highlights key opportunities for civilian social workers to engage with and better serve military and veteran clients within the context of some specific social work practice areas. In the name of social justice, it is imperative that civilian social workers recognize their role and responsibility to serve these clients. Civilian social workers should be prepared to provide direct services to service members, veterans, and their families, particularly in geographically isolated communities where military

or VA services may not be accessible. Accordingly, we make three key recommendations for civilian social workers who seek to more competently serve service members, veterans, and their families.

A critical first step for civilian social workers is to obtain appropriate education and training about military culture, military and government systems of care, the issues currently affecting military and veteran populations, and appropriate policy and practice interventions. Although this article serves as an overview of the issues facing this special population, it only begins to address the knowledge base needed by civilian social workers. Civilian social workers must recognize and seek to understand the challenges facing military and veteran clients and the resources available to support them. Training may involve formal educational opportunities in which social workers learn, for example, how to treat the mental health consequences of combat operational stress, or it may entail informal efforts, such as meeting with one's military or government counterparts to better understand military systems of care. Schools of social work, in particular, must also recognize their responsibility in preparing the next generation of social workers to serve this population by addressing their needs in the development of curriculums, for the needs of service members, veterans, and their families will be pronounced for years to come.

To enhance civilian social workers' practice with military and veteran populations, we also recommend that the social work field develop and maintain a comprehensive directory of resources and programs available to service members, veterans, and their families. This directory would enable civilian social workers in all locations to link clients to information and resources designed to meet their needs. As professionals responsible for making appropriate referrals and connecting clients with available resources, social workers are appropriately charged with this task. Given the abundance of organizations and agencies offering services to these populations, the effort will clearly demand a collaborative, and perhaps regionalized, approach.

Finally, this article underscores the importance of collaboration across military and civilian systems, a responsibility well suited for social workers, who are trained to adopt a multidisciplinary approach to practice. Civilian social workers must acknowledge their responsibility to reach out to their military counterparts in an effort to achieve the most streamlined system of care possible. When military and civilian systems operate in isolation, an opportunity to coordinate well-informed and effective intervention is lost.

Military service members and their families are no different from the general population in seeking social services to deal with life's issues, though the military lifestyle may amplify the complexity of their situations. However, social workers using a strengths-based perspective can capitalize on the potential benefits of deployment, which may include a sense of accomplishment from supporting the mission and cohesion with other service members. Spouses and children may also gain new skills and a sense of accomplishment from successfully managing deployment tasks. Service members, veterans, and their families will continue to have deployment-related challenges for many years to come, even if troop withdrawal begins tomorrow. Social workers have a critical responsibility to support this population, though the window of opportunity to affect these individuals and their families is small. We must attend to their wounds while they are still fresh, before the development of unhealthy behaviors and coping mechanisms compromises their resiliency. As a profession, social work must adopt a proactive approach regarding its engagement with this population through military and civilian partnerships, dissemination of useful resources and clinical tools, and appropriate education and training. Social workers must lead the campaign to identify and connect service members, veterans, and their families to the services they need.

Sidebar

Child welfare social workers should seek collaborative relationships with local military FAPs, which have valuable information about military families that may better inform child welfare decisions.

Sidebar

The VA currently estimates that almost 200,000 veterans are homeless nightly, and approximately 400,000 will be homeless at some point during the course of a year.

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